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Liberty Health Connect Policy
Policy Wordings

Liberty Videocon General Insurance Company (hereinafter called the "Company", "Insurer" , **"We, Our, or Us"**) will provide insurance cover to the person(s) (hereinafter called the "Insured" , **"You, Your, or Yourself"**) based on the Proposal and Declaration made and agreed premium paid within such time, as may be prescribed under the provisions of the Insurance Act, 1938, for the Policy Period stated in the Schedule or during any further period for which the Company may accept payment for the renewal or extension of this Policy, subject always to the following terms, conditions, exclusions, and limitations and the Schedule. This Policy records the agreement between the Company (We) and the Insured (You), and sets out the terms of insurance and obligations of each party.

Part I: Definitions

The words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

1. **"Accident"** or **"Accidental"** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. "**Age**" means the completed age of the Insured Person as on his last birthday.

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

4. **"Ambulance**" means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

5. **"Any one illness**" will mean continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment may have taken.

6. **"Basic Sum Insured"** means the amount specified against each Insured Person/s representing the Company's maximum liability for any or all the claims during the Policy Period specified in the Schedule to this Policy, subject to terms, conditions and exclusions of this Policy.
In case of policies with more than one year tenure, the Basic Sum Insured specified on the Policy is the limit for each year. These limits will lapse at the end of every year and fresh limits up to the full Basic Sum Insured as opted, will be available for the next year.

7. **"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 and exclusions, are directly made to the network provider by the Insurer to the extent pre-authorization approved.

8. **"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.

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

10. **"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"** means 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

1. **"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 ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

11. "**Cumulative Bonus/Loyalty Perk"** shall mean any increase in the Sum Insured granted by the Insurer without an associated increase in premium.

12. " **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 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-

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

13. **"Day care Procedure/Treatment"** refers to medical treatment, and/or surgical procedure which is –

a. undertaken under General or Local Anesthesia in a hospital/day care centre for less than 24 hours because of technological advancement, and
b. which would have otherwise required hospitalization of more than 24 hours.

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

14. **"Deductible"** is 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.

15. **"Dependent Child"** refers to a child (naturally or legally adopted),who is financially dependent on the Primary Insured or Proposer and does not have his/her independent sources of income between the age of 91 days and eighteen (18) years, or up to and including the age of twenty-five (25) years if undergoing full time education at an accredited educational institution.

16. **"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.

17. **"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.

18. **"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:

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

19. "**Family**" means the Insured, his/her lawful spouse, dependent child/children, Parents and/or Parents-in-laws .

20. **"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.

21. **"Family Floater"** means Policy wherein all Insured Person/s of a family are covered under a single Basic Sum Insured. Basic Sum Insured for family floater policy is the amount specified in the Policy Schedule which represents the Company's maximum total & cumulative liability for all Insured Person/s for any or all claims incurred during the Policy Period.

2. **"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:

a) has qualified nursing staff under its employment round the clock;

b) has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

c) has qualified medical practitioner (s) in charge round the clock;

d) has a fully equipped operation theatre of its own where surgical procedures are carried out;

e) maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

22. **"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 24 consecutive hours.

23. **"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.

24. **"Injury"** means a bodily injury resulting solely and directly from an Accident which occurs during the Policy Period.

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

26. **"Insured"** means an individual, a Resident Indian, who has proposed for Insurance and on whose name the Policy is issued.

27. **"Insured Person/s"** means the person/s named in the Schedule to the Policy, who is/are Indian Resident/s and for whom the insurance is also proposed and appropriate premium paid.

28. **"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.

29. **"Medical Advise"** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

30. **"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 license provided that this person is not a member of the Insured Person's family.

31. **"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.

32. **"Medically Necessary"** Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part o f 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.

33. **"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.

34. **"Non-Network"** means any hospital, day care centre or other provider that is not a part of the Network.

35. **"Nominee"** means the person named in the Proposal or Schedule to whom the benefits under the Policy is nominated by the Insured Person.

36. "**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.

37. **"Policy"** means this Policy document, the Proposal Form and Declaration, including Endorsements and Schedule as amended from time to time.

38. **"Policy Period"** means the period between the inception date and expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.

39. **"Pre-hospitalization"** means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured person's Hospitalisation was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3. **Post-hospitalization Medical Expenses"** means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

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

40. **"Portability"** means transfer by an individual health insurance policy holder (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.

41. **"Pre-Existing Disease"** refers to 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 prior to the first Policy issued by the Insurer.

42. **"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.

