Royal Sundaram

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.

MASTER PRODUCT -TOTAL HEALTH PLUS

IMPORTANT NOTES ABOUT THIS INSURANCE

- Please read and check the details of this Policy carefully to ensure its accuracy and see that it meets your requirements.
- Please inform us immediately of any change in your address, occupation, state of health, or of any other changes affecting any Insured Person.
- The Policy is an evidence of the contract between You and Royal Sundaram Alliance Insurance Company Limited.
- The information given to us in the Proposal form and Declaration signed by you/Proposer and/or over telephone to our tele-agent by You / proposer, forms the basis of this Contract. Any non disclosure or suppression of material information relating to any Insured Person will make the contract void. No claim shall be paid and policy will be cancelled.
- The Policy, Schedule and any Endorsement thereon shall be considered as one document and any word or expression to which a specific meaning has been attached in any of them shall bear such meaning throughout.
- Provided that You pay the premium for all the persons intended to be Insured under this Policy and We receive and accept it, We will provide the insurance described in the Policy.
- Insurance under this Policy is given subject to the Endorsements if any, exclusions, terms and conditions shown below and failure in compliance may result in the claim being denied.

A. PERSONS WHO CAN BE INSURED

This insurance is available to persons who are aged between 91 days and 65 years at the Commencement Date of the Policy.

B. DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the female wherever the context so permits:

Accident/Accidental

An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Alternative treatments

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

Cashless facility

"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.

Condition Precedent

Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Congenital Anomaly

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
Congenital anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly
Congenital anomaly which is in the visible and accessible parts of the body.

Contribution

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion. This clause shall not apply to any benefit offered on fixed benefit basis.

Co-Payment

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

Day Care Centre

A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with 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—

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Day Care Treatment

Day care treatment refers to medical treatment, and/or surgical procedure which is:

I. undertaken under General or Local Anesthesia 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.

Dental Treatment

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/ implants.

Excluded Hospital

An excluded hospital means any hospital which the company might discourage the insured to take treatment of any sickness or illness, due to fraud or moral hazard or misrepresentation indulged by the hospital.

Floater Sum Insured

Floater Sum Insured means the Sum Insured as specified in the

schedule of the policy and available for any one or all members of his family who have been mentioned as Insured Persons in the schedule, for one or more claims during the period of insurance.

Grace Period

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.

Hospital

A hospital means any institution established for in-patient 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:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospitalization

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

Illness

Illness means a 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.

a. **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.

b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

   - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.
   - it needs ongoing or long-term control or relief of symptoms.
   - it requires your rehabilitation or for you to be specially trained to cope with it.
   - it continues indefinitely.
   - it comes back or is likely to come back.

Intensive Care Unit

Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Maternity Expense

Maternity expenses shall include

(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.

Medically Necessary

Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

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

Medical Advise

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

Medical Practitioner

A Medical Practitioner is 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 set up 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. The registered practitioner should not be the insured or close family members.

Network Provider

"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.

Non- Network

Any hospital, day care centre or other provider that is not part of the network.

Notification of Claim

Notification of claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address/telephone number to which it should be notified.

Policy

Policy means the complete set of documents consisting of the Proposal, Policy Wording, Schedule and Endorsements and Attachments, if any.

Policy Period

Policy Period means the period commencing with the start date mentioned in the Schedule till the end date mentioned in the Schedule.

Portability

Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

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 hospitalization was required and

II. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Pre-existing Condition

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months to prior to the first policy issued by the insurer.

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.

Proposal Form

The form in which the details of the insured person are obtained for a Health Insurance Policy. This also includes information obtained over phone or on the internet and stored on any electronic media.

Proposer

Insured or any person who signs the proposal form on behalf of the insured.

Qualified Nurse

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

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.

Renewal

Renewal defines 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.

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 .

Schedule

Schedule means that portion of the Policy which sets out Your personal details, the type and plan of insurance cover in force, the period and sum insured etc. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.

Sum Insured

Sum Insured means the amount stated in the Policy Schedule, which is the maximum amount We will pay for all hospitalisation claims made by You in one policy period (per annum for multi year tenure) irrespective of the number of claims You make.

Surgery

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.

