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 - ACE HEALTH ADVANTAGE

IMPORTANT NOTES ABOUT THIS INSURANCE

- Please read and check the details of this Policy carefully to ensure its accuracy andsee 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.
- 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.
- 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.

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:

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **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.
3. **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
4. **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.
5. **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.
6. **Condition precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
7. **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 of sum insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
8. **Cumulative Bonus:** Cumulative Bonus shall mean any increase in the sum assured granted by the Insurer without an associated increase in premium
9. **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
10. **Day Care Treatment** - Day care treatment refers to medical treatment and/or surgical procedure which is:
    a. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and.
    b. 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.
11. **Deductible** - A 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. The deductible shall apply per hospitalization.
12. **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.
13. **Dependant Child** - A dependant child refers to a child (natural or legally adopted) upto the completed age of 21, who is

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financially dependant on the primary insured or proposer and does not have his/her independent sources of income.

14. **Diagnostic Centre** – Diagnostic Centre means the diagnostic centres which have been empanelled by Us (or Our TPA's) as per the latest version of the schedule of diagnostic centres maintained by Us, which is available to You on request.

15. **Domiciliary Hospitalisation** - Domiciliary hospitalization means medical treatment for a period exceeding 3 days, 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 removed to a hospital, or.

    b. the patient takes treatment at home on account of non availability of room in a hospital.

16. Emergency Care means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

17. **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.

18. **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.

19. 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 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;

    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.

20. 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.

21. 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.

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

23. In Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

24. **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.

25. Maternity Expense/Treatment 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.

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

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

28. 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.

29. 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.

30. 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.

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

32. 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.

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

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

35. 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.

36. Pre-Existing Disease - 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.

37. Pre-Hospitalization 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.

38. Post-Hospitalization Expenses

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

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

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

39. 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.

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

41. 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.

42. 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.

43. 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 .

44. 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.

45. 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.

46. 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.

47. Sum Insured – Sum Insured means the amount stated in the Policy Schedule against each insured person, which is the maximum amount We will pay for all admissible claims in one policy period (per annum for multi year tenure) irrespective of the number of claims of the Insured Person.

48. Floater Sum Insured means the Sum Insured as specified in the schedule of the policy is 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.

49. 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.

50. 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.

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

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

53. 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, deductible, co-payment, 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 Cumulative Bonus 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.

b. Nursing Expenses incurred during In-Patient hospitalization. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees.

c. 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.

d. Pre-hospitalization expenses – We shall pay for expenses incurred 30 days prior to date of admission into the hospital.

e. Post-hospitalization expenses - We shall pay for expenses incurred 60 days after the date of discharge from the hospital.

f. 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.

g. 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/Insurers 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 applicable under this policy shall be reduced by 5% if there is no claim under the expiring policy.

D. EXCLUSIONS

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 under this policy. Under Silver Plan and 2 years of continuous insurance from the Commencement Date of the cover with Us under this policy. Under Gold, Platinum and Super Platinum Plans 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/Hypoglycemic shocks

2. **30 days waiting period**

   Any claim during the first 30 days from the Commencement Date of the First Policy with us 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/Benign 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. During first three years of the policy under Silver Plan and during first two years of the policy under Gold, Platinum and Super Platinum Plan 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 chroidial 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 Exclusion

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. Spo2 Probe.
   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.
   bb. 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, corrective 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 only.
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 Ayurvedic, Homeopathic, Naturopathy or any other system of medication 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.
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.
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. 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 number 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 48 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.

The claim 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 Toll Number 1860 425 0000

- 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 the information We ask for about the claim and he 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.
- Insured must help Us to take legal action against anyone if required.
- 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.

2. Payment of Claim

- All claims under this Policy shall be payable in Indian Currency.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document.
- 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.
- At the time of claim settlement, Company may insist on KYC documents of the Proposer, as per the relevant AML guidelines in force.
- 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.
- In case of a policy issued on an installment premium basis, balance premium due if any, shall be adjusted against the claim amount.
- 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 subject to a minimum premium retention of Rs.250/- plus applicable service taxes.

Short period scales - Annual Policies

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

For Multi year policies refund of premium shall be calculated as follows;

a) Total premium shall be divided by the policy tenure to arrive annual premium

b) Multi year discount shall be adjusted based on the actual tenure completed including the year of cancellation.

c) Annual premium shall be retained for each completed years and for the year in which the policy is cancelled the above table shall be applied.

d) For the remaining unexpired period the entire premium shall be refunded.

5. 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.

d. In case of payment of premium by Installments there will not be any refund of premium if the insured cancels the policy.

6. 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.
- Upon non receipt of the installment premium when it becomes due.

7. 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.

8. 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.

9. Geographical Area

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

10. Contribution

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

11. 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.

12. 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.

13. 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.

14. 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 3 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.

The renewal premium shall be subject to changes (as approved by IRDA) if any, as specified in the prospectus.

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/medical. condition 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. 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.

21. Compliance with Policy provisions

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

22. 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 number of Customer Service 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.

ADDITIONAL BENEFITS

1. Ambulance Charges

Subject otherwise to terms, conditions and exclusions of the policy, the following additional benefits are extended on payment of appropriate premium

- Emergency ambulance charges for transporting the patient to the hospital upto a
- Sum of Rs 2500/- per admissible hospitalization for Silver & Gold Plan.