43. **"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.

44. **"Renewal"** Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period

45. for treating the renewal continuous for the purpose of all waiting periods

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

47. **"Schedule"** means Schedule attached to and forming part of this Policy mentioning the details of the Insured / Insured Persons, the Basic Sum Insured in respect of each Insured Person, the Policy Period, the Coverages and the limits to which benefits under the Policy are subject to.

48. **"Subrogation**" shall mean the right of the insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

49. **"Surgery"** 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 and prolongation of life performed in a hospital or day care centre by a medical practitioner.

50. **"OPD treatment"** is one in which the Insured 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.

51. **"Third Party Administrator or TPA**" means any person who is licensed under the IRDA (Third Party Administrator- Health Services) Regulations, 2001 by the Authority, and is engaged , for a fee or remuneration by an Insurance Company, for the purpose of providing health Services.

52. **"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.

53. **"We/Our/Us"** means the Liberty Videocon General Insurance Company Limited

54. **"You/Your"** means the Insured named in the Schedule who has concluded this Policy with Us.

Part II: Scope of Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay and/or reimburse expenses mentioned under Scope of Cover in the manner, for the period and to the extent of the Basic Sum Insured and as per the relevant plan opted by the Insured Person/s and so specified in the Schedule to this Policy.

1. Hospitalisation Expenses

a. In-Patient Treatment Expenses

The Company undertakes to indemnify Insured person against any disease or Any One Illness or any injury during the Policy Period and if such disease or injury shall require any such Insured Person, upon the advice of a duly qualified physician/Medical Practitioner to incur in-patient care expenses for medical/surgical treatment at any Hospital / Nursing Home in India, towards following expenses, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

i. Room, Boarding expenses
ii. Intensive Care Unit bed charges
iii. Doctor's fees
iv. Nursing Expenses
v. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy
vi. Prescribed Drugs and medicines consumed on the premises
vii. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
viii. Dressing, Ordinary splints and plaster casts
ix. Cost of Prosthetic devices if implanted during a surgical procedure

b. Day Care Treatment

The Company will indemnify medical expenses incurred on a treatment towards a Day Care procedure, where the procedure or surgery is taken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care center but not in the Outpatient department of a Hospital.

2. Pre-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately before the Insured Person was hospitalised, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
ii. There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

3. Post-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately after the Insured Person was discharged following Hospitalisation, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and

ii. There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

4. Domiciliary Hospitalisation Treatment

The Company will indemnify medical expenses incurred by an Insured Person/s for Domiciliary Hospitalization treatment taken at his home in India limited to 10% of the Basic Sum Insured for the entire Policy Period. If We accept a claim under this cover, We will not make any payment for Pre &Post Hospitalisation expenses.

No payment will be made if the condition for which the Insured Person requires medical treatment is:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract
b. Infection including Laryngitis and Pharyngitis, Cough and
c. Cold, Influenza,
d. Arthritis, Gout and Rheumatism,
e. Chronic Nephritis and Nephritic Syndrome,
f. Diarrhoea and all type of Dysenteries including Gastroenteritis,
g. Diabetes Mellitus and Insipidus,
h. Epilepsy,
i. Hypertension,
j. Psychiatric or Psychosomatic Disorders of all kinds
k. Pyrexia of unknown Origin.

5. Hospital Daily Cash Allowance

The Company will pay the amount as specified in the Schedule to this Policy against Hospital Cash allowance benefit for each continuous and completed period of 24 hours of hospitalization of the Insured Person, for a maximum up to 10th day of continuous hospitalization., provided a valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy. A deductible of first 48 hours of hospitalization is applicable.

6. Emergency Local Road Ambulance Charges

The Company will indemnify expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following Accidental Bodily Injury/ illness / disease occurring during the Policy Period., provided that:

i) Our maximum liability shall be as specified in the Schedule to this Policy.
ii) There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy
iii) The coverage also includes the cost of the transportation of the Insured Person from one Hospital to another nearest Hospital which is prepared to admit the Insured Person and provide necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person was first admitted, provided that the transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

7. Organ Donor Expenses

The Company will indemnify organ donor's screening charges & the medical expenses for an organ donor's treatment for the harvesting of the organ donated up to the amount as specified in the Schedule to this Policy, provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 (Amended)and the organ donated is for the use of the Insured Person, and
ii. We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and
iii. A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

8. Second Opinion

A second medical opinion service from our expert panel is available for all Insured Person/s seeking information that will give them confidence in their medical diagnosis and treatment plan. At the request of the Insured Person/s, the company shall arrange for a Second Opinion which is subject to the following:

i. This benefit can be availed only once during the policy Period by the Insured Person
ii. The Insured Person is free to choose whether or not to obtain the Second Opinion, and if obtained, whether or not to act on the same.
iii. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon
iv. Any Second Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

9. Recovery Benefit

The Policy provides for payment to the Insured Person of the sum as specified in the Schedule to this Policy in the event of his / her hospitalization for a continuous period of not less than 10 days subject to a valid claim being admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

In case of a family floater, this benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy Period subject to overall limit of the Basic Sum Insured.

