



Royal Sundaram General Insurance Co. Limited

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097. Regd.

Office : 21, Patullos Road, Chennai - 600 002

Lifeline

Customer Information Sheet

CUSTOMER INFORMATION SHEET – LIFELINE

Sr. No.	TITLE	DESCRIPTION	REFER TO POLICY SECTION NUMBER
1	Product Name	Lifeline	
2	What am I covered for:	<ol style="list-style-type: none"> 1. Inpatient Care: Medical Expenses for Medical Practitioner’s fees, Diagnostic tests, Medicines, drugs and consumables, Treatment Charges, Nursing Charges, Operation Theatre charges, Intensive Care Unit charges, Intravenous fluids, blood transfusion, injection administration charges, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure. Modern Treatments will be covered upto 50% of Sum Insured. For claim under this benefit hospitalization has to be longer than 24 hours. 2. Pre-hospitalization Medical Expenses: Medical Expenses incurred due to Illness upto 30 days for Classic Plan and 60 days for Supreme & Elite Plan immediately before admission to a hospital. 3. Post-hospitalization Medical Expenses: Medical Expenses incurred due to Illness upto 60 days for Classic, 90 days for Supreme & 180 days for Elite Plan immediately post discharge from Hospital. 4. Day-Care Treatment: Medical Expenses for Day Care Treatments (including Chemotherapy, Radiotherapy, Hemodialysis, any procedure which needs a period of specialized observation or care after completion of the procedure) where such procedures are undertaken by an Insured Person as an In-patient in a Hospital/Day Care Center for a continuous period of less than 24 hours. Any procedure undertaken on an OPD Treatment basis in a Hospital/Day Care Center will not be covered. Pre and Post Hospitalization Medical expenses shall not be payable for this benefit. All Daycare treatments are covered. 5. Ambulance Cover: We will cover Reasonable & Customary Charges for ambulance expenses incurred to transfer the Insured Person by surface transport following an Emergency to the nearest Hospital. There is a sub-limit of Rs 3,000 for Classic, Rs. 5,000 for Supreme & Rs. 10,000 for Elite Plan, per hospitalization. 6. Organ Donor Expenses: Medical Expenses for an organ donor’s treatment for harvesting of the organ. 7. Domiciliary Hospitalization: Medical Expenses for medical treatment taken at home if the treatment continues for an uninterrupted period of 3 days and the condition for which treatment is taken would otherwise have 	<p>D.1</p> <p>D.2</p> <p>D.3</p> <p>D.4</p> <p>D.5</p> <p>D.6</p> <p>D.7</p>

	<p>necessitated hospitalization. Pre-Hospitalization Medical expenses are payable. However, Post-Hospitalization medical expenses are not payable.</p> <p>8. No Claim Bonus: Classic – 10% of base sum insured upto a max of 50% of base sum insured; Supreme & Elite - 20% of base sum insured upto a max of 100% of base sum insured.</p> <p>9. Re-load of Sum Insured – We will provide a Re-load of Sum Insured equal to 100% of base sum insured in case base sum insured and No Claim Bonus has been partially or completely exhausted. Re-load of sum insured can be utilized for different illness. Re-load of Sum Insured is not available for Worldwide Emergency Hospitalization and International Treatment for specified critical illness. Re-load of Sum Insured is applicable only for Baseline Cover Benefits and not for Optional Benefits.</p> <p>10. Ayush Treatment – We will cover medical expenses for Alternative Treatment taken in government hospital or in any institute recognized by the government and /or as defined under definition of AYUSH hospital in the Policy Document, upto the limit specified.</p> <p>11. Vaccination in case of Animal Bite –We will cover medical expenses for OPD treatment for vaccination or immunization for treatment post an animal bite.</p> <p>12. Health Check-up - Cost of a health check-up as per your plan eligibility subject to renewability of the policy. This benefit is over and above the Base Sum Insured</p> <p>13. Preventive Healthcare & Wellness and Disease Management – We will provide various preventive healthcare & wellness related activities like health related articles on your registered email ids. Disease Management initiative by us for our existing customers wherein for certain specified Health Risks such as Heart, Kidney, Liver, Cancer, Hypertension, Diabetes etc. our customers will be provided assistance to manage their risk better through preventive check-ups, advise on Nutrition, diet, exercise regime, wearables to monitor various health parameters etc. This will not be substitute of doctor consultation.</p> <p>14. Second Opinion for Critical Illness (Available for Supreme & Elite Plan only) – Available once during Policy period for 11 critical illness.</p> <p>15. Emergency Domestic Evacuation (Available for Supreme & Elite Plan only) – Available once during Policy Period in case of medical emergency and on advise of treating doctor. Covered upto Rs.1lakh for Supreme and Rs.3lakhs for Elite Plan.</p> <p>16. Worldwide Emergency Hospitalization (Available for Elite Plan only) – Covered upto 50% of Sum Insured or Rs.20lakhs whichever is lower, once a policy year.</p>	<p>D.8</p> <p>D.9</p> <p>D.10</p> <p>D.11</p> <p>D.12</p> <p>D.13</p> <p>D.14</p> <p>D.15</p> <p>D.16</p>
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Sum Insured	25 lakhs	30 lakhs	50 lakhs	100 lakhs	150 lakhs										
Sub Limit	2lakhs	2lakhs	2lakhs	2.50lakhs	2.50lakhs										