- sum of Rs.3500/- per admissible hospitalisation for Platinum Plan.
- sum of Rs.5000/- per admissible hospitalisation for Super Platinum Plan.

and overall policy limit of.

- Rs.5000/- for Silver & Gold Plan.
- Rs.7000/- for Platinum Plan.
- Rs.10000/- for Super Platinum Plan.

will be reimbursed on producing the bills in original.

2. Cost of contact lens, spectacles and hearing aids (Extended on payment of additional premium as evidenced in the schedule of the policy).

The Insured is eligible, once in 4 years, for, subject to a maximum of Rs. 20000/-, on completion of four consecutive years under this policy with us towards the following:

a. One pair of spectacles or contact lenses, or.

b. A hearing aid, excluding batteries.

Provided that the above are prescribed by a Medical Practitioner and does not include anything of cosmetic in nature.

i) The benefit under this section is subject to a co payment of 25% of the expenses incurred by the insured person.

ii) Under a Family Floater cover, the limits are per policy.

iii) The prescription of the medical practitioner and the bills/ receipts/invoices are necessary for making a claim.

iv) This benefit is payable once in 4 years only.

3. Critical Illness (Extended on payment of additional premium as evidenced in the schedule of the policy)

The Policy shall pay lump sum amount as mentioned in the Schedule subject to terms, conditions, limitations and exclusions mentioned herein, if the Insured Person is Diagnosed to be suffering from any of the defined Critical illness, contracted or sustained by the Insured Person during the Period of Insurance, and if all of the following conditions are satisfied.

(a) The Insured Person experiences a Critical Illness specifically listed and defined in this benefit ; and.

(b) The Critical Illness experienced by the Insured is the first incidence of that Critical Illness; and.

(c) The signs or symptoms of the Critical Illness experienced by the Insured Person commenced more than one hundred and eighty (180) days following the Commencement Date; and.

(d) The Insured Person should survive more than thirty (30) days from the date of Diagnosis of Critical Illness.

Only one lump sum payment shall be provided during the Insured's lifetime regardless of the number of Critical Illness, incapacities or treatments suffered by him/her.

Definition of Diagnosis: Diagnosis means the identification of a disease/illness/medical condition made by a Specialist Physician, based upon such specific evidence, as required, in the definition of the particular Critical Illness concerned, or, in the absence of such specific evidence, based upon radiological, clinical, histological, laboratory evidence or any other medical tests following medical advancement, acceptable to the Company.

Important Note:

This benefit shall become null and void in respect of the Insured Persons, where a claim has already been admitted under any of Our Critical Illness (Lumpsum) Policy.

CANCER OF SPECIFIED SEVERITY

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

(1) Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, cervical dysplasia CIN-1, CIN -2 & CIN-3.

(2) Any skin cancer other than invasive malignant melanoma.

(3) All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.

(4) Papillary micro - carcinoma of the thyroid less than 1 cm in diameter.

(5) Chronic lymphocyctic leukaemia less than RAI stage 3.

(6) Microcarcinoma of the bladder.

(7) All tumors in the presence of HIV infection.

STROKE RESULTING IN PERMANENT SYMPTOMS

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

The following are excluded:

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

MAJOR ORGAN /BONE MARROW TRANSPLANT

The actual undergoing of a transplant of:

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

The following are excluded:

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

MULTIPLE SCLEROSIS – with persisting symptoms

1. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

I. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis.

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

III. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month part.

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

OPEN CHEST CABG

1. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

2. The following are excluded

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

II. Any key-hole or laser surgery.

MAJOR BURNS – 20%

Third degree(full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body.

OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

FIRST HEART ATTACK - OF SPECIFIED SEVERITY:

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

1. Typical clinical symptoms (for example, characteristic chest pain).

2. New characteristic changes (ST-T elevation) on ECG and progressing to development of pathological Q waves.

3. The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;

4. Troponin T > 1.0 ng/ml

5. AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The following are excluded:

1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.

2. Other acute Coronary Syndromes.

3. Any type of angina pectoris.

Diagnosis must be confirmed by a Consultant Cardiologist

The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.

ii. Other acute Coronary Syndromes.

iii. any type of angina pectoris.

In the event of any claim becoming admissible under the Policy, the Company will pay to the Proposer, the Sum Insured mentioned in the Schedule for this benefit.

Exclusions for Critical Illness

a) Pre Existing Disease.

b) Any heart, kidney and circulatory disorders in respect of Insured Persons caused by Hypertension/Diabetes.

2. 180 Days Waiting Period: Any Critical Illness of which, the signs or symptoms first occurred within One Hundred and Eighty (180) days from the Commencement Date.

3. Venereal disease, intentional self-injury, drug overdose or attempted suicide.

4. 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.

5. Complication of any surgery, therapy or treatment administered on the Insured Person which is not prescribed or required by a Registered Medical Practitioner/Registered Medical Institution in their professional capacity.

6. Taking of drug unless it is taken on proper medical advice and is not for the treatment of drug addiction.

7. Any person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, 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 boxing, caving, horse racing, jet skiing, martial arts, off piste skiing, scuba diving, any flying activity (other than as a passenger in a commercially licenced aircraft) and activities of similar hazard.

8. Any Illness, sickness or disease, other than specified as Critical Illness.

9. Congenital anomalies or any complications or conditions arising there from.

10. Directly or indirectly contributed or aggravated or prolonged by childbirth or