Third Party Administrator

Third Party Administrator [TPA] means the person or organization named in the Schedule who has been appointed by the Insurer to provide administrative services on its behalf and at its direction.

Unproven/Experimental treatment

Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

We/Our/Us/Company and Insurer – We/Our/Us and Insurer means Royal Sundaram Alliance Insurance Company Limited.

You/Your/Yourself and Insured – You/Your and Yourself means the Insured Person shown in the Schedule.

C. BENEFITS

1. Hospitalisation Benefit

The Policy covers Reasonable and Customary Charges for a medically necessary inpatient treatment incurred during the policy period towards hospitalization for the disease, illness, medical condition or injury contracted or sustained by the Insured Person during the Period of Insurance stated in the Schedule subject to terms, conditions, limitations and exclusions mentioned in the Policy.

In the event of any claim becoming admissible under the Policy, the Company will pay to the Proposer, the Reasonable and Customary Charges, subject to the various limits mentioned hereunder, but not exceeding the Sum Insured and the Indexation Benefit if any, mentioned in the Schedule for all claims admitted during the Period of Insurance.

a. Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing Home (subject to a per day limit of 2% of Sum Insured for Non Intensive Care Unit & 4% of Sum Insured for Intensive Care Unit under Gold Plus Plan).

b. Nursing Expenses incurred during In-Patient hospitalization.

c. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees.

d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/internal implants and Cost of Organs.

e. Pre-hospitalization expenses – We shall pay for expenses incurred 30 days (under Gold Plus Plan)/60 days (under Platinum Plus Plan) prior to date of admission into the hospital.

f. Post-hospitalization expenses - We shall pay for expenses incurred 60 days (under Gold Plus Plan)/90 days (under Platinum Plus Plan) after the date of discharge from the hospital.

g. Day Care Treatment – We shall pay for medical expenses for day care procedures (as per Annexure II) requiring less than 24 hours of hospitalisation but not towards expenses incurred in the out patient department of any hospital.

h. Claim amount payable per person towards the treatment of following disease, illness, medical condition or injury during the period of insurance is subject to a limit of:

Treatment	Limit of claim
Cataract	10% of the Sum Insured subject to a maximum of Rs.50,000/-
Dialysis, Chemotherapy and Radiotherapy	10% of the Sum insured per month.
Physiotherapy Charges	Rs.250/- per day

Hospitalization Expenses incurred beyond 180 days from date of expiry of the policy in respect of hospitalization commencing within the Period of Insurance shall not be payable.

Additional Features

1. **Cashless Facility: (Through Third Party Administrators - TPA)** Cashless facility is offered through Third Party Administrators (TPA) who will be guided by TPA Regulations formed by IRDA.

   In network hospitals, provided pre-admission authorisation in writing is taken from TPA appointed by Us, Insured need not pay for the eligible expenses at the hospital. The TPA will pay it directly. The cashless facility can be availed subject to compliance of the procedure laid down in the information handbook issued along with this Policy.

   The TPA may reject a cashless claim if the timelines are not met or if information provided is not sufficient to decide on the admissibility of the claim. In such cases, Insured may approach the Insurer for a Reimbursement Claim.

   In non-network hospitals, all admissible hospitalisation expenses will only be reimbursed.

   The proposer can seek for a change of TPA within the list of empanelled TPAs with Us 30 days prior to the date of expiry of this policy. The list of empanelled TPAs shall be available upon request in writing.

2. **Ambulance Referral Facility**
   TPA will be providing a referral facility for availing ambulance in case of emergency.

3. **Income Tax Relief**
   This insurance scheme is approved by IRDA and the premium is eligible to get exemption under Section 80D of the Income Tax Act, 1961.

4. **No Claim Discount**
   The renewal premium for an Insured person applicable under this policy shall be reduced by 5% if there is no claim for that Insured Person under the expiring policy . Under a floater policy the discount is applicable if there is no claim for all members of the expiring policy.

D. EXCLUSIONS

(i) The policy does not cover any expenses incurred towards the following:

1. **Pre-existing Disease**
   All ailments/diseases/conditions which are pre-existing when the cover incepts for the first time.