10. Nursing Allowance

This benefit provides for payment of a daily allowance, as specified in the Schedule to this Policy, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence provided

- such services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to a disease / illness / injury for which the Insured Person has been hospitalized.
- A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy
- A deductible of first 48 hours of hospitalization is applicable for Any One Illness/injury.

Part III: Additional Features

Restoration of Sum Insured

The Policy provides, as applicable to the relevant plan specified in the schedule to the policy, that, where the Basic Sum Insured is exhausted due to claims made and paid during the

Policy Year or made during the Policy Year and accepted as payable, then the Company agrees to automatically make available a Restore Sum Insured equal to 100% of the Basic Sum Insured for the particular policy year, provided that:

a. The Restored Sum Insured will be utilized only after the Basic Sum Insured and loyalty perk earned if any have been completely exhausted in that Policy Period; and
b. The Restored Sum Insured cannot be clubbed with balance if any available under the Basic Sum Insured and loyalty perk earned if any.
c. The Restored Sum Insured can be used only for such claims as is admissible in terms of Part II-1 of the Policy.
d. The Restored Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease for which a claim has been paid in the current policy year under Part II-1 of the Policy.
e. The Restored Sum Insured will be available during the Policy Year till it is exhausted completely.
f. Any unutilized restored amount cannot be carried forward to any subsequent Policy Year.
g. The Restored Sum Insured shall not be considered while calculating the Loyalty Perk
h. The total amount of restored Sum Insured shall not exceed the Basic Sum Insured for that Policy Year.
i. In case of portability, the credit for Sum Insured would be only to the extent of the Basic Sum Insured.

If the policy is a Family Floater, then the Restored Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Basic Sum Insured was exhausted and for whom we have not incurred or paid any claim during the current Policy Period.

Part IV: General Exclusions

1. **Waiting Period Exclusions:**
   a. **30 days Waiting Period Exclusion:**
   A waiting period of 30 days from the commencement date of the first Policy will apply to all disease/ illness contracted other than accidental bodily injury requiring hospitalization.
   b. **First Year Waiting Period Exclusion:**
   During the first year of operation of this insurance cover, expenses on treatment of the following diseases are not payable: Cataract, Benign Prostatic Hypertrophy, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Fissure, Gastric and Duodenal ulcers, gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus, polycystic ovarian diseases; skin tumors unless malignant, benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); & Congenital Internal Diseases.
   c. **Two Year Waiting Period Exclusion:**
   During the first two years of the operation of this insurance cover, the expenses on treatment of following diseases are not payable: Calculus diseases of Gall bladder and Urogenital system, Hypertension and Diabetes and related complications, Joint

Replacement due to Degenerative condition, Surgery for prolapsed inter vertebral disc unless arising from accident, Age related Osteoarthritis and Osteoporosis, Spondylosis / Spondylitis, Surgery of varicose veins and varicose ulcers.

Diabetes & related complications including but not limited to: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks.

Hypertension & related complications including but not limited to: Coronory Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed/Haemorrhages. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, exclusion below shall be applicable.

d. Pre- Existing Condition Exclusion:

Pre-existing Conditions and any complications arising from the same will not be covered until 48 months, 36 months or 24 months of continuous coverage have elapsed, as per the plan chosen, since inception of your first Policy with Us.

2. We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary elsewhere in this Policy:

1. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
2. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.
3. Any treatment arising from or traceable to any fertility, infertility, sub fertility or assisted conception procedure or sterilization, birth control procedures, hormone replacement therapy, contraceptive supplies, or services including complications arising due to supplying services or Assisted Reproductive Technology.
4. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.
5. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
6. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.
7. Experimental, investigational or unproven treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or consequence of undergoing such experimental or unproven treatment.
8. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces,

stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants.