		<p>The Insured Person should have been Hospitalized for a minimum period of 48 hours continuously; We will not make any payment under this endorsement in respect of an Insured Person for more than 30 days of Hospitalisation in total under any Policy Year.</p> <p>Claims made in respect of this benefit will not be subject to the Sum Insured. Hospital Cash benefit is not available for hospitalization in case of Supreme Plus and Elite Plus optional covers.</p> <p>3. Include US and Canada for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illnesses. This benefit can be availed only at the inception of First Policy with Us. (available only for Elite Plan)</p> <p>4. Supreme Plus: If you opt for Supreme Plus, following benefits will be offered in additional to the base cover:</p> <p>1. Additional facility of app based cabs as a part of Ambulance Cover: We will cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital or discharge to the Hospital. This benefit is available only on reimbursement basis on the basis of submission of an invoice generated by a digital app based cab service and the invoice should mention details such as date, location of pick-up and drop and time of pick-up and drop. e.g. ola and uber. Hand-written paper invoice will not be accepted. The maximum benefit will be restricted up to sub-limit of ambulance cover applicable to your Plan. The benefit is available only for cab ride taken by the Insured Person at the time of Hospital admission or discharge. These charges are payable only if Inpatient claim is admissible.</p> <p>2. Refresh of Sum Insured: Refresh of Sum Insured is a part of Re-load of Sum Insured. Re-load benefit is payable only in case of a) Base Sum Insured and No Claim Bonus is completely exhausted. b) same Insured for Illness other than for which claims has already been paid in the same policy year. c) different Insured for the same Illness for which claims has already been paid in the same policy year.</p> <p>Refresh of Sum Insured is payable to the Same Insured person for same illness for which claim is already paid in the same policy year. Refresh of Sum Insured is available only once in Lifetime of the Policy at a Policy level. Refresh of Sum Insured is not available for Worldwide Emergency Hospitalization and International Treatment</p>	<p>Optional Endorsements -3</p> <p>Optional Endorsement - 4</p>
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		<p>for specified critical illness. Refresh of Sum Insured is applicable only for Baseline Cover Benefits and not for Optional Benefits. For triggering Refresh of Sum insured, Insured Person or immediate kin will have to provide his written consent for utilizing Refresh of Sum Insured.</p> <p>3. In-patient for Pre-existing Disease in case of Life Threatening Condition: We will cover hospitalization expenses resulting from any of the Pre-existing disease which has been specifically disclosed by you at the time of inception of the policy and has been mentioned in the Policy schedule issued to you. This benefit is available only once in the Lifetime of the Policy at a policy level. This benefit is available only on reimbursement mode. This benefit is limited to a maximum of Rs. 1,00,000.</p> <p>4. Bariatric Surgery: If You are hospitalized on the advice of a Doctor and required you to undergo Bariatric Surgery during the Policy period, then We will pay Expenses related to Bariatric Surgery. This benefit is available to Insured Person 18 years and above. Our maximum liability under this benefit will be restricted to Rs. 50,000. Any future complications arising out of bariatric treatment post-surgery will not be covered. To claim under this benefit, you should be covered under Supreme Plus for a period of 72 months without any break. At the time of claiming this benefit, Insured person should be covered under Supreme Plus.</p> <p>5. Mobility Devices</p> <ol style="list-style-type: none"> 1. We shall cover expenses incurred by Insured Person towards mobility devices such as walkers, manual wheelchair, crutches, splints, external prosthetics, slings, plasters, etc. which has been advised as a part of treatment to deal with the disability induced by an accident. These expenses can be part of in-patient or post-discharge. This is not payable in case of Pre-hospitalisation,, out-patient treatment and any sickness related claims. 2. This benefit is only available if the claim of accidental injury has been admissible by us. 3. Our maximum liability will be restricted to 5% of the Sum Insured or Rs. 50,000 whichever is lesser. <p>6. Second Opinion for additional 11 specified Critical Illnesses (Total 22 Critical Illnesses)</p> <p>Following Additional 11 Critical Illnesses are covered for Second Opinion:</p>	
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		<ol style="list-style-type: none"> 1. Angioplasty 2. Benign brain Tumor 3. Blindness 4. Deafness 5. End stage lung Failure 6. End stage liver failure 7. Loss of speech 8. Loss of limbs 9. Major head trauma 10. Primary (idiopathic) pulmonary hypertension 11. Third degree burns <p>5. Elite Plus: If you opt for Elite Plus, following benefits will be offered in additional to the base cover:</p> <ol style="list-style-type: none"> 1. Additional facility of app based cabs as a part of Ambulance Cover: We will cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital or discharge to the Hospital. This benefit is available only on reimbursement basis on the basis of submission of an invoice generated by a digital app based cab service the invoice should mention details such as date, location of pick-up and drop and time of pick-up and drop. e.g. ola and uber. Hand-written paper invoice will not be accepted. The maximum benefit will be restricted up to sub-limit of ambulance cover applicable to your Plan. The benefit is available only for cab ride taken by the Insured Person at the time of Hospital admission or discharge. These charges are payable only if Inpatient claim is admissible. 2. Refresh of Sum Insured: Refresh of Sum Insured is a part of Re-load of Sum Insured. Re-load of Sum Insured is payable only in case of a) Base Sum Insured and No Claim Bonus is completely exhausted. b) same Insured for Illness other than for which claims has already been paid in the same policy year. c) different Insured for the same Illness for which claims has already been paid in the same policy year. <p>Refresh of Sum Insured is payable to the Same Insured person for same illness for which claim is already paid in the same policy year. Refresh of Sum Insured is available only once in Lifetime of the Policy at a Policy level. Refresh of Sum Insured is not available for Worldwide Emergency Hospitalization and International Treatment for specified critical illness. Refresh of Sum Insured is applicable only for Baseline Cover Benefits and not for Optional Benefits. For triggering Refresh of Sum insured,</p>	<p>Optional Endorsement - 5</p>
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		<p>Insured Person or immediate kin will have to provide his written consent for utilizing Refresh of Sum Insured.</p> <p>3. In-patient for Pre-existing Disease in case of Life Threatening Condition: We will cover hospitalization expenses resulting from any of the Pre-existing disease which has been specifically disclosed by you at the time of inception of the policy and has been mentioned in the Policy schedule issued to you. This benefit is available only once in the Lifetime of the Policy at a policy level. This benefit is available only on reimbursement mode. This benefit is limited to a maximum of Rs. 2,00,000.</p> <p>4. Bariatric Surgery: If You are hospitalized on the advice of a Doctor and required you to undergo Bariatric Surgery during the Policy period, then We will pay Expenses related to Bariatric Surgery. This benefit is available to Insured Person 18 years and above. Our maximum liability under this benefit will be restricted to Rs. 200,000. Any future complications arising out of bariatric treatment post-surgery will not be covered. To claim under this benefit, you should be covered under Elite Plus for a period of 48 months without any break. To claim under this benefit, Insured Person should be covered under Elite Plus at the time of claim.</p> <p>5. Mobility Devices</p> <ol style="list-style-type: none"> 1. We shall cover expenses incurred by Insured Person towards mobility devices such as walkers, manual wheelchair, crutches, splints, external prosthetics, slings, plasters, etc. which has been advised as a part of treatment to deal with the disability induced by an accident. These expenses can be part of in-patient or post-discharge. This is not payable in case of only pre-hospitalisation, out-patient treatment and any sickness related claims. 2. This benefit is only available if the claim of accidental injury has been admissible by us. 3. Our maximum liability will be restricted to Rs. 50,000. <p>6. Second Opinion for additional 11 specified Critical Illnesses (Total 22 Critical Illnesses)</p> <p>Following Additional 11 Critical Illnesses are covered for Second Opinion:</p> <ol style="list-style-type: none"> 1. Angioplasty 	
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		<ol style="list-style-type: none"> 2. Benign brain Tumor 3. Blindness 4. Deafness 5. End stage lung Failure 6. End stage liver failure 7. Loss of speech 8. Loss of limbs 9. Major head trauma 10. Primary (idiopathic) pulmonary hypertension 11. Third degree burns <p style="text-align: center;">7. International Treatment abroad for 3 additional Critical illnesses (Total 14 specified critical illnesses)</p> <p>Following additional 3 Critical Illnesses are covered for International Treatment abroad:</p> <ol style="list-style-type: none"> 1. End Stage Liver Disease 2. End Stage Lung Disease 3. Third Degree burn <p style="text-align: center;">8. In-Vitro Fertilisation(IVF) Treatment</p> <p>The Company will reimburse medical expenses incurred on IVF Treatment, where indicated, for sub-fertility subject to:</p> <ol style="list-style-type: none"> a. A waiting period of 48 months from the date of inception of the Elite Plus with the Company for the insured person. b. The maximum cumulative liability in lifetime of the policy of the Company for such treatment shall be limited to Rs.2,50,000/-. c. For the purpose of claiming under this benefit, in- patient treatment is not mandatory. d. For claim under this benefit, Insured person should have opted for Elite Plus for a period of 48 months without any break. e. Re-load and Refresh of Sum Insured Benefit shall not be applicable for this benefit. f. This Benefit can be used for a maximum of 3 cycles subject to a maximum of Rs. 2,50,000 as a cumulative benefit. g. To be eligible for this benefit both husband and wife should stay insured continuously without break for a period of 48 months under Elite Plus. h. This benefit does not cover Surrogacy. i. This benefit covers intrauterine insemination (IUI), Intra-Cytoplasmic Sperm Injection (ICSI), In-Vitro Fertilisation(IVF). j. Maximum age of female member should be less than 45 years. 	
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		<ul style="list-style-type: none"> k. To claim under this benefit, we would require certificate and case history from the treating doctor which has necessitated treatment. l. Available once in lifetime of the policy for a maximum of 3 IVF cycles. m. Under this benefit, maximum of 3 cycles of the treatment as mentioned above should be utilized in maximum 3 consecutive policy years. n. At the time of claiming the benefit, Insured person should be covered under Elite Plus at the time of claim. o. Any treatment or side effects resulting in hospitalization arising as a consequence to infertility treatment is not payable. 	
	<p>What are the major exclusions in the policy:</p>	<p>Investigation & Evaluation, Rest Cure, rehabilitation and respite care, Obesity/ Weight Control, Change-of-Gender treatments, Cosmetic or plastic Surgery, Hazardous or Adventure sports, Breach of law, Excluded Providers, Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences, Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons, Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure, Refractive Error, Unproven Treatments, Sterility and Infertility, Maternity, Alternative treatment, Ancillary Hospital Charges, Charges for medical papers, Circumcision, Conflict and disaster, Congenital conditions, Convalescence and Rehabilitation, Dental/oral treatment, Drugs and dressings for OPD Treatment or take-home use, Hereditary conditions, Items of personal comfort and convenience, including but not limited to : (A)Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services (B) Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization (C) Drugs or treatment not supported by prescription etc., OPD Treatment, Preventive Care, Self-inflicted injuries, Sexual problems, Sexually transmitted diseases, Sleep disorders, Treatment for Alopecia, Treatment for developmental problems, Treatment received outside India, Artificial life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life, Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense.</p>	<p>E</p>

			Optional Endorsement-5(8)
	Payment basis	Cashless facility or reimbursement of covered expenses up to specified limits.	
	Loss Sharing	<ol style="list-style-type: none"> Top-up plan on Aggregate annual Deductible options of Rs 1 Lakh, 2 Lakhs, 3 Lakhs, 4 Lakhs, 5 Lakhs and 10 Lakhs can be availed along with premium Discount. Customer can select any available sum insured under Classic & Supreme Plan All claims of International Treatment for specified Critical Illness will be subject to 20% Co-payment 	Optional Endorsement -1 D.17(e)
	Renewal Conditions	<ul style="list-style-type: none"> This is a life-long renewal product on mutual consent subject to application of Renewal and realization of renewal premium The Waiting Periods mentioned in the Policy wording will get reduced by 1 year with every continuous renewal of your Health Insurance Policy. There is no maximum cover ceasing age in this Policy. Renewal premium is subject to change with prior approval from IRDAI. There will be no underwriting on Policy renewal. The first year underwriting results will continue if the policy is continued without a break. Alterations in the policy such as Increase/ decrease in Sum Insured or Change in Plan/Product, addition/ deletion of members, addition deletion of Medical Condition will be allowed at the time of Renewal of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing policy will not be altered We will allow a grace period of 30 days in case of one year, 2 years, 3 years policies and 15 days in case monthly, quarterly, half-yearly mode from the due date of the renewal premium for payment to us. In case of monthly mode, two instances of grace period are allowed and in case of quarterly and half-yearly, only one instance of grace period is allowed. Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation, fraud, non-disclosure or non-cooperation from the insured <p>Renewal of Policy The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.</p>	F.1.10 & F.2.13

		<ol style="list-style-type: none"> i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal. ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years. iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days in case of one year and 15 days in case of monthly, quarterly and half- yearly payments to maintain continuity of benefits without break in policy. Coverage is not available during the grace period. v. No loading shall apply on renewals based on individual claims experience 																																									
	Renewal benefits	<ul style="list-style-type: none"> • Classic – 10% of base sum insured upto a max of 50% of base sum insured; Supreme & Elite - 20% of base sum insured upto a max of 100% of base sum insured. • There will not be any reduction in No Claim Bonus as a result of claim by the Insured Person in any Policy year • For Classic- Health Check-up is available once in 2 years • For Supreme and Elite- health check-up is available every year. 	D.8																																								
	Cancellation	<p>i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.</p> <table border="1"> <thead> <tr> <th>Cancellation date upto (x months)</th> <th>1</th> <th>2</th> <th>3</th> </tr> </thead> <tbody> <tr> <td>Upto 1 month</td> <td>75%</td> <td>87%</td> <td>91%</td> </tr> <tr> <td>Upto 3 months</td> <td>50%</td> <td>74%</td> <td>82%</td> </tr> <tr> <td>Upto 6 months</td> <td>25%</td> <td>61.5%</td> <td>73.5%</td> </tr> <tr> <td>Upto 12 months</td> <td>0%</td> <td>48.5%</td> <td>64.5%</td> </tr> <tr> <td>Upto 15 months</td> <td>NA</td> <td>24.5%</td> <td>47%</td> </tr> <tr> <td>Upto 18 months</td> <td>NA</td> <td>12%</td> <td>38.5%</td> </tr> <tr> <td>Upto 24 months</td> <td>NA</td> <td>0%</td> <td>30%</td> </tr> <tr> <td>Upto 30 months</td> <td>NA</td> <td>NA</td> <td>8%</td> </tr> <tr> <td>Beyond 30 months</td> <td>NA</td> <td>NA</td> <td>0%</td> </tr> </tbody> </table> <p>Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation</p>	Cancellation date upto (x months)	1	2	3	Upto 1 month	75%	87%	91%	Upto 3 months	50%	74%	82%	Upto 6 months	25%	61.5%	73.5%	Upto 12 months	0%	48.5%	64.5%	Upto 15 months	NA	24.5%	47%	Upto 18 months	NA	12%	38.5%	Upto 24 months	NA	0%	30%	Upto 30 months	NA	NA	8%	Beyond 30 months	NA	NA	0%	F.1.7
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		<p>where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.</p> <p>i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.</p> <p>For half- yearly payment mode</p> <p>Upto 90 days- 50% Refund</p> <p>Post 90 days- Nil</p> <p>For Quarterly payment mode</p> <p>Upto 30 days- 50%</p> <p>After 30 days- Nil</p> <p>For Monthly payment Mode</p> <p>Cancellation- No refund</p> <p>Automatic Cancellation:</p> <p>a. Individual Policy:</p> <p>The Policy shall automatically terminate on death of the Insured Person .</p> <p>b. Family Floater Policies:</p> <p>The Policy shall automatically terminate in the event of the death of all the Insured Persons.</p> <p>c. Refund:</p> <p>A refund in accordance with the table in Section F.1.7 above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.</p>	
	<p>Claims</p>	<p>For cashless service – weblink of network hospital royalsundaram.in/health-insurance</p> <p>Intimation – Before 3 days in case of planned hospitalisation and within 2 days of admission in case of emergency hospitalisation.</p>	<p>G</p>