   These ailments/diseases/conditions shall however be covered after 3 years of continuous insurance from the Commencement Date of the cover with Us.

   This exclusion will also apply to any complications arising from pre-existing ailments/diseases/conditions. Such complications will be considered to be part of the pre-existing health condition or disease. For example, if a person is suffering from diabetes or hypertension or both, then the policy would be subject to the following exclusions

Diabetes	Hypertension
Diabetic Retinopathy	Coronary Artery Disease
Diabetic Nephropathy	Cerebro Vascular Accident
Diabetic Foot / wound	Hypertensive Nephropathy
Diabetic Angiopathy	Internal Bleeding/ Haemorrhages
Diabetic Neuropathy	
Hyper / Hypoglycaemic shocks	

2. **30 days waiting period**: Any claim during the first 30 days from the Commencement Date of the First Policy shall not be payable.

3. **First Year Exclusions:** During the first year of the policy any expenses incurred towards the following disease / surgical procedures are not covered:
   1. Congenital Internal Anomaly,
   2. Any type of Migraine/Vascular head ache,
   3. Stones in the Urinary and Biliary systems,
   4. Surgery on Tonsils/Adenoids,
   5. Gastric and Duodenal Ulcer,
   6. Any type of Cyst/Nodules/Polpys/Bening Tumours/Breast Lumps.

4. **Two Year Exclusions**: During the first two years of the policy any expenses incurred towards the following disease / surgical procedures are not covered:
   1. Spondylosis/Spondilitis.
   2. Any type, Inter vertebral Disc Prolapse and such other Degenerative Disorders.
   3. Cataract.
   4. Benign Prostatic Hypertrophy.
   5. Hysterectomy, Salphingo – Oophorectomy.
   6. Fistula.
   7. Fissure in Anus.
   8. Piles.
   9. Hernia.
   10. Hydrocele.
   11. Sinusitis and Deviated Nasal Septum.
   12. Heart ailments.
   13. Chronic Renal Failure or end stage Renal Failure.
   14. Any type of cancer including but not limited to Carcinoma/ Sarcoma, Blood Cancer.
   15. Diabetes and its related complications both direct and indirect.
   16. Hypertension and its related complications both direct and indirect.
   17. Organ Transplant.
   18. Retinal detachment surgery with or without vitrectomy.

5. **Three Year Exclusions**: During the first three years of the policy any expenses incurred towards the following disease/surgical procedures are not covered:
   1. Osteoarthritis of any joint.
   2. Treatment of Joint replacement Surgery by any cause other than accident.
   3. Chronic Obstructive Pulmonary Disease (C.O.P.D).
   4. Operations for age related macular degeneration (ARMD) or choroidal neo vascular membrane (CNVM).

   Exclusion 2, 3, 4 and 5 will not be applicable if caused directly due to an accident during period of insurance.

   However if the above mentioned diseases under exclusion 2, 3, 4 and 5 are Pre Existing as defined, at the time of proposal then they will be considered as falling under Exclusion 1

(ii) General Exclusions

In addition to the foregoing, the following shall not be covered under the policy unless specified otherwise in the schedule of the policy