9. Any weight management services, procedures and treatment, services and supplies including those related to treatment of conditions and complication arising out of obesity (including morbid obesity)
10. Any procedure, investigation, treatment related to sleep disorder or sleep apnea syndrome, general debility, convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, rehabilitation measures, private duty nursing (unless covered under the Policy), respite care, long term nursing care, custodial care or any treatment in an establishment that is not a Hospital.
11. External Congenital Anomaly.
12. Treatment of mental illness, stress, psychiatric or psychological disorders.
13. Aesthetic treatment, cosmetic surgery/implants or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury or Burns.
14. Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.
15. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident
16. All preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment or when it is medically necessary and part of the treatment), vitamins and tonics.
17. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
18. Non-allopathic treatment
19. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.
20. Treatment received outside India
21. Charges incurred at Hospital Primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury for which Inpatient Care/Day Care Treatment is required
22. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.
23. Any Illness or Injury arising from Insured Person committing any breach of law with criminal intent.
24. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.
25. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.
26. Personal comfort and convenience items or services including but not limited to TV(wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's

diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

27. Stem Cell implantation, harvesting, storage or any kind of treatment using stem cells
28. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head.
29. Any Hospitalisation primarily for investigation and / or diagnosis purpose.
30. 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:

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.
c. 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

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

31. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants
32. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products
33. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions
34. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.
35. Any treatment/loss required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parachuting, hang gliding, rock or mountain climbing, winter sports, mountaineering (where ropes or guides are customarily used), caving or potholing, hunting or equestrian, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), polo, snow and ice sports ,professional sports or any other potentially dangerous sport.

Part V: General Conditions

1. Disclosure of information norm

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of mis- representation, mis-description or non-disclosure of any material

particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or device being used by the Insured/ Insured Person/s or any one acting on his/their behalf to obtain a benefit under this Policy.

2. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements, including the payment of premium of this Policy and compliance with specified claims procedure insofar as they relate to anything to be done or complied with by the Insured shall be a Condition Precedent to any liability of the Company to make any payment under this Policy.

3. Alterations to the Policy

This Policy together with the Policy Schedule constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except the Company, and any change We make will be evidenced by a written endorsement signed and stamped by the Company.

4. Material Change

It is a Condition Precedent to the Company's liability under the Policy that the Insured Person/s shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his/ their own expense. The Company may, in its discretion, adjust the scope of cover and/or the premium paid or payable, accordingly.

5. Records to be maintained

The Insured Person/s shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured Person/s shall furnish such information to the Company as may be required under this Policy at any time during the Policy Period or until the final adjustment, if any and resolution of all Claims under this Policy.

6. Notice of charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person/s, his/her nominees or legal representatives, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

7. Contribution

If at the time when any claim arises which exceeds the Basic Sum Insured under this Policy(after considering the deductibles or co- pay), there is in existence any other insurance whether it be effected by or on behalf of whom the claim may have arisen covering the same loss, liability, compensation, costs or Expenses, the Policy holder shall have the right to choose the Insurers with whom the claim is to be lodged.

In all such cases, unless otherwise agreed to in writing the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation, costs or

expenses subject to the maximum liability for any claim under this Policy being limited to the Sum Insured applicable. This clause applies only to coverage under the indemnity section of the Policy and does not apply to benefit sections.

8. **Subrogation**

In the event of payment under this Policy, the Company shall be subrogated to all the Insured /Insured Person's rights of recovery thereof against any person or organisation, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person/s 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 /Insured Person'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 applies only to coverage under the indemnity section of the Policy and does not apply to benefit sections of the Policy.

9. **Fraudulent Claims**

If any claim 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/Insured Person/s or any one acting on his / her behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no Court action or suit is commenced within twelve months after such rejection all benefits under this Policy shall be forfeited.

10. **Extended policy tenure**

In case the Insured Person/s purchase/s LVGIC's Travel Insurance policy or is out of the country for a period of more than 15 days continuously, then this Policy will be extended for the number of days the Insured/Insured Person/s is/are out of the country at no additional charge.

11. **Renewal**

The Policy shall ordinarily be renewable except on the grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Insured. Policy will automatically terminate at the end of the Policy Period. However Grace Period of 30 days for renewing the Policy is provided under this Policy.

We are under no obligation to give notice that it is due for renewal or to renew it on the same terms whether as to premium or otherwise.