		Claim Document submission: within 30 days from the date of discharge.	
	Policy Servicing/ Grievances/Complaints	<p>Grievances/Complaints -Company Officials: Mr. T M Shyamsunder – Grievance Redressal Officer</p> <p>IRDAI/(IGMS/Call Centre): - https://igms.irda.gov.in/ - IRDA Grievance toll-free number: 155255</p> <ul style="list-style-type: none"> • Ombudsman Details– Please refer Annexure 1 to Customer Information Sheet 	F.1.16
	Insured's Rights	<p>Free Look: The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.</p> <p>The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.</p> <p>If the insured has not made any claim during the Free Look Period, the insured shall be entitled to</p> <ol style="list-style-type: none"> a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; <p>Implied renewability: Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.</p> <ul style="list-style-type: none"> • Migration and Portability related queries please email us at healthpolicy.helpdesk@royalsundaram.in and write us at: <p>Royal Sundaram Insurance Co. Ltd.</p>	F.1.15



Royal Sundaram General Insurance Co. Limited

(Formerly known as Royal Sundaram Alliance Insurance Company Limited)

Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097. Regd.

Office : 21, Patullos Road, Chennai - 600 002

Lifeline

Customer Information Sheet

		<p>2nd Floor, Delphi C-wing, Hiranandani Business Park, Powai, Mumbai- 400076</p> <ul style="list-style-type: none"> • Increase in SI during the Policy term is not allowed. • Turn Around Time (TAT) for issue of PreAuth and settlement of Reimbursement <p>Cashless - 3 hours from time of receipt of all requisite documents Reimbursement – 21 days from the date of receipt of all requisite documents</p> <p>Customer has an option to choose installment payment options i.e. Monthly, quarterly and half-yearly mode.</p>	
	Insured's Obligations	<ul style="list-style-type: none"> • Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid. • Disclosure of Material Information during the policy period such as change in occupation 	
	Policy Tenure	1 year / 2 years / 3 years	

Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.



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Lifeline

Customer Information Sheet

Lifeline Premium Excluding GST

Benefit illustration in respect of policies offered on individual and family floater basis

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)	Sum Insured (Rs.)	Coverage opted on individual basis covering multiple member of the family under single policy (sum insured is available for each member of the family)	Discount if any	Premium after Discount	Sum Insured (Rs.)	Coverage opted on family floater basis with overall sum insured (Only one sum insured is available for entire family)			Coverage opted on family floater basis with overall sum insured (Only one sum insured is available for entire family)					
							Premium (Rs.)	Floater Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Floater Discount, if any	Premium after discount (Rs.)		
Individual															
							2 Adult			2 Adult 2 Child					
							Premium (Rs.)	Floater Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Floater Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	
18	₹ 3,523	2 lakh Classic	NA	NA	NA	NA	₹ 5,312	₹ 0	₹ 5,312	2 lakh Classic	₹ 9,864	₹ 0	₹ 9,864	2 lakh Classic	
25	₹ 3,740	2 lakh Classic	NA	NA	NA	NA	₹ 5,468	₹ 0	₹ 5,468	2 lakh Classic	₹ 10,024	₹ 0	₹ 10,024	2 lakh Classic	
35	₹ 5,286	2 lakh Classic	NA	NA	NA	NA	₹ 7,288	₹ 0	₹ 7,288	2 lakh Classic	₹ 12,534	₹ 0	₹ 12,534	2 lakh Classic	
45	₹ 9,175	2 lakh Classic	NA	NA	NA	NA	₹ 12,328	₹ 0	₹ 12,328	2 lakh Classic	₹ 17,548	₹ 0	₹ 17,548	2 lakh Classic	
55	₹ 16,438	2 lakh Classic	NA	NA	NA	NA	₹ 22,145	₹ 0	₹ 22,145	2 lakh Classic	₹ 27,315	₹ 0	₹ 27,315	2 lakh Classic	
65	₹ 28,108	2 lakh Classic	NA	NA	NA	NA	₹ 38,296	₹ 0	₹ 38,296	2 lakh Classic	₹ 43,382	₹ 0	₹ 43,382	2 lakh Classic	
70	₹ 35,918	2 lakh Classic	NA	NA	NA	NA	₹ 49,232	₹ 0	₹ 49,232	2 lakh Classic	₹ 54,262	₹ 0	₹ 54,262	2 lakh Classic	
2 Adult															
18	₹ 4,404	4 lakh Classic	NA	NA	NA	NA	₹ 6,640	₹ 0	₹ 6,640	4 lakh Classic	₹ 11,097	₹ 0	₹ 11,097	4 lakh Classic	
25	₹ 4,675	4 lakh Classic	NA	NA	NA	NA	₹ 6,835	₹ 0	₹ 6,835	4 lakh Classic	₹ 11,295	₹ 0	₹ 11,295	4 lakh Classic	
35	₹ 6,608	4 lakh Classic	NA	NA	NA	NA	₹ 9,110	₹ 0	₹ 9,110	4 lakh Classic	₹ 14,347	₹ 0	₹ 14,347	4 lakh Classic	
45	₹ 11,469	4 lakh Classic	NA	NA	NA	NA	₹ 15,410	₹ 0	₹ 15,410	4 lakh Classic	₹ 20,614	₹ 0	₹ 20,614	4 lakh Classic	
55	₹ 20,548	4 lakh Classic	NA	NA	NA	NA	₹ 27,682	₹ 0	₹ 27,682	4 lakh Classic	₹ 32,823	₹ 0	₹ 32,823	4 lakh Classic	
65	₹ 35,135	4 lakh Classic	NA	NA	NA	NA	₹ 47,870	₹ 0	₹ 47,870	4 lakh Classic	₹ 52,906	₹ 0	₹ 52,906	4 lakh Classic	
70	₹ 44,898	4 lakh Classic	NA	NA	NA	NA	₹ 61,541	₹ 0	₹ 61,541	4 lakh Classic	₹ 66,506	₹ 0	₹ 66,506	4 lakh Classic	
5 lakh Supreme															
18	₹ 4,570	5 lakh Supreme	NA	NA	NA	NA	₹ 6,891	₹ 0	₹ 6,891	5 lakh Supreme	₹ 11,320	₹ 0	₹ 11,320	5 lakh Supreme	
25	₹ 4,852	5 lakh Supreme	NA	NA	NA	NA	₹ 7,094	₹ 0	₹ 7,094	5 lakh Supreme	₹ 11,525	₹ 0	₹ 11,525	5 lakh Supreme	
35	₹ 6,858	5 lakh Supreme	NA	NA	NA	NA	₹ 9,454	₹ 0	₹ 9,454	5 lakh Supreme	₹ 14,678	₹ 0	₹ 14,678	5 lakh Supreme	
45	₹ 11,902	5 lakh Supreme	NA	NA	NA	NA	₹ 15,993	₹ 0	₹ 15,993	5 lakh Supreme	₹ 21,183	₹ 0	₹ 21,183	5 lakh Supreme	
55	₹ 21,325	5 lakh Supreme	NA	NA	NA	NA	₹ 28,728	₹ 0	₹ 28,728	5 lakh Supreme	₹ 33,852	₹ 0	₹ 33,852	5 lakh Supreme	
65	₹ 36,463	5 lakh Supreme	NA	NA	NA	NA	₹ 49,679	₹ 0	₹ 49,679	5 lakh Supreme	₹ 54,695	₹ 0	₹ 54,695	5 lakh Supreme	
70	₹ 46,595	5 lakh Supreme	NA	NA	NA	NA	₹ 64,324	₹ 0	₹ 64,324	5 lakh Supreme	₹ 68,809	₹ 0	₹ 68,809	5 lakh Supreme	
10 lakh Supreme															
18	₹ 5,976	10 lakh Supreme	NA	NA	NA	NA	₹ 9,011	₹ 0	₹ 9,011	10 lakh Supreme	₹ 13,288	₹ 0	₹ 13,288	10 lakh Supreme	
25	₹ 6,345	10 lakh Supreme	NA	NA	NA	NA	₹ 9,869	₹ 0	₹ 9,869	10 lakh Supreme	₹ 13,611	₹ 0	₹ 13,611	10 lakh Supreme	
35	₹ 8,968	10 lakh Supreme	NA	NA	NA	NA	₹ 12,363	₹ 0	₹ 12,363	10 lakh Supreme	₹ 17,572	₹ 0	₹ 17,572	10 lakh Supreme	
45	₹ 15,564	10 lakh Supreme	NA	NA	NA	NA	₹ 20,913	₹ 0	₹ 20,913	10 lakh Supreme	₹ 26,078	₹ 0	₹ 26,078	10 lakh Supreme	
55	₹ 27,886	10 lakh Supreme	NA	NA	NA	NA	₹ 37,568	₹ 0	₹ 37,568	10 lakh Supreme	₹ 42,646	₹ 0	₹ 42,646	10 lakh Supreme	
65	₹ 47,683	10 lakh Supreme	NA	NA	NA	NA	₹ 64,965	₹ 0	₹ 64,965	10 lakh Supreme	₹ 69,902	₹ 0	₹ 69,902	10 lakh Supreme	
70	₹ 60,932	10 lakh Supreme	NA	NA	NA	NA	₹ 83,518	₹ 0	₹ 83,518	10 lakh Supreme	₹ 88,359	₹ 0	₹ 88,359	10 lakh Supreme	
50 lakh Elite															
18	₹ 37,723	50 lakh Elite	NA	NA	NA	NA	₹ 50,334	₹ 0	₹ 50,334	50 lakh Elite	₹ 76,065	₹ 0	₹ 76,065	50 lakh Elite	
25	₹ 42,480	50 lakh Elite	NA	NA	NA	NA	₹ 55,857	₹ 0	₹ 55,857	50 lakh Elite	₹ 80,705	₹ 0	₹ 80,705	50 lakh Elite	
35	₹ 47,789	50 lakh Elite	NA	NA	NA	NA	₹ 66,475	₹ 0	₹ 66,475	50 lakh Elite	₹ 91,323	₹ 0	₹ 91,323	50 lakh Elite	
45	₹ 59,772	50 lakh Elite	NA	NA	NA	NA	₹ 81,820	₹ 0	₹ 81,820	50 lakh Elite	₹ 105,289	₹ 0	₹ 105,289	50 lakh Elite	
55	₹ 83,557	50 lakh Elite	NA	NA	NA	NA	₹ 120,510	₹ 0	₹ 120,510	50 lakh Elite	₹ 143,589	₹ 0	₹ 143,589	50 lakh Elite	
65	₹ 122,160	50 lakh Elite	NA	NA	NA	NA	₹ 204,673	₹ 0	₹ 204,673	50 lakh Elite	₹ 227,752	₹ 0	₹ 227,752	50 lakh Elite	
70	₹ 156,011	50 lakh Elite	NA	NA	NA	NA	₹ 250,029	₹ 0	₹ 250,029	50 lakh Elite	₹ 267,551	₹ 0	₹ 267,551	50 lakh Elite	
150 lakh Elite															
18	₹ 46,080	150 lakh Elite	NA	NA	NA	NA	₹ 65,404	₹ 0	₹ 65,404	150 lakh Elite	₹ 99,401	₹ 0	₹ 99,401	150 lakh Elite	
25	₹ 56,229	150 lakh Elite	NA	NA	NA	NA	₹ 73,709	₹ 0	₹ 73,709	150 lakh Elite	₹ 105,239	₹ 0	₹ 105,239	150 lakh Elite	
35	₹ 68,543	150 lakh Elite	NA	NA	NA	NA	₹ 82,226	₹ 0	₹ 82,226	150 lakh Elite	₹ 113,756	₹ 0	₹ 113,756	150 lakh Elite	
45	₹ 83,554	150 lakh Elite	NA	NA	NA	NA	₹ 107,347	₹ 0	₹ 107,347	150 lakh Elite	₹ 136,616	₹ 0	₹ 136,616	150 lakh Elite	
55	₹ 102,035	150 lakh Elite	NA	NA	NA	NA	₹ 145,448	₹ 0	₹ 145,448	150 lakh Elite	₹ 176,541	₹ 0	₹ 176,541	150 lakh Elite	
65	₹ 146,778	150 lakh Elite	NA	NA	NA	NA	₹ 238,801	₹ 0	₹ 238,801	150 lakh Elite	₹ 269,894	₹ 0	₹ 269,894	150 lakh Elite	
70	₹ 189,405	150 lakh Elite	NA	NA	NA	NA	₹ 295,919	₹ 0	₹ 295,919	150 lakh Elite	₹ 327,543	₹ 0	₹ 327,543	150 lakh Elite	
Total premium for all members of the policy (2Adult with ages 25 years and 2 children with age < 18 yrs=4 members in all) is Rs.14526/-.		NA		NA		NA		NA		NA		NA		Total premium when policy opted on a floater basis is Rs.10024/-.	
Sum Insured available for each individual is Rs.2 lakhs		NA		NA		NA		NA		NA		NA		Sum Insured of Rs.2 lakhs is available for the entire family	