1. Circumcision unless necessary for treatment of a disease, not excluded hereunder or necessitated due to an accident.
2. Implantable electronic devices (such as replacement batteries or replacement devices)
3. Cost of cochlear implant(s)
4. External Durable Devices
   a. Walking Aids Charges.
   b. Bipap Machine.
   c. Commode.
   d. CPAP/CPAD Equipments.
   e. Infusion Pump.
   f. Oxygen Cylinder (for Usage outside the hospital).
   g. Pulseoxymeter Charges.
   h. Spacer.
   i. Spirometre.
   j. SPO Probe 2.
   k. Nebulizer Kit.
   l. Steam Inhaler.
   m. Armsling.
   n. Thermometer.
   o. Cervical Collar.
   p. Splint.
   q. Diabetic Foot Wear.
   r. Knee Braces (Long/Short/Hinged).
   s. Knee Immobilizer/Shoulder Immobilizer.
   t. Lumbo Sacral Belt (except in respect of surgery of lumbar spine).
   u. Nimbus Bed or Water or Air Bed Charges (except in respect any ICU hospitalization requiring a stay of more than 3 days or the insured suffering from Paraplegia quadriplegia).
   v. Ambulance Collar.
   w. Ambulance Equipment.
   x. Microshield.
   y. Oxygen Convertor/nebulizers for Asthmatic condition.
   z. Belts, braces and stockings.
   aa. Glucometer and Gluco strips.
   ab. Thermometer and similar related devices.
5. Prosthesis, corrective devices, durable medical equipments and items and medical appliances/apparatus/machines, which are not required intraoperatively or for the Illness for which the Insured required Hospitalisation.
6. Convalescence, general debility, `Run-down' condition or rest cure, Congenital External Disease or defects or anomalies, Tubectomy, Vasectomy, Venereal disease, intentional self injury or attempted suicide.
7. All expenses arising out of any condition directly or indirectly caused by or associated with Human T-Cell Lymphotropic Virus Type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS/HIV.
8. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
9. Admission for diagnostic studies alone.
10. Expenses on vitamins and tonics unless forming part of treatment for injury or disease.
11. Claims directly or indirectly caused by or arising from or attributable to:
    a. War, Invasion, Act of Foreign Enemy, Warlike Operations (whether war be declared or not).
    b. Biological, nuclear or chemical terrorism.
    c. Nuclear weapons/materials or Radioactive Contamination.
    d. Ionising radiation or contamination by any Nuclear fuel or from any Nuclear waste from burning Nuclear fuel or.
    e. Radioactive, toxic, explosive or other dangerous properties of any explosive nuclear machinery or part of it.
12. Any routine or preventative examinations, vaccinations, inoculation or screening, unless forming part of treatment for animal bite requiring hospitalization.
13. Sex change or treatment, which results from, or is in any way related to, sex change.
14. Hormone replacement therapy,(including hormone replacement treatment following any disease / surgery) Cytotron Therapy, Oxymed Therapy, Arterial Clearance Therapy and similar such therapies.
15. Treatment of obesity (including morbid obesity) and any other weight control programs, services, surgeries or supplies.
16. The treatment of psychiatric and Psychosomatic disorders, mental or insanity related diseases.
17. Any cosmetic, plastic surgery, aesthetic or related treatment of any description, surgery for refractive error and any complication arising from these treatments, whether or not for psychological reasons, unless medically required as part of treatment of cancer, accidents and burns.
18. Expenses incurred towards treatment of illness/disease/injury/ condition arising out of use/misuse or abuse of alcohol, solvents, substance or drugs (whether prescribed or not).
19. Diseases due to tobacco abuse such as Atherosclerosis, Ischemic Heart Disease, Coronary Artery Disease, hemorrhagic stroke, ischemic stroke, Chronic Obstructive Pulmonary Disease, Chronic Obstructive Airway Disease, Emphysema, Chronic Bronchitis, Buerger's Disease (Thromboangitis Obliterans) All types of pre malignant conditions /cancer in situ, oral cancer, Leukoplakia, Larynx cancer, Cancer of Oesophagus, Stomach, Kidney, Pancreas and Cervical Cancers only due to tobacco abuse .
20. Any treatment received in convalescent homes, convalescent hospitals,health hydros, nature cure clinics or similar establishments.
21. Any stay in Hospital not warranting inpatient treatment.
22. Any treatment received outside India.
23. Any other alternative medicine except Allopathy (Modern Medicine).
24. Taking of drug unless it is taken on proper medical advice and is not for the treatment of drug addiction.