The premium payable on renewal shall be paid to the Company on or before the Policy End Date and in any event before the expiry of the Grace Period. The Insured shall give the Company written notice along with Renewal Application, of any material changes to the risk insured under the Policy. If no such written notice is received by us along with renewal application it shall be deemed that there is no material change to the risk.No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

Insured Person/s could avail of policy renewal in terms of the applicable portability norms governing such renewals and the same would be renewed in accordance with the Company's underwriting policy

The Insured Person is allowed to exercise the available option for change of TPA and the same has to be communicated to us at least 30 days before renewal of the Policy.

If the Portfolio performance deteriorates beyond 125% the product would be reviewed following the due process laid out by the Regulator including but not limited to the withdrawal provision as mentioned under condition no.18 of this Policy.

12. Entry Age

Minimum entry Age – Adult –18 years; Dependent Child -91 days Maximum entry Age – 65 Years

13. Basic Sum Insured Enhancement

Basic Sum Insured can be enhanced only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and with the specific approval and acceptance by the Company.. In all such case of increase in the Basic Sum Insured, waiting period will apply afresh in relation to the amount by which the Basic Sum Insured has been enhanced.

14. Health Check-up

The Insured Person/s above18 years of age is/are entitled to a free health check-up at a diagnostic center specified by the Company after a block of every 2 years of continuous yearly Policy renewal with Us irrespective of the claims made under the Policy and subject to continuation of Policy with Us. This is available for the Insured Person/s who were insured with Us for the above specified period.

15. Loyalty Perk

This Policy provides for auto increase in Basic Sum Insured by 10% on the Basic Sum Insured for every claim free Policy year up to a maximum of 100% of the Basic Sum Insured

a. For a Family Floater policy, the loyalty perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person during the expiring Policy Year. The loyalty perk which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Loyalty Perk of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Loyalty Perkin the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Loyalty Perk carried forward under such renewed floater Policy would be the least of the Loyalty Perk/s earned under the expiring Policy/ies..
d. Entire loyalty perk 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.
e. Where a portion of/ full Loyalty Perk earned is utilized following a claim, the balance if any available will be carried forward for the immediate renewal. However, the Policy would not qualify for any fresh Loyalty Perk on the immediate Policy renewal.

16. Cancellation/Termination

This Policy will terminate at the expiration of the period for which premium has been paid or on the Expiration Date shown in Policy Schedule.

Cancellation by Insurer:

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. The Company may, in the event of non-cooperation of the Insured/Insured person/s cancel this Policy, by giving 15 days notice in writing by Registered Post Acknowledgment due to the Insured/ Insured Person/s at his / their last known address in which case the Company shall be liable to repay a rateable proportion of the premium for the unexpired term from the date of the cancellation subject to there being no claim made/ reported under the Policy.

Cancellation by Insured/Insured Person:

The Insured may elect to cancel the Policy by giving 15 days notice in writing to the Company. If no claim has been made under the Policy then the Company shall from the date of receipt of notice cancel the Policy and retain 15% of the premium relating to the balance period for policy tenure more than 1 year and for policies with a tenure period of one year refund the premium as per the Table below;

Period on Risk	Rate of Premium Refunded
Up to 1 Month	75% of Annual Rate
Up to 3 Months	50% of Annual Rate
Up to 6 Months	25% of Annual Rate
Exceeding 6 Months	Nil

In the event of the death of the Insured Person/s during the currency of the Policy, due to any reason and subject to there being no claim reported under the Policy, the Policy would cease to operate and the nominee/legal heir would be entitled to a refund in premium from the date of death to the expiry of policy and such refund would be governed by the provisions relating to the Cancellation by Insured / Insured Person/s as specified above. In case of a family floater, upon the death of the Policy holder, this Policy shall continue till the end of the Policy Period. If the other Insured Person/s wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of an Insured.

17. Withdrawal of Product

In case the product is found to be financially unviable or is deficient in any manner, the Company shall, in terms of Insurance Regulatory & Development Authority (Health Insurance) Regulations 2013, have the option to withdraw this product from the market subject to prior approval of such withdrawal from the Regulatory Authority. Any withdrawal of the product would be duly intimated to existing customers, who on expiry of the existing Policy, will have an option to obtain renewal under similar product/s available with Us. The Company shall allow the benefit of Portability in all such cases.

18. Free Look Cancellation

A period of 15 days from the date of receipt of Policy document is available to review the terms ,conditions and exclusions of the Policy. The Insured has the option of cancelling the

Policy stating the reasons for cancellation if he has any objections to any of the terms ,conditions and exclusions. The company shall refund the premium paid after adjusting the amounts spent on medical examination of the Insured person/s, Stamp Duty Charges and proportionate risk premium in case the risk has already commenced. Cancellation will be allowed only if there are no claims reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is available only at the time of inception of the first Policy contract with us and not at the time of renewal of the Policy.