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B Preamble

The insurance cover provided under this Policy to the Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium, and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) for Yourself and on behalf of all persons to be insured. Please inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting You or any Insured Person.

If any Claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any).

C Definitions

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural, references to the male include the female and references to any statutory enactment include subsequent changes to the same:

C.1 Standard Definitions

C.1.1 Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.1.2 AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

C.1.3 AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- a) Central or State Government AYUSH Hospital; or
- b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or


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- c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion :
- i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

C.1.4 Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved.

C.1.5 Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

C.1.6 Congenital Anomaly refers to a condition (s) which is present since birth, and which is abnormal with reference to form, structure or position.

- a) Internal Congenital Anomaly : Which is not in the visible and accessible parts of the body
- b) External Congenital Anomaly: Which is in the visible and accessible parts of the body

C.1.7 Co-payment means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

C.1.8 Critical Illness means the following:

1. CANCER OF SPECIFIED SEVERITY

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0



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- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukaemia less than RAI stage 3
- vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- ix. All tumors in the presence of HIV infection.

2. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

- i. Other acute Coronary Syndromes
- ii. Any type of angina pectoris
- iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

- i. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES



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I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- i. no response to external stimuli continuously for at least 96 hours;
- ii. life support measures are necessary to sustain life; and
- iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

- i. Transient ischemic attacks (TIA)
- ii. Traumatic injury of the brain
- iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:



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- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

C.1.9 Cumulative Bonus (No Claim Bonus) means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

C.1.10 Day Care Center:

A day care centre means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up within a Hospital and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-



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- i. has qualified nursing staff under its employment;
- ii. has qualified medical practitioner (s) in charge;
- iii. had a fully equipped operation theatre of its own where surgical procedures are carried out;
- iv. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

C.1.11 Day Care Treatment

Day care Treatment means medical treatment, and/or surgical procedure which is:

- i) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement and;
- ii) which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

C.1.12 Deductible

Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

C.1.13 Disclosure to Information Norm: The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

C.1.14 Domiciliary Hospitalisation: means medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital or;
- the patient takes treatment at home on account of non availability of room in a hospital.

C.1.15 Emergency Care means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

C.1.16 Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

C.1.17 Hospital means any institution established for Inpatient care and Day Care Treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

- i. has Qualified Nursing staff under its employment round the clock;
- ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and atleast 15 inpatient beds in all other places;



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- iii. has qualified Medical Practitioner (s) in charge round the clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with Section D.16 and Section D.17, **Hospital (outside India)** means an institution (including nursing homes) established outside India for indoor medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

C.1.18 Hospitalization means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

C.1.19 Illness means sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

- i. Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
- ii. Chronic condition- A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-
 1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
 2. it needs ongoing or long-term control or relief of symptoms
 3. it requires your rehabilitation for You or for you to be specifically trained to cope with it
 4. it continues indefinitely –
 5. it comes back or is likely to come back.

C.1.20 Injury: Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

C.1.21 Inpatient Care means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

C.1.22 ICU Charges

ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges .



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C.1.23 Maternity Expenses

Maternity expenses means—

- a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization)
- b) expenses towards lawful medical termination of pregnancy during the Policy Period

C.1.24 Medical Advice:

Medical advice means Any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

C.1.25 Medical Expenses:

Medical expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

C.1.26 Medical Practitioner: A Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy setup by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. It excludes the treatment by a doctor who is an immediate family member i.e. self, spouse, children and parents)

C.1.27 Medically Necessary Treatment: Medically necessary treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

- a) is required for the medical management of the Illness or injury suffered by the insured;
- b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- c) must have been prescribed by a Medical Practitioner;
- d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

C.1.28 Migration means, the right accorded to health insurance policy holders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

C.1.29 Network Provider means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

C.1.30 New Born Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

C.1.31 Non-Network means any Hospital, Day Care Centre or other provider that is not part of the Network.

C.1.32 Notification of Claim

Notification of claim means the the process of intimating a claim to the insurer or TPA by through any of the recognized modes of communication



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C.1.33 OPD Treatment is one in which the Insured Person visits a clinic/ hospital, or associated facility like a consultation room, for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-Patient.

C.1.34 Portability means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

C.1.35 Post-hospitalization Medical Expenses

Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required and;
- ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

C.1.36 Pre-Existing Disease ():

Pre-existing disease means any condition, ailment, injury or disease

- (a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
- (b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

C.1.37 Pre-hospitalization Medical Expenses

Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

- I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required and;
- II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

C.1.38 Qualified Nurse

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

C.1.39 Reasonable and Customary Charges

Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / injury involved.

C.1.40 Renewal

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.



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C.1.41 Room rent

Room rent means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

C.1.42 Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

C.1.43 Unproven/Experimental treatment: Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

C.2 Specific Definitions

C.2.1 Accidental means sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.2.2 Alternative Treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

C.2.3 Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date.

C.2.4 Base Sum Insured means the amount specified as Sum Insured at the inception of a Policy Year and in the event the Policy is upgraded or downgraded on any continuous Renewal, then exclusive of Cumulative Bonus, if any, the Sum Insured for which premium is paid at the commencement of the Policy Year for which the prevalent upgrade or downgrade is sought.

C.2.5 Diagnostic Tests: Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

C.2.6 Emergency means a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

C.2.7 Family Floater Policy means a Policy in terms of which, two or more persons of a Family are named in the Schedule of Insurance Certificate as Insured Persons. In a Family Floater Policy, Family means a unit comprising of upto six members who are related to each other in the following manner:

- i) Legally married husband and wife as long as they continues to be married; and/or
- ii) Up-to four of their children who are less than 25 years on the date of commencement of the cover under the Policy.