25. Any fertility, infertility or sub-fertility or assisted conception treatments (including but not limited to Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation) any treatment related to sterilization.
26. Any person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, flying an aircraft other wise than as a passenger on a regular air carrier, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and activities of similar hazard.
27. Cost incurred towards non-allopathic treatment even if the treatment is administered and/or recommended by an allopathic medical practitioner.
28. Cost of allopathic treatment if administered and /or recommended by non allopathic medical practitioner.
29. Treatment taken from persons not registered as Medical Practitioners under respective medical councils or acting outside the scope of licence or registration granted to him by any medical council.
30. Charges for Nurses/Attendants, etc. incurred during Pre-hospitalisation period and / or Post-hospitalisation period.
31. Treatment by a family member or self-medication or any treatment that is not scientifically recognized.
32. Costs of donor screening or treatment including surgery to remove organs in the event of the insured acting as a donor.
33. Any travel or transportation expenses excluding ambulance charges.
34. Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.
35. Genetic disorders and stem cell implantation/surgery/storage.
36. All non-medical expenses of any kind whatsoever, Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies, if charged separately and does not form part of the room rent.
37. Treatment arising from or traceable to pregnancy/childbirth including voluntary termination of pregnancy. This exclusion shall however not apply in case of ectopic pregnancy . This exclusion shall not apply if it is otherwise included in additional benefit ,subject to limits mentioned therein.
38. The cost of spectacles, contact lenses and hearing aids,
39. Dental treatment or dental surgery of any kind unless requiring hospitalisation as a result of accidental bodily injury.
40. Outpatient treatment charges except as otherwise included in additional benefit , subject to limits mentioned therein.
41. Domiciliary Hospitalization.
42. Insured‘s/Proposer‘s involvement in any activities resulting in any breach of law with criminal intent.
43. Treatment taken in excluded hospitals , as per Annexure III.
44. Excluded expenses as per Annexure I.

E. ADDITIONAL BENEFITS

Subject otherwise to terms, conditions and exclusions of the policy, the following additional benefit(s) are extended.

1. Indexation

The Sum Insured under this Policy shall be progressively increased by slabs of 10% of the Sum Insured subject to a maximum accumulation of 5 slabs.

Sum Insured for the purpose of calculation of indexation shall be the original Sum Insured i.e Sum Insured of the first policy with us or the revised sum insured whichever is lower.

The indexation benefit shall not be applicable for any claim relating to pre existing diseases.

The Indexation benefit shall be applicable only on the benefit-1 ‘Hospitalisation Benefit.’

2. Accident Hospitalisaion

The Company shall reimburse the Insured Person, Reasonable and Customary charges incurred in a Hospital as an Inpatient towards medical expenses for treatment of injury arising out of an accident, up to 50% of the Sum Insured mentioned in the Policy Schedule as Hopsitalisation Benefit.

Further, it is condition precedent that payment of any such claim under this benefit shall be payable after exhausting the available Sum Insured under the hospitalisation benefit.

3. Ambulance Charges

Emergency ambulance charges for transporting the patient to the hospital upto a sum of Rs 1500 per admissible hospitalization and overall policy limit of Rs.3000 will be reimbursed on producing the bills in original.

4. Master Health Checkup

Reimbursement of expenses, subject to a maximum of Rs.1,500/- (under Gold Plus Plan) & Rs.3000/- (under Platinum Plus Plan) per Insured Person, towards Master Health Check up for the Insured Person, after each 4 consecutive claim free years. This is payable once in 4 claim free years.

In respect of a floater policy, if a claim is reported/ admitted/ settled under the policy, no insured member shall be eligible for the above benefit.

5. Maternity Benefit

a. The maximum amount payable under this Benefit is 10% of the Sum Insured subject to maximum of Rs.30,000/- (under Gold Plus Plan) & Rs.50000/- (under Platinum Plus Plan) irrespective of number of policies. Any complication arising out of pregnancy will be deemed to be covered under this extension only, and the limits mentioned herein would apply.

b. This Benefit is admissible only if the expenses are incurred in Hospital/Nursing Home as In-Patient in India. Hospitalization expenses incurred up to 3 days after a normal delivery and 5 days after a cesarean delivery shall be covered. Any extended stay shall be covered only if medically necessary.

c. Expenses incurred towards Maternity Treatment shall not be payable during the first 36 months from the Commencement Date of the cover for the Insured person. The waiting period may be relaxed only in case of miscarriage /abortion induced by accident or other medical emergency.

d. Pre Hospitalization and Post Hospitalization expenses shall not be covered under this benefit.

e. This benefit shall be applicable only in respect of delivery of first two living children. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

6. Hospital Cash

For each completed 24 hours of hospitalization the daily benefit of Rs. 500/- (under Gold Plus Plan)/Rs. 1000 (under Platinum

Plus Plan) will be payable. This benefit follows admitted liability under hospitalization benefit.