19. Continuity Benefits

For all roll over cases (Portability Policies) Continuity Benefits shall be offered to all the Insured/Insured Person/s in accordance to IRDA Portability guidelines.

Dependent child/children covered with Us under Family Floater shall have the option to continue renewal by migrating to a suitable policy at the end of the specified exit age. Due credit for Continuity in respect of the previous policy years will be allowed provided the earlier policies have been maintained without a break.

20. Disclaimer

It is being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in a court of law then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

21. Area of Validity

The policy shall provide for eligible medical treatment taken within India & all the benefits under the policy shall be payable in Indian rupees only.

22. Policy Disputes

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to, by both the Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

23. 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 thereto 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 the 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 dispute or difference shall be referable to arbitration as herein before 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.

24. Notice

Every notice and communication to the Company required by this Policy shall be in writing, within specified time and be addressed to the nearest office of the Company. In case the Policy is sold via voice log the notice to the Company may be placed via same mode.

25. Electronic Transaction

The Insured agrees to adhere to and comply with all such terms, conditions and exclusions as the Company may prescribe from time to time, and hereby agrees and validates that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, has his concurrence and full understanding of the terms and conditions affecting this Contract and shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure adherence to conditions of section 41 of the Insurance Act 1938 with full disclosures on terms, conditions and exclusions. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and sent to the Insured Person, duly validated/confirmed by the Insured Person.

26. Claim Procedure:

a. **Notification of claim:** Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:
   i. Policy Number / Health Card No
   ii. Name of the Insured / Insured Person availing treatment
   iii. Details of the disease/illness/injury
   iv. Name and address of the Hospital
   v. Any other relevant information

Intimation must be given atleast 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre – Post Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured Person/s. The Insured Person/s shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. The Company shall settle claims, including its rejection, within thirty days of receipt of the last required documents.

b. For opting Cashless Facility: (applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person 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 48 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.
    i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
    ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner.
    iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation.
    iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.
    v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.

c. ***Reimbursement Claims*** - 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 immediately on hospitalization /injury/ death, failing which admission of claim would be based on the merits of the case at our discretion.The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 15 days of discharge from the hospital the following:
    i. Claim form duly completed in all respects
    ii. Original Bills, Receipt and Discharge certificate / card from the Hospital.
    iii. Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions.
    iv. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.

v. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
vi. Attending Doctor's / Consultant's / Specialist's / - Anesthetist's original bill and receipt, and certificate regarding diagnosis.
vii. Medical Case History / Summary.
viii. Original bills & receipts for claiming Ambulance Charges
ix. Any additional documents or information, as may be deemed necessary by the Company or TPA.

The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Basic Sum Insured opted.

No sum payable under this Policy shall carry interest except as required by section 9(6) of the Protection of Policy Holder's Interest, Regulation 2002 whereby payment of the claim amount due shall be made within 7 days from the date of acceptance of the offer of settlement by the Insured/ Insured Person. In case of any delay in payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed .

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.

INDICATIVE CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- ***In-patient Treatment /Day Care Procedures***
- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no. and break up of each Item, duly signed by the Insured.
- ☐ Original payment Receipt of the hospital bill with receipt number
- ☐ First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from attending Medical Practitioner / Surgeon demanding such test.
- ☐ Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts
- ☐ Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same

- ❑ Original medicine bills and receipts with corresponding Prescriptions.
- ❑ Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
- ❑ Hospital Registration Number and PAN details from the Hospital
- ❑ Doctors registration Number and Qualification from the doctor

➢ ***Road Traffic Accident***

In addition to the In-patient Treatment documents:

- ❑ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
  In Non Medico legal cases
- ❑ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
  In Accidental Death cases
- ❑ Copy of Post Mortem Report (if conducted) & Death Certificate

➢ ***For Death Cases***

In addition to the In-patient Treatment documents:

- ❑ Original Death Summary from the hospital.
- ❑ Copy of the Death certificate from treating doctor or the hospital authority.
- ❑ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

➢ ***Pre and Post-hospitalisation expenses***

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Medicine bills, original payment receipt with prescriptions.
- ❑ Original Investigations bills, original payment receipt with prescriptions and report.
- ❑ Original Consultation bills, original payment receipt with prescription.
- ❑ Copy of the Discharge Summary of the main claim.