C.2.8 Hospitalized means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

C.2.9 Individual Policy means a Policy in terms of which only one person is named in the Schedule of Insurance Certificate as Insured Person.



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- C.2.10 Information Summary Sheet** means the record and confirmation of information provided to Us or Our representatives over the telephone for the purposes of applying for this Policy.
- C.2.11 Inpatient** means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.
- C.2.12 Insured Person** means person named as insured in the Schedule of Insurance Certificate. Any Family member may be added as an Insured Person during the Policy Period if We have accepted his application for insurance and issued an endorsement confirming the addition of such person as an Insured Person.
- C.2.13 Policy** means these terms and conditions, any annexure thereto and the Schedule of Insurance Certificate (as amended from time to time), Your statements in the proposal form and the Information Summary Sheet and the policy wording (including endorsements, if any).
- C.2.14 Policy Period** means the period between the date of commencement and the expiry date specified shown in the Schedule of Insurance Certificate.
- C.2.15 Policy Year** means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.
- C.2.16 Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.
- C.2.17 Rehabilitation:** Treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.
- C.2.18 Re-load Sum Insured** means the restoration of hundred percent of the Base Sum Insured in accordance with Section D.9 (Re-load of Sum Insured) of the Policy.
- C.2.19 Schedule of Insurance Certificate** means the schedule provided in the insurance certificate issued by Us, and, if more than one, then the latest in time.
- C.2.20 Sum Insured** means the sum shown in the Schedule of Insurance Certificate which represents Our maximum total and cumulative liability for any and all claims under the Policy during the Policy Year.
- C.2.21 Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
- C.2.22 We/Our/Us** means Royal Sundaram General Insurance Co. Limited.
- C.2.23 Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously relieved without any break.
- C.2.24 You/Your/Policyholder** means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us.

Any reference to any statute shall be deemed to refer to any replacement or amendment to that statute.

D Benefits covered under the policy



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The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the Product Benefits Table, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for in the Product Benefits Table and as shown in the Schedule of Insurance Certificate :

D.1 Inpatient Care

We will cover Medical Expenses for:

- (a) Medical Practitioners' fees;
- (b) Room Rent, boarding expenses;
- (c) Intensive Care Unit charges;
- (d) Diagnostics Procedures charges;
- (e) Medicines, drugs and consumables;
- (f) Treatment Charges
- (g) Nursing Charges;
- (h) Intravenous fluids, blood transfusion, injection administration charges;
- (i) Anesthesia, Blood, Oxygen, Operation theatre charges, surgical appliances;
- (j) The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.
- (k) Modern Treatments: The following procedures will be covered (whichever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:
 - a. Uterine Artery Embolization and HIFU
 - b. Balloon Sinuplasty
 - c. Deep Brain stimulation
 - d. Oral chemotherapy
 - e. Immunotherapy- Monoclonal Antibody to be given as injection



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- f. Intra vitreal injections
- g. Robotic surgeries
- h. Stereotactic radio surgeries
- i. Bronchical Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- k. IONM - (Intra Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

D.2 Pre-hospitalization Medical Expenses

We will, on a reimbursement basis cover expenses for consultations, investigations and medicines of an Insured Person which are incurred due to an Accident, Injury or Illness immediately prior to the Insured Person's date of Hospitalization up to the limits specified in the Product Benefits Table, provided that a claim has been admitted under Inpatient Care under Section D.1 above and is related to same illness/condition.

D.3 Post-hospitalization Medical Expenses

We will, on a reimbursement basis cover expenses for consultations, investigations and medicines of an Insured Person which are incurred due to an Accident, Injury or Illness immediately post discharge of the Insured Person's from the Hospital up to the limits specified in the Schedule, provided that a claim has been admitted under Inpatient Care under Section D.1 above and is related to same illness/condition.

D.4 Day Care Treatment

We will cover Medical Expenses of an Insured Person in case of Medically Necessary Day Care Treatment or Surgery that require less than 24 hours Hospitalization due to advancement in technology and which is undertaken in a Hospital/Day Care Center on the recommendation of a Medical Practitioner. Any OPD Treatment undertaken in a Hospital/Day Care Center will not be covered. Pre and Post Hospitalization Medical Expenses are not payable under this benefit. All Day Care Procedures are covered.

D.5 Ambulance Cover

We will cover Reasonable and Customary Charges for ambulance expenses up to the limit specified in Product Benefit Table that are incurred towards transportation of an Insured Person by surface transport following an Emergency to the nearest Hospital with adequate facilities. These charges are payable if:

- (a) The ambulance service is offered by a healthcare or ambulance service provider; and



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- (b) We have accepted an Inpatient Care claim under the provisions of Section D.1 above.

D.6 Organ Donor Expenses

We will cover Inpatient Care Medical Expenses towards the donor for the harvesting of the organ donated provided that:

- (a) the organ donor is any person in accordance with the Transplantation of Human Organs Act, 1994 and other applicable laws.
- (b) the organ donated is for the use of the Insured Person who has been asked to undergo an organ transplantation on Medical Advise;
- (c) We have admitted a claim under Section D.1 towards Inpatient Care. Organ donor expenses will be covered within the sum insured for the patient (who is undergoing the transplant)

We will not cover:

- (a) Pre-hospitalization or Post-hospitalization Medical Expenses or screening expenses of the donor or any other Medical Expenses as a result of the harvesting from the donor;
- (b) Costs directly or indirectly associated with the acquisition of the donor's organ;
- (c) Any other medical treatment or complication in respect of donor, consequent to harvesting.

D.7 Domiciliary Hospitalization

We will cover Medical Expenses for medical treatment taken at home if this continues for an uninterrupted period of 3 days and the condition for which treatment is taken would otherwise have necessitated Hospitalization as long as either (i) the attending Medical Practitioner confirms that the Insured Person could not be transferred to a Hospital or (ii) the Insured Person satisfies Us that a Hospital bed was unavailable.

If a claim has been accepted under this Benefit, the claims for Pre-hospitalization Medical Expenses shall be payable, However, Post-hospitalization Medical Expenses shall not be payable.

D.8 No Claim Bonus

We will increase Your Sum Insured by 10% of Base Sum Insured per Policy Year upto a maximum of 50% of Base Sum Insured of renewed Policy for Classic Plan and 20% of Base Sum Insured per Policy Year upto a maximum of 100% of Base Sum Insured of renewed Policy for Supreme and Elite plan, if the Policy is renewed with Us provided that there are no claims paid/outstanding in the expiring Policy Year by any Insured Person:

- You understand and agree that the sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in total Sum Insured;
- Any earned No Claim Bonus will not be reduced for claims made in the future;

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- You will not earn No Claim Bonus on Policy Renewal if any claim is made in expiring Policy Year. However, if there is no claim made in subsequent Policy Year, You will earn No Claim Bonus on Renewal as per the plan;
- If two or more Individual Policies of Lifeline are renewed as Family Floater Policy, then the No Claim Bonus of each member under Individual policies to be carried forward for credit in the Floater policy shall be least No Claim Bonus available amongst the Insured Persons in their expired Individual Policies.
- No Claim Bonus which is accrued during the claim free year will be available to those Insured Persons who were insured in such claim free year and continued to be insured in the subsequent Policy Year;
- If the Base Sum Insured is increased/decreased, No Claim Bonus will be calculated on the basis of Base Sum Insured of the last completed Policy Year and will be capped to max No Claim Bonus allowed for renewed plan Base Sum Insured;
- No Claim Bonus shall be applicable on an annual basis subject to the continuation of the Policy;
- The entire No Claim Bonus will be forfeited if the Policy is not continued/renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later.

D.9 Re-load of Sum Insured

We will provide a 100% Re-load of Sum Insured once in a Policy Year, provided that:

- a) the Base Sum Insured and No Claim Bonus (if any) is insufficient as a result of previous claims in that Policy Year;
- b) The Re-load Sum Insured shall not be available for claims towards an Illness/Disease/Injury (including complications) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person under Inpatient Care under Section D.1;
- c) The Re-load of Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section D of the policy and shall not apply to the first claim in the Policy Year;
- d) The Reload of Sum Insured shall not be available for claims towards an Illness/Disease/Injury (including complications) under Worldwide Emergency Hospitalization under Section D.16 and International Treatment abroad for specified Critical Illness under Section D.17;
- e) The Re-load Sum Insured will not be considered while calculating the No Claim Bonus;
- f) In the policy is issued on a floater basis, the Re-load Sum Insured will also be available on the floater basis;
- g) If the Re-load Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
- h) Re-load of Sum Insured is applicable only for Baseline Cover benefits and not for optional benefits



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For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:

- i. The Sum Insured
- ii. No Claim Bonus

During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:

- i. The Sum Insured
- ii. No Claim Bonus
- iii. Re-load Sum Insured

D.10 Ayush Treatment

We will reimburse the Medical Expenses incurred for Inpatient Care taken under Alternative Treatment in

- a) Central or State Government AYUSH Hospital; or
- b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner. Our maximum liability will be limited up to the amount provided in the Product Benefits Table.

Exclusion E 2.1 i.e. Alternative Treatment does not apply to this benefit.

D.11 Vaccination in case of Animal Bite

We will cover Medical Expenses of OPD Treatment for vaccinations including inoculation and immunizations in case of post-bite treatment. Our maximum liability will be limited up to the amount provided in the Product Benefits Table. This benefit is available only on reimbursement basis.

D.12 Health Checkup

We will arrange for a health checkup as per Your plan eligibility as defined in the Product Benefits Table provided that You or any Insured Person has requested for the same. We will cover health check-ups arranged by Us through Our empanelled Network Provider, provided that:

- i. This benefit shall be available only to those Insured Persons that are age 18 years or above on the Policy Period Start Date provided further that this benefit shall not be available to those Insured Person who is covered under the Policy as the Policyholder's child;
- ii. For Classic plan– every 2nd consecutive renewal; For Supreme, & Elite, Plan– Available at each renewal. This is available post payment of premium.