This benefit is not applicable in case of an admitted liability under hospitalization benefit for day care procedures.

The daily benefit as mentioned is payable for a maximum period of 30 days per annum per person.

Exclusions for Hospital Cash

The Company shall not be liable for any claim in connection with or in respect of:

1.1 Pre-existing Disease and any disease, illness, medical condition, injury, which is a complication of a Pre-existing Disease.

1.2 All other exclusions flowing from base policy.

7. Outpatient Treatment

(Applicable for Platinum Plus Plan only)

The Company hereby agrees subject to the terms, conditions herein contained or otherwise expressed herein, that, if during the Period of Insurance stated in the Schedule of the policy, the Insured shall incur any medical charges related to medical treatment taken at a Hospital (or any clinic) the Company shall pay to the Insured, the amount of such Medical Charges as are reasonably and necessarily incurred thereof, but not exceeding Rs.2500/- for each Insured Person in case of Individual Sum Insured or for all Insured Persons in case of Floater Sum Insured.

a) Basis of assessment of Claims

The claim payable under this benefit shall be such Medical Charges incurred by the Insured for medical treatment of the Insured for any Illness or Bodily Injury but not exceeding the Limit of Indemnity as specified under this benefit.

b) Claims Procedure

Claim Documents: The Insured shall be required to furnish the following documents in original for or in support of a claim

- Duly completed claim form.
- Discharge Card (if applicable) or OPD card of the Hospital. If any.
- Prescription of the treating Medical Practitioner, bills, receipts, etc.
- Bills from chemists supported by proper prescription.
- Test reports and payment receipts.
- Any other document as required by the Company.

Payment of Claims:

Claims pertaining to each Insured can be lodged only once during the Period of Insurance. The Company shall not receive any claims prior to completion of 90 days of the commencement of the Policy. Claims under this benefit shall be payable only on re-imbursement basis. No claim shall be admissible under this benefit, 30 days after expiry of the Period of Insurance, whether the policy is renewed or not.

F. CONDITIONS

1. Claims Procedure

Provided that the due 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.

The Claims Procedure is as follows:

For admission in network Hospital - The Insured must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 72 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.

For admission in non-network Hospital - Preliminary notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us within seven days from the date of hospitalization /injury/ death, failing which admission of claim is at Insurer‘s discretion.

Please ensure that You send the claim form duly completed in all respects along with all the following documents within 30 days from the date of discharge from Hospital.

- **Mandatory documents**
  1. Test reports and prescriptions relating to First / Previous consultations for the same or related illness.
  2. Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the hospital.
  3. Death summary in case of death of the insured person at the hospital.
  4. Hospital Receipts / bills / cash memos in Original (including advance and final hospital settlement receipts).
  5. All test reports for 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. Doctor’s prescriptions with cash bills for medicines purchased from outside the hospital.
  7. FIR/MLC. in the case of accidental injury and English translation of the same, if in any other language.
  8. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury.
  9. 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 by Us.
  10. For a) maternity claims, discharge summary mentioning LMP, EDD & Gravida b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker.
  11. Copies of health insurance policies held with any other insurer covering the insured persons.
  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.
- **Documents to be submitted if specifically sought**
  1. Copy of indoor case records (including nurse‘s notes, OT notes and anesthetists‘ notes, vitals chart).
  2. Copy of extract of Inpatient Register.

3. Attendance records of employer/educational institution.
4. Complete medical records (including indoor case records and OP records) of past hospitalization/ treatment if any.
5. 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.

- In the event if the Insured having multiple insurance policies and prefers to lodge a partial claim with the Company, the Company shall accept photo copies of the documents duly certified by the first insurance company.
- Insured /Insured Person must give Us at his expense, all related information We ask for about the claim.
- Insured must help Us to take legal action against anyone if required, If required, the Insured/Insured Person must give consent to obtain Medical opinion from any 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.
- If required, Insured should procure from the hospital or cooperate with the Insurer in procuring the Internal Case Papers (ICP) of the hospital relating to the treatment for which claim has been made.
- Insurers have the right to reject the claim if the documents are inadequate and if the requirements for additional documents by the Insurer are not complied with in reasonable time of not more than 45 days from the time of making such request.