➢ ***Ambulance Benefit***

- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Bill with Original Payment Receipt.
- ❑ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

➢ ***Reimbursement of Organ Donor Expenses***

In addition to the documents of general hospitalization

- ❑ Organ Function test / blood test proving organ failure.
- ❑ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

➢ ***Hospital Cash Allowance***

Same as In-patient Hospitalisation treatment

➢ ***Restoration/Reinstatement of the Sum Insured***

Same as In-patient Hospitalisation treatment

➢ ***Recovery Benefit***

Same as In-patient Hospitalisation treatment

➢ ***Nursing Allowance***

In addition to the In-patient Treatment documents:

- ❑ Duly signed prescription for Private Nursing requirement and its necessity from the treating Medical Practitioner
- ❑ Original Bill with Original Payment Receipt of Nursing charges from the utilized Nursing Burrow/Private Nurse

We may call for additional documents/ information as relevant to the claim.

Applicable to all claims under the Policy:

In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, the Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.

The Policy would generally exclude the Standard List of excluded items as may be stipulated by the Authority from time to time unless otherwise agreed upon by the Company and specified so in the Policy document.

Part VI – Loading/Discount Parameters

1. Sub standard Risk Rating: Substandard proposals are medically evaluated for acceptance based on an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Basic Sum Insured.

2. **Family Discount:** A Family discount of 10% will be given if more than 2 family members are covered on Individual Sum Insured basis

3. **Multi-year Policy Discount:** A discount of 7.5% will be given on selection of 2 year tenure policies.

Part VII – Grievance Redressal Procedure

We assure the best customer service from our end to our valued Insured/Insured Person(s) and request you to adopt following procedure in case of any service related query or grievance.
You may communicate your query or grievances by sending a letter to below mentioned address or to your nearest branch or email at below mentioned email ID or by calling at our below mentioned call center number.

Customer Care Cell
Liberty Videocon General Insurance Company Limited
10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai
E-mail: _____
Toll Free No: _____
Please include your Policy number in all your communication with the Company. This will help us resolve the issue more efficiently.
If You are not satisfied with redressal of Your grievance, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of the Ombudsman offices are mentioned below;

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road,AHMEDABAD-380 014. Tel.:- 079-27546840 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462 023. Tel.:- 0755-2569201 Fax : 0755-2769203 Email bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009.Tel.:- 0674-2596455 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
CHANDIGARH	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.:- 0172-2706468 Fax : 0172-2708274 Email ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar	Tamil Nadu, UT– Pondicherry Town and

	Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email insombud@md4.vsnl.net.in	Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23239633 Fax : 011-23230858 Email iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.:- 0361-2132204/5 Fax : 0361-2732937. Email ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-65504123 Fax: 040-23376599, Email insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
ERNAKULAM	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759 Fax : 0484-2359336. Email iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Insurance Ombudsman, Office of the Insurance Ombudsman, North British Bldg., 29, N.S. Road, 4th Floor, KOLKATA-700 001. Tel : 033-22134866 Fax : 033-22134868. Email iombkol@vsnl.net	West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim
LUCKNOW	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331 Fax : 0522-2231310 Email insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel : 022-26106928 Fax : 022-26106052 Email ombudsmanmumbai@gmail.com	Maharashtra , Goa

The updated grievances redressal procedure shall be provided on the website of the Company and is subject to change in compliance with guidelines/regulations issued by Insurance Regulatory and Development Authority.

STATUTORY NOTICE: INSURANCE IS THE SUBJECT MATTER OF THE SOLICITATION

Benefit Schedule

Liberty Health Connect Policy- Details						
	Age Group	Minimum Age at Entry (Adult) - 18 Years				
		Maximum Age at Entry (Adult) - 65 Years				
		Children between 91 days and 25 years can be insured provided either parent is getting insured under the Policy				
	Renewal	Lifelong				
	Tenure	1 / 2 years				
	Option	Individual Sum Insured basis and Family Floater Sum Insured basis				
	Family Discount	10% if more than 2 family members are covered on Individual Sum Insured basis				
	Relationship Covered	Self, Spouse, Dependent Children, Parents, Parents-in-laws (maximum 2 Adults can be covered under one Family Floater Policy)				
	Basic Sum Insured (BSI)	**Applicable Per Year and Per Insured member in an Individual Sum Insured Policy and for all Insured members combined in a Family Floater Policy. Benefits from 1 to 10 are included within the Basic Sum Insured.**	**3,4,5, 7.5L**	**2,3,4,5, 6,7.5,10 L**	**3,4,5,6 ,7.5,10 ,15L**	**2,3,4,5, 6,7.5,10 ,15L**
Sr. no	**Benefits**	**Description**	**E-Connect**	**Basic**	**Elite**	**Supreme**
1	Hospitalisation Expenses					
A	In-Patient Treatment Expenses	Minimum 24 Hrs hospitalisation as an In-patient	✓	✓	✓	✓
B	Day Care Treatment	Medical treatment, and/or surgical procedure undertaken in a hospital/day care center in less than 24 hours due to Technological advancement.	✓	✓	✓	✓
2	Pre-hospitalisation Expenses	Medical expenses incurred prior to the covered Hospitalization	30 days	60 days	60 days	60 days