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- iii. This benefit is provided irrespective of any claim being made in the Policy Year.
- iv. This benefit is over and above the Base Sum Insured.

D.13 Preventive Healthcare & Wellness and Disease Management

We will provide various preventive healthcare & wellness related activities like health related articles on your registered email ids. Disease Management initiative by us for our existing customers wherein for certain specified Health Risks such as Heart, Kidney, Liver, Cancer, Hypertension, Diabetes etc. our customers will be provided assistance to manage their risk better through preventive check-ups, advise on Nutrition, diet, exercise regime, wearables to monitor various health parameters etc. Any information provided under this will be recommendatory in nature and will not be substitute of doctor consultation.

D.14 Second Opinion for Critical Illness (For Supreme and Elite Plan only)

We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the Critical Illness during the Policy Period. The expert opinion would be directly sent to the Insured Person.

You understand and agree that You can exercise the option to secure a second opinion, provided:

- i. We have received a request from You to exercise this option;
- ii. The second opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner;
- iii. This benefit can be availed once by an Insured Person during a Policy Year and once during the lifetime of an Insured Person for the same illness;
- iv. This benefit shall be available only to those Insured Persons that are age 18 years or above on the Policy Period Start Date provided further that this benefit shall not be available to those Insured Person who is covered under the Policy as the Policyholder's child;
- v. This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;
- vi. The Insured Person is free to choose whether or not to obtain the second opinion, and if obtained then whether or not to act on it;
- vii. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any second opinion or for any consequence of actions taken or not taken in reliance thereon;
- viii. The second opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medical legal purposes;



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- ix. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by Medical Practitioner;
- x. For the purpose of this benefit covered Critical Illness shall include:
 1. Cancer of Specified Severity
 2. First Heart Attack of Specified Severity
 3. Open Chest CABG
 4. Open Heart Replacement or Repair of Heart Valves
 5. Coma of Specified Severity
 6. Kidney Failure requiring Regular Dialysis
 7. Stroke resulting in Permanent Symptoms
 8. Major Organ/Bone Marrow Transplant
 9. Permanent paralysis of Limbs
 10. Motor Neurone Disease with Permanent Symptoms
 11. Multiple Sclerosis with Persisting Symptoms

D.15 Emergency Domestic Evacuation (For Supreme & Elite Plan only)

We will reimburse You for Your reasonable & necessary transportation from one Hospital to another Hospital in case of life threatening emergency condition for treatment of an Illness or Injury which is admissible and payable under the Policy, subject to:

- i. Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition;
- ii. Our maximum liability will be limited to the limits specified in Product Benefits Table;
- iii. You understand and agree that any expenses over and above the limits specified, You will have to make the payment directly to the service provider;
- iv. It is hereby agreed and understood that service provided by the Service Provider under this benefit, We make no representation and/or give no guarantee and/or assume no responsibility for the appropriateness, quality or effectiveness of the service sought or provided. The Emergency Domestic Evacuation service shall be on best efforts basis;
- v. This benefit can be availed once by an Insured Person during a Policy Year.
- vi. This benefit is on per Insured Person basis.

D.16 Worldwide Emergency Hospitalization (excluding US and Canada) (For Elite Plan only)

We will cover Medical Expenses of the Insured Person incurred outside India, up to limits specified in the Product Benefits Table, provided that:



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- a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such cannot be postponed until the Insured Person has returned to the India and is payable under Section D.1 of the Policy;
- b) The Medical Expenses payable shall be limited to Inpatient Hospitalization only;
- c) Any payment under this Benefit will only in Indian rupees on a cashless or re-imbursment basis;
- d) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion;
- e) Each admissible claim will be subject to a deductible of USD 1,000;
- f) Our overall liability will be limited to 50% of Sum Insured upto a max of Rs.20 lakhs;
- g) This benefit is available Worldwide excluding US and Canada.
- h) Re-load of Sum Insured will not be available for this benefit;
- i) This benefit is available as cashless facility through pre-authorization by Our Service Provider as well as re-imbursment basis through Us. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;
 - a. In the event of an Emergency, the Insured Person or Network Hospital shall call Our Service Provider immediately, on the helpline number specified in the Insured Person's Schedule of Insurance Certificate, requesting for a pre-authorization for the medical treatment required;
 - b. Our Service Provider will evaluate the request and the eligibility of the Insured Person under the Policy and call for more information or details, if required;
 - c. Our Service Provider will communicate directly to the Hospital whether the request for pre-authorization has been approved or denied;
 - d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider shall be borne by the Insured Person;
 - e. It is agreed and understood that We shall not cover any costs or expenses incurred in relation any persons accompanying the Insured Person during the period of Hospitalization, even if such persons are also Insured Persons.
- j) It is hereby agreed and understood that pre-authorization under this benefit shall be provided by Service Provider and we shall make our best endeavours to ensure that services are provided in a prompt and efficient manner.



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k) Exclusion E.2.20 i.e. Treatment received outside India does not apply to this benefit.

D.17 International Treatment for 11 specified Critical Illness (excluding US and Canada) (For Elite Plan only)

We will cover Reasonable & Customary Medical Expenses of the Insured Person incurred outside India for treatment of 11 specified Critical Illness if the Insured Person suffers from any of these 11 Critical Illness during the Policy Period and while the Policy is in force, provided that:

- (a) The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of the 90 days initial waiting period;
- (b) Such Claim in India should have been admissible under the Inpatient Care.
- (c) The Critical Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 days initial waiting period;
- (d) Medical treatment for the Specified Illness is taken outside India;
- (e) All claims will be subject to 20% co-payment;
- (f) This benefit is available Worldwide excluding US and Canada
- (g) Re-load of Sum Insured will not be available for this benefit;
- (h) We will cover the one time Return Airfare of Insured Person for whom claim has been accepted, upto a maximum of Rs.300,000 on reimbursement basis only.
- (i) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion;
- (j) This benefit is available only as cashless facility through pre-authorization by Our Service Provider. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;
 - i. In the event of the diagnosis of a Specified Illness, the Insured Person should call Our Service Provider immediately and in any event before the commencement of the travel for treatment overseas, on the helpline number specified in the Schedule of Insurance Certificate requesting for a pre-authorization for the treatment;
 - ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person the Policy and call for more information or details, if required.
 - iii. Our Service Provider will communicate directly to the Hospital and the Insured Person whether the request for pre-authorization has been approved or denied.
 - iv. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond

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the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.

(k) For this benefit, Critical Illness means the following :

1. Cancer of Specified Severity
2. First Heart Attack of Specified Severity
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure requiring Regular Dialysis
7. Stroke resulting in Permanent Symptoms
8. Major Organ/Bone Marrow Transplant
9. Permanent paralysis of Limbs
10. Motor Neurone Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms

Exclusion E 2.20 i.e. Treatment received outside India does not apply to this benefit.

D.18 Maternity Benefits (For Elite Plan only)

a. Maternity Benefits

1. We will cover Medical Expenses for the delivery of Insured Person's child subject to the following:
 - a. This benefit is available for Insured Person related as legally married husband and wife, where both are covered under the same Family Floater Policy. If a widow is an Insured Person, the benefit under this can be availed only in respect of a pregnancy conceived by her when she and her husband were both covered as Insured Persons during this Policy Period or under the immediately preceding policy with Us;
 - b. Our maximum liability per pregnancy Medical Expenses for the same will be subject to the specified subsidiary limit as shown in the Product Benefits Table.
2. We will cover Medical Expenses related to a Medically Necessary termination of pregnancy subject to the conditions mentioned above.
3. The benefits mentioned above shall be claimed maximum twice during Your lifetime.
4. The following expenses are not covered under Maternity Benefit:
 - a. Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses;
 - b. Medical Expenses for ectopic pregnancy which are covered under the In-patient benefit.
5. We will not cover any claim under Maternity Benefit during the first 36 months of the coverage of the Insured Person who has given birth to the child



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6. In case, customer is porting from any other policy providing maternity benefit, the respective waiting period served in that policy will be considered as waiting period waiver in Lifeline policy as per portability guideline.

b. New Born Cover

If we have accepted a Maternity Benefits claim as mentioned above, then We will cover:

- a. Medical Expenses towards the medical treatment of the Insured Person's new born baby while the Insured Person is Hospitalized as an In-patient for delivery.
- b. Cover the new born baby as an Insured Person until the expiry date of the Policy Year without the payment of any additional premium.

c. Vaccination for New Born Baby –

We will cover Reasonable and Customary Charges for vaccination expenses of the New Born Baby for the vaccinations shown in the Product Benefits Table until the new born baby completes one year. If the Policy Period ends before the New Born Baby has completed one year, then, We will only cover such vaccinations until the baby completes one year, provided that We have accepted the baby as an Insured Person at the time of renewal of the Policy.

D.19 OPD Treatment (For Elite Plan Only)

We will cover an Insured Person's Reasonable & Customary Charges for Medically Necessary consultation with a Medical Practitioner, as an OPD Treatment to assess the Insured Person's health condition for any Illness. We will also pay for any Diagnostic Tests prescribed by the Medical Practitioner and medicines purchased under and supported with a Medical Practitioner's prescription upto the sub-limits shown in the Product Benefits Table.

We will also cover the Reasonable & Customary Charges for Dental Treatment, Cost of Spectacles, Contact Lenses and Hearing Aids once in 2 years with a sublimit of 30% of OPD Treatment sublimit shown in the Product Benefits Table.

E Exclusions

We shall not be liable under this Policy for any claim in connection with or in respect of the following:

E.1 Standard Exclusions

E.1.1 Pre-Existing Diseases - Code- Excl01

- a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months (in case of classic)/ 36 months (in case of Supreme) and 24 months (in case of Elite) of continuous coverage after the date of inception of the first policy with insurer.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.