The documents should be sent to:

Health Claims Department

M/s.Royal Sundaram Alliance Insurance Co.Ltd.,

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

Claim documents may also be submitted to local Royal Sundaram Offices address of which can be obtained by calling our customer services in 1860 425 0000.

2. Payment of Claim

- All valid claims will be settled within 15 working days upon receipt of due written evidence of such loss and any further documentation information and assistance that the Company may require. The company shall be released from any obligation to pay benefits if any of the obligations are breached.
- 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.
- The Company shall be liable to pay any 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 delay in payment beyond 7 days from the date of acceptance.
- The claim if admissible shall be paid to the legal heir/ nominee of the proposer in case if the proposer is not surviving at the time of payment of claim.
- At the time of claim settlement, Company may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.
- In respect of hospitalization benefit, claims falling within two policy periods, the Sum Insured considered for such claim shall be the available Sum Insured under both policy periods.

3. Transfer

Transferring of interest in this Policy to anyone else is not allowed.

4. Cancellation

The Company may at any time cancel this Policy on the grounds of mis-representation, fraud, non-disclosure of material facts on the Proposal Form or non-cooperation by the insured, by giving fourteen (14) days notice in writing by courier/registered post/acknowledgement due post to the Insured at address recorded / updated in the policy. In the event of such cancellation on the grounds of mis representation or fraud or non disclosure of material facts, the policy shall be void, no refund of premium shall be made and no claim shall be payable under the policy. In the event of cancellation on the grounds of non cooperation, the company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of cancellation.

The Insured may also cancel this Policy by giving fifteen (15) days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and retain the premium for the period. This Policy has been in force at the Company's short period scale as mentioned below provided that no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the insured.

Short Period Scales – Annual Policies

Period on Risk	Rate of Premium to be retained
Up to 1 month	25% of annual premium
Up to 3 months	50% of annual premium
Up to 6 months	75% of annual premium
Exceeding 6 months	Full annual premium

5. Automatic Termination

The cover shall terminate immediately on the earlier of the following events:

- Upon the death of the Insured Person in which case the Company will refund premium calculated on pro-rata basis for the unexpired period subject there being no claim under the policy.
- Upon exhaustion of the sum insured under hospitalisation benefit and additional benefits.

6. Notice

Every notice and communication to the Company required by this Policy shall be in writing to the office of the Company, through which this insurance is effected. However Initial notification of claim can be made by telephone.

7. Misdescription

This Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

8. Geographical Area

The cover granted under this insurance is valid for treatments taken in India only.

9. Contribution

If at the time of a claim under this Policy, there is any other insurance covering the same loss, the right contribution apply. This clause shall however not be applicable for benefit sections of the policy.

10. Continuation of Terms and Conditions

The Insured has to renew the policy without any break to ensure continuity of cover from the commencement. A grace period of 30 days is allowed to renew the policy and maintain continuity of coverage.

However during such grace period, the company shall not be liable for hospitalisation, if any, occurring after the expiry of the policy and before the date of actual receipt of premium for renewal.

11. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured's rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights. The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause shall however not be applicable for benefit sections of the policy.

12. Fraud

If any claim is in any respect fraudulent, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his behalf to obtain any benefit under this Policy, all benefits under this Policy will be forfeited and the Company may choose to void the Policy and reclaim all benefits paid in respect of such Insured Person.

13. Renewals

This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof. Policy must be renewed within the Grace Period of thirty days of expiry to maintain the continuity of Coverage. However no coverage shall be available during the period of such break.

A policy that is sought to be renewed after the Grace Period of 30 days will be underwritten as a fresh policy at the discretion of Us. Any condition/diseases contracted during the break-in period shall not be covered and shall be treated as Pre-existing condition and waiting period for such disease will commence afresh.

In the event of mis-description, fraud, non co-operation by the insured or non disclosure of material facts coming to our knowledge, policy shall not be considered for renewal.

At renewal, the coverages, terms & conditions and premium may change, in which case a three months notice shall be sent to the Proposer at his last known address as recorded in the policy. Any change in premium on account of change of age will not require any prior notice.