3	Post-hospitalisation Expenses	Medical expenses incurred after the covered Hospitalization	60 days	90 days	90 days	90 days
4	Domiciliary Hospitalisation Treatment	Home hospitalisation due to non-availability of hospital bed or because the patient is not in a condition to be moved to a hospital	10% of SI	10% of SI	10% of SI	10% of SI
5	Hospital daily Cash Allowance	Daily cash Per day of hospitalization max upto 10th day of continuous hospitalization with deductible of 48 hours	Rs.500/day	Rs.500/day	Rs.1000/day	Rs.1000/day
Sr. no	**Benefits**	**Description**	**E-Connect**	**Basic**	**Elite**	**Supreme**
6	Emergency Local Road Ambulance Charges	Ambulance expenses incurred while transfer the Insured Person to the nearest Hospital (per hospitalization/included within the basic SI)	Rs.1500	Rs.1500	Rs.2000	Rs.2000
7	Organ Donor Expenses	Organ donor's screening charges & the medical expenses for an organ donor's treatment for the harvesting of the organ (Included within the Basic SI)	Upto 1 lac	upto basic SI	upto basic SI	upto basic SI
8	Second Opinion	Medical second opinion to augment confidence in the medical diagnosis and treatment plan available once during the Policy period.	✓	✓	✓	✓
9	Recovery Benefit	A lump-sum of Rs. 10, 000 in case of hospitalization for more than 10 days.				✓
10	Nursing Allowance	Payment of Rs.500 as daily allowance up to 30 days per Policy period, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence				✓
	Additional Features					
1	Restoration of Basic Sum Insured (Injury and Sickness hospitalization both)	100% restoration of basic SI on occurrence of another unrelated event	✓		✓	✓
2	Extended policy tenure	Extended policy tenure when out of country for a continuous period of more than 15 days	✓	✓	✓	✓
	Renewal Features					
1	Health Check Up	Free Health Check up after a block of 2 Renewals with Us (irrespective of Claims History)	✓	✓	✓	✓
2	Loyalty Perk	Auto increase in Sum Insured by 10% on basic sum insured for every claim free year up to max. of 100%.	✓	✓	✓	✓
3	Change in Plan/Enhancement of Sum Insured	Change in Plan and/or enhancement in Sum Insured can be done subject to approval by the Company.	✓	✓	✓	✓
	Waiting Period					
1	30 days Exclusion	Yes	✓	✓	✓	✓

2	1 Year Exclusion	Cataract, Benign Prostatic Hypertrophy, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Fissure, Gastric and Duodenal ulcers, gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus, polycystic ovarian diseases; skin tumors unless malignant, benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); Congenital Internal Diseases	✓	✓	✓	✓
3	2 Years Exclusion	Calculus diseases of Gall bladder and Urogenital system, Diabetes including- Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot /wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper/Hypoglycaemic shocks and Hypertension including Cerebro Vascular accident, Hypertensive Nephropathy, Internal Bleeds/ Haemorrhages, Coronary Artery Disease. Joint Replacement due to Degenerative condition, Surgery for prolapsed inter vertebral disc unless arising from accident, Age related osteoarthritis and Osteoporosis, Spondylosis / Spondylitis, Surgery of varicose veins and varicose ulcers,	✓	✓	✓	✓
4	Pre- existing Diseases Waiting Period	Policy will cover the Pre - existing diseases after a specified waiting period of	4 Years	4 Years	3 Years	2 Years

Health Check Up- The following list of investigations is available at the block of two Policy renewals with Us for the Insured Person/s more than 18 years. This benefit is available irrespective of the claim history.

Sum Insured (in Lakhs)	List of Investigations
2,3,4	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, S.Cholestrol, SGPT, Creatinine, ECG
5,6,7.5,10,15	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, Lipid profile, Kidney Function Test, Medical Examination Report