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- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of 48 months (in case of classic)/ 36 months (in case of Supreme) and 24 months(in case of Elite) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

E.1.2 Specified disease/procedure waiting period- Code- Excl02

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures is as under:
 - a) Cataract
 - b) Stones in biliary and urinary systems
 - c) Hernia / Hydrocele
 - d) Hysterectomy for any benign disorder
 - e) Lumps / cysts / nodules / polyps / internal tumours
 - f) Gastric and Duodenal Ulcers
 - g) Surgery on tonsils / adenoids
 - h) Osteoarthritis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
 - i) Fissure / Fistula / Haemorrhoid
 - j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
 - k) Benign Prostatic Hypertrophy
 - l) Knee/Hip Joint replacement
 - m) Dilatation and Curettage
 - n) Varicose veins
 - o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
 - p) Chronic Renal Failure or end stage Renal Failure

E.1.3 30-day waiting period- Code- Excl03

- a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.



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E.1.4 Investigation & Evaluation- Code- Excl04

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E.1.5 Rest Cure, rehabilitation and respite care- Code- Excl05

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

E.1.6 Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

E.1.7 Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

E.1.8 Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

E.1.9 Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

E.1.10 Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.



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E.1.11 Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

E.1.12 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12

E.1.13 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13

E.1.14 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. Code- Excl14

E.1.15 Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. This exclusion does not apply for OPD Treatment (Section D.19) under Elite Plan.

E.1.16 Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

E.1.17 Sterility and Infertility: Code- Excl17

Expenses related to Sterility and infertility. This includes:

- (i) Any type of contraception, sterilization
- (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- (iii) Gestational Surrogacy
- (iv) Reversal of sterilization

E.1.18 Maternity: Code Excl18

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion does not apply to Elite Plan.


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E.1.19 Existing Disease which can be permanently Excluded: In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes. The disease which can be excluded under this section are as under:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign


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		neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0 Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1 to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 - Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 - Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.


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7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 - Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 -Acute hepatitis B without delta-agent and without hepatic coma; B17.0 -Acute delta-(super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37


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13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

E.2 Specific Exclusions

E.2.1 Alternative treatment Code Excl19

Any Alternative Treatment except for the benefits under Section D.10 (Ayush Treatment)

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E.2.2 Ancillary Hospital Charges Code Excl20

Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, night charges, registration, documentation and filing, surcharges. Service charges levied by the Hospital under whatever head.

E.2.3 Charges for medical papers Code Excl21

Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Accident, Illness or Injury.

E.2.4 Circumcision Code Excl22

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

E.2.5 Conflict and disaster Code Excl23

Treatment for any illness or injury resulting from nuclear or chemical contamination, war, riot, revolution, acts of terrorism or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

- a. The Insured Person put himself in danger by entering a known area of conflict where active fighting or insurrections are taking place
- b. The Insured Person was an active participant in the above mentioned acts or events of a similar nature.
- c. The Insured Person displayed a blatant disregard for personal safety

E.2.6 Congenital conditions Code Excl24

Treatment for any External Congenital Anomaly.

E.2.7 Convalescence and Rehabilitation Code Excl25

Hospital accommodation when it is used solely or primarily for any of the following purposes:

- a. Convalescence, rehabilitation, supervision or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in Hospital.
- b. receiving general nursing care or any other services that do not require the Insured Person to be in Hospital and could be provided in another establishment that is not a Hospital
- c. receiving services from a therapist or complementary medical practitioner or a practitioner of Alternative Treatment.



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E.2.8 Dental/oral treatment Code Excl26

Dental treatment including Surgical Procedures for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the tempromandibular joint.

This exclusion does not apply for OPD Treatment (Section D.19) under Elite Plan.

EXCEPTION: We will pay for a Surgical Procedure for which the Insured Person is Hospitalized as a result of an Accident and which is undertaken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

E.2.9 Drugs and dressings for OPD Treatment or take-home use Code Excl27

Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization expenses under Section D.3 above. This exclusion does not apply for OPD Treatment (Section D.19) under Elite Plan

E.2.10 Hereditary conditions (Specified) Code Excl28

Any treatment arising from and/or taken for Crohn's Disease ,Ulcerative colitis, Cystic kidneys, Neurofibromatosis, Factor V Leiden Thrombophilia, Familial Hypercholesterolemia, Hemophilia, Hereditary Fructose Intolerance, Hereditary Hemochromatosis, Hereditary Spherocytosis.

E.2.11 Items of personal comfort and convenience, including but not limited to: Code Excl29

- A. Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.
- B. Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization.
- C. Drugs or treatment not supported by prescription.
- D. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
- E. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.
- F. External and or durable medical/non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc.
- G. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and similar items and also any medical equipment which is subsequently used at home.
- H. Nurses hired in addition to the Hospital's own staff.

E.2.12 OPD Treatment Code Excl30

OPD Treatment is not covered.



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However, this exclusion does not apply for:

- a. Vaccination in case of Animal Bite (Section D.11)
- b. OPD Treatment (Section D.19) (available only in case of Elite plan)
- c. Vaccination for New Born Baby (Section D.18 (c) (available only in case of Elite plan)

E.2.13 Preventive Care Code Excl31

All preventive care, vaccination including inoculation and immunisations except in case of

- a. Vaccination in case of Animal Bite (Section D.11)
- b. Vaccination for New Born Baby (Section D.18(c) (available only in case of Elite plan)

E.2.14 Self-inflicted injuries Code Excl32

Treatment for, or arising from, an injury that is intentionally self-inflicted, including attempted suicide.

E.2.15 Sexual problems Code Excl33

Treatment of any sexual problem including impotence (irrespective of the cause) or erectile dysfunction.

E.2.16 Sexually transmitted diseases Code Excl 34

Treatment for any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

E.2.17 Sleep disorders Code Excl35

Treatment for sleep apnea, snoring, or any other sleep-related breathing problem.

E.2.18 Treatment for Alopecia Code Excl 36

Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

E.2.19 Treatment for developmental problems Code Excl 37

Treatment for, or related to developmental problems, including but not limited to:

- a. including attention deficit hyperactivity disorder (ADHD);
- b. deviated nasal septum (correction of deviation of nasal septum for cosmetic purpose)

E.2.20 Treatment received outside India Code Excl38

Any treatment received outside India.

This exclusion does not apply for Section D.16 (Worldwide Emergency Hospitalization) and Section D.17(International Treatment for Critical Illness).



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E.2.21 Artificial Life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life. Code Excl39

E.2.22 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion: Code Excl40

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
- b) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

E.2.23 90 days Initial Waiting Period for Critical Illness Code Excl41

We will not cover any treatment for critical illness symptoms of which first occur or manifest itself during the first 90 days since the date of commencement of the policy.

E.2.24 Personal Waiting Periods Code Excl 42

A special waiting period not exceeding 48 months, may be applied to Individual Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule of Insurance Certificate and will be applied only after receiving Your specific consent.

E.2.25 The expenses that are not covered in this policy are placed under List-I of Annexure-II.

F General Terms and Clauses

F.1 Standard General Terms and Clauses

F.1.1 Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

F.1.2 Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.



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F.1.3 Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

F.1.4 Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

F.1.5 Multiple Policies

1. In case of multiple policies taken by an insured person during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the suns insured under a single policy after, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

F.1.6 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.


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For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

F.1.7 Cancellation

- i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation date upto (x months) from the Policy Period Start Date	Refund of Premium (basis Policy Period)		
	1 Year	2 Year	3 Year
Upto 1 month	75%	87%	91%
Upto 3 months	50%	74%	82%
Upto 6 months	25%	61.5%	73.5%
Upto 12 months	0%	48.5%	64.5%
Upto 15 months	NA	24.5%	47%
Upto 18 months	NA	12%	38.5%
Upto 24 months	NA	0%	30%
Upto 30 months	NA	NA	8%

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Beyond 30 months	NA	NA	0%
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Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

- ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

For half- yearly payment mode

Upto 90 days- 50% Refund

Post 90 days- Nil

For Quarterly payment mode

Upto 30 days- 50%

After 30 days- Nil

For Monthly payment Mode

Cancellation- No refund

Automatic Cancellation:

- a. Individual Policy:

The Policy shall automatically terminate on death of the Insured Person .

- b. Family Floater Policies:

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

- c. Refund:

A refund in accordance with the table in Section F.1.7 above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.



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F.1.8 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link:

<https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf>

F.1.9 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link:

<https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Portability.pdf>

F.1.10 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days in case of one year and 15 days in case of monthly, quarterly and half- yearly payments to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience



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F.1.11 Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

F.1.12 Moratorium Period:

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of eight continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

F.1.13 Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Policy Schedule/Certificate of insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

- i. Grace Period of 15 days (in case of monthly mode grace period is allowed and would be available two times and in case of quarterly and half-yearly- grace period will be available only once) would be given to pay the instalment premium due for the policy.
- ii. During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
- iii. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated grace Period.
- iv. No interest will be charged if the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

F.1.14 Possibility of Revision of Terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

F.1.15 Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.


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The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

F.1.16 Redressal of Grievance

In case of any grievance the insured person may contact the company through

- i. Website: <https://www.royalsundaram.in/customer-request>
- ii. Toll free: 1860 258 0000, 1860 425 0000
- iii. E-mail: customer.services@royalsundaram.in
- iv. Sr. Citizen can email us at : seniorcitizengrievances@royalsundaram.in
- v. Fax : 91-44-7113 7114
- vi. Courier:
Grievance Redressal Unit
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers,
No.2/319, Rajiv Gandhi Salai (OMR)
Karapakkam, Chennai – 600097

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Mr. T M Shyamsunder
Grievance Redressal Officer

Royal Sundaram General Insurance Co. Limited
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For updated details of grievance officer, kindly refer the link <http://www.royalsundaram.in>



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If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Insurance Ombudsman addresses given in Annexure I.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://ligms.irda.gov.in>

F.1.17 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

F.2 Specific Terms and Clauses

F.2.1 Alteration to the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

F.2.2 In case of non-disclosure of a condition which is other than list of Permanent exclusions under 4G, we can incorporate additional waiting period of not exceeding 48 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

F.2.3 Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

F.2.4 Reasonable Care

The Insured Person shall take all reasonable steps to safeguard against any Accident or Illnesses that may give rise to any claim under this Policy.

F.2.5 Material Change

It is a Condition Precedent to the Our's liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business at his own expense (refer Annexure III). We may, in its discretion, adjust the scope of cover and/or



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the premium paid or payable, accordingly. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the contract.

F.2.6 Change of Policyholder

The policyholder may be changed only at the time of Renewal of the Policy. The new Policyholder must be a member of the Insured Person's immediate family. The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed upon request in case of his demise.

F.2.7 No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

F.2.8 Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

F.2.9 Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all Claims under this Policy.

F.2.10 Territorial Jurisdiction

The geographical scope of this Policy applies to events within India other than for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness. However, all admitted or payable claims shall be settled in India in Indian rupees other than for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness.

F.2.11 Policy Disputes

Any and all disputes or differences under or in relation to this Policy herein shall be determined by Indian law and shall be subject to the jurisdiction of the Indian Courts.

F.2.12 Loading/Co-payment

We shall apply a risk loading on the premium payable or Co-payment for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 150% per diagnosis / medical



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condition and an overall risk loading of 200%. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured). The maximum risk Co-payment shall not exceed 30% per diagnosis/medical condition and an overall risk co-payment of 30%.

We will inform You about the applicable risk loading or Co-payment through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within the next 15 days.

F.2.13 Renewal conditions

- i. This Policy will automatically terminate at the end of the Policy Period. This Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. All Renewal application should reach Us on or before the Policy Period End Date.
- ii. We may in Our sole discretion, revise the Product and Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
- iii. The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period. For the purpose of this provision, Grace Period means a period of 30 days in case of one year and 15 days in case of monthly, quarterly and half- yearly payments immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity benefits such as Waiting Periods and coverage of Pre Existing Diseases. Coverage is not available for the period for which premium is not received by Us and We shall not be liable for any Claims incurred during such period. The provision of Section 64VB of the Insurance Act shall be applicable.
- iv. Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.
- v. We reserve the right to carry out underwriting in relation to any alterations like increase/decrease in Sum Insured, change in plan/coverage, addition/deletion of members, addition/deletion of Medical Conditions, request at the time of Renewal of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing Policy will not be altered.
- vi. This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. We shall duly intimate You regarding the withdrawal of this product and the options available to You at the time of Renewal of this Policy.
- vii. In case of floater policies, children attaining 25 years at the time of renewal will be moved out of the floater into an individual cover however all continuity benefits on the policy will remain intact. Cumulative Bonus earned will be suitably passed on the fresh policy of child.

F.2.14 Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:



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- i. To Us, at the address as specified in Schedule of Insurance Certificate
- ii. The Policyholder's, at the address as specified in Schedule of Insurance Certificate
- iii. No insurance agents, brokers, other person or entity is authorized to received any notice on behalf of Us unless explicitly stated in writing by Us
- iv. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

F.2.15 Overriding Effect of Policy Schedule

In case of any inconsistency in terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

G Other Terms and Conditions

G.1 Claim Procedure

Provided that the due adherence/observance and fulfillment of the terms and conditions of this Policy (conditions and all Endorsements hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by the Insured and / or Insured person be a condition precedent to any liability of the Company under this Policy. Cashless Claims will be settled through TPA and Re-imburement Claims will be settled by Us. The Claims Procedure is as follows:

G.1.1 For admission in Network Hospital (Cashless Claims) (For Domestic Claims only)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorisation approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, copay amount, deductible amt etc, shall be borne by the insured.

G.1.2 For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed (Re-imburement Claims) (For Domestic Claims as well as Worldwide Emergency Hospitalization)

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending hospital, should be given to the Insurer within 72 hours before admission incase of planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.



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- **Submission of claim:** The insured shall submit the claim form along with attending physician's certificate duly filled and signed in all respects with the following claim documents not later than 30 days from the date of discharge.

Mandatory documents

1. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
2. Death summary in case of death of the insured person at the hospital.
3. First consultation papers
4. Doctor's prescriptions confirming diagnosis/advising hospitalization
5. All test reports such as X-rays, ECG, Scan, MRI, Pathology etc, including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Hospital Final Bill and advance and final hospital payment receipts, in Original.
7. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
8. F.I.R./MLC. in the case of accidental injury and English translation of the same, if in vernacular language.
9. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury (in the absence of FIR)
10. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required.
11. For a) maternity claims, Discharge Summary mentioning LMP, EDD & Gravida b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants
12. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
13. Complete medical records of past hospitalization/treatment, if any.
14. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital.
15. For OPD claims and Vaccination Animal Bite claims – Bills/Receipts and doctor's prescription advising the same
16. For Emergency Domestic Evacuation
 - a) Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition
 - b) Bills/Receipts of transportation agency/ambulance company/air ambulance receipts



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17. For Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness – Insured Person/Attendants -passport, Visa, Tickets and Boarding Passes

Documents to be submitted if specifically sought:

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart). (if available)
2. Copy of extract of Inpatient Register.
3. Attendance records of employer/educational institution.
4. Attending Physician's certificate clarifying
 - reason for hospitalization and duration of hospitalization
 - history of any self-inflicted injury
 - history of alcoholism, smoking
 - history of associated medical conditions, if any
6. Previous master health check-up records/pre-employment medical records, if any.
7. Any other document necessary in support of the claim on case to case basis.

The claim documents should be sent to:

Health Claims Department

Royal Sundaram General Insurance Co. Ltd
 Vishranthi Melaram Towers,
 No.2/319, Rajiv Gandhi Salai (OMR)
 Karapakkam, Chennai - 600097

Payment of Claim

- No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.
- Insured must give at his expense, all the information asked by Us about the claim and he must help to take legal action against anyone if required.
- If required the Insured / Insured Person must give consent to obtain Medical Report from Medical Practitioner at Our expense.
- If required the Insured or Insured Person must agree to be examined by a medical practitioner of Our choice at Our expense.


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- All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this insurance will have to be taken in India only except for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document.
- All claims are to be notified to Us within a timeline as per Section (G.1.2). In case where the delay in intimation is proved to be genuine and for reasons beyond the control of the Insured Person or Nominee specified in the Schedule of Insurance Certificate, We may condone such delay and process the claim. Please note that the waiver of the time limit for notice of claim and submission of claim is at Our evaluation.
- We shall be liable to pay interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed, for sums paid or payable under this Policy, upon acceptance of an offer of settlement by the insured but there is a delay in payment beyond 7 days the date of acceptance.
- At the time of claim settlement, We may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.

Annexure I

The contact details of the **Insurance Ombudsman** offices are as below-

Office Details	Jurisdiction of Office Union Territory, District)	Date Of Taking Charge
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ciains.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	03/10/2019
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19	Karnataka.	


Royal Sundaram General Insurance Co. Limited

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Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097. Regd. Office : 21, Patullos Road, Chennai - 600 002

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<p>Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in</p>		
<p>BHOPAL - Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in</p>	<p>Madhya Pradesh Chattisgarh.</p>	
<p>BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in</p>	<p>Orissa.</p>	<p>11/09/2019</p>
<p>CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in</p>	<p>Punjab, Haryana(excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.</p>	
<p>CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284</p>	<p>Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).</p>	


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Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in		
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.	12/09/2019
GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	
JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.	
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,	Kerala, Lakshadweep,	07/11/2018


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Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Mahe-a part of Union Territory of Puducherry.	
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.	30/09/2019
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	11/09/2019
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	


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Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in		
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	17/09/2019
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.	09/10/2019
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	03/12/2019



Lifeline

Royal Sundaram General Insurance Co. Limited
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Company Limited)

Corp. Office : Vishranthi Melaram Towers, No. 2 / 319,
Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.
Regd. Office : 21, Patullos Road, Chennai - 600 002

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OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W), Mumbai - 400 054.
Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949 Email: inscoun@ecoi.co.in

Shri M.M.L. Verma, Secretary General
Smt Moushumi Mukherji, Secretary

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Annexure II
List I – Items for which coverage is not available in the policy

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS

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20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
	MORTUARY CHARGES
	WALKING AIDS CHARGES
	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
	SPACER
	SPIROMETRE
	NEBULIZER KIT

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	STEAM INHALER
	ARMSLING
	THERMOMETER
	CERVICAL COLLAR
	SPLINT
	DIABETIC FOOT WEAR
	KNEE BRACES (LONG/ SHORT/ HINGED)
	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
	LUMBO SACRAL BELT
	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)

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55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY

List II — Items that are to be subsumed into Room Charges

	Item
	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
	HAND WASH
	SHOE COVER
	CAPS



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	CRADLE CHARGES
	COMB
	EAU-DE-COLOGNE / ROOM FRESHNERS
	FOOT COVER
	GOWN
	SLIPPERS
	TISSUE PAPER
	TOOTH PASTE
	TOOTH BRUSH
	BED PAN
	FACE MASK
	FLEX I MASK
	HAND HOLDER
	SPUTUM CUP
	DISINFECTANT LOTIONS
	LUXURY TAX
	HVAC



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	HOUSE KEEPING CHARGES
	AIR CONDITIONER CHARGES
	IM IV INJECTION CHARGES
	CLEAN SHEET
	BLANKETS/VARMER BLANKET
	ADMISSION KIT
	DIABETIC CHART CHARGES
	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
	DISCHARGE PROCEDURE CHARGES
	DAILY CHART CHARGES
	ENTRANCE PASS / VISITORS PASS CHARGES
	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
	FILE OPENING CHARGES
	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
	PATIENT IDENTIFICATION BAND / NAME TAG



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	PULSEOXYMETER CHARGES
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List III — Items that are to be subsumed into Procedure Charges

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES

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18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES



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13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure III

Format to be filled up by the proposer for change in occupation of the Insured

Policy No	Name of the Insured	Date of birth/Age	Relationship with Proposer	City of residence	Previous Occupation or Nature of Work	New Occupation or Nature of Work

Place: _____

Proposer's Signature _____

Date: _____

Name: _____

(DD/MM/YYYY)