The product/plan may be withdrawn at any time, by giving a notice of 3 months to the Proposer at the address recorded / updated in the policy. When the policy is withdrawn, the product/plan shall not be available for renewal at the due date. However, the cover under such policy shall continue till the expiry date shown in the Schedule of the policy. In the event of withdrawal of a product, Company shall offer similar alternative product from its currently marketed product suites.

14. Customer Service

If at any time the Insured Person requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hour.

15. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to difference or, if they cannot agree upon a single Arbitrator within 30 days of any party invoking Arbitration, the same shall be referred to a panel of three Arbitrators, comprising of two Arbitrators, one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to Arbitration as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such Arbitrator/Arbitrators of the amount of the loss or damage shall be first obtained.

16. Disclaimer

It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

17. Jurisdiction

The Policy is subject to the laws of India and the jurisdiction of its Courts.

18. Change of Address

The Insured must inform in writing of any change in his/her address. This is to ensure better service in terms of communication and any failure to do so shall not amount to non-adherence to policy conditions so long as the changed address is within India.

19. Change in Sum Insured

Any change in the Sum Insured can be opted only at the time of renewal, subject to no claim under the expiring policy and the increase is restricted to 100% of the current Sum Insured and is at the discretion of company. When the Company is admitting liability for disease/illnesses/medicalcondition/ injury contracted by the Insured Person during the previous period of Insurance(s) with Us, then we shall pay either the Sum Insured for that Insured Person in the policy during the first occurrence of such disease/illness/medical condition/burns or the available Sum Insured under the current Policy, whichever is less.

When the Company is admitting liability for pre existing disease the least sum insured opted in all years of insurance will be considered.

20. Free Look-in

At the inception of the policy you will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable. If you have not made any claim during the free look period, you will be entitled to the following, provided no claim has been settled or lodged for the period the policy has been in

force:

a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured person and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

21. Portability

This policy is portable. If proposer desires to port to this policy, application in the appropriate form should be made before 45 days from the date of renewal. The company retains the rights to underwrite proposals falling under portability as per the company's underwriting guidelines. In the event of acceptance of proposal under portability the commencement date for the purpose of applying time bound exclusions and Pre-existing Disease(s) shall be deemed from the first inception date of any Indemnity Health Insurance Policy and to the extent of the coverage as it regards the Sum Insured, provided the Policy has been continuously renewed without any break in the policy.

For Portable policies, Portability benefit will be offered to the extent of - sum of previous sum insured and accrued cumulative bonus, if available. The portability rights apply only to Hospital Benefit.

22. Compliance with Policy provisions

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

23. Grievances

In case the Insured Person is aggrieved in any way, the Insured Person may contact the Company at the specified address or contact through the number mentioned hereunder during normal business hours or by E mail.

The Insured Person may approach the Insurance Ombudsman, within whose jurisdiction the branch or office of Royal Sundaram Alliance Insurance Company Limited is located for the following grievances

a. Any partial or total repudiation of claims by the Company.

b. Any dispute regard to premium paid or payable in terms of the policy.

c. Any dispute on the legal construction of the policies in so far as such disputes relate to claims.

d. Delay in settlement of claims.

e. Non-issue of any insurance document to customer after receipt of the premium.

f. Any other grievance, apart from the above mentioned.

The Insurance Ombudsman's offices are located at Ahmedabad, Bhubaneshwar, Bhopal, Chandigarh, Chennai, Guwahati, Kochi, Kolkatta, Lucknow, Hyderabad, Mumbai and Delhi. Address, contact person and contact number details are given as per Annexure IV.

WHAT IF I EVER NEED TO COMPLAIN?

We hope, of course, that you will never feel the need to complain. Nevertheless, sometimes things do go wrong. When they do, we want to know straight away, so we can put them right as quickly as possible, and take steps to make sure they don't happen again.

In all instances, call our Customer Services at our Chennai office at 1860 425 0000 or e-mail at customer.services@royalsundaram.in or write us to Royal Sundaram Alliance Insurance Company Limited, Vishranthi Melaram Towers, No. 2 / 319 Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Royal Sundaram Alliance Insurance Company Limited

IRDA Registration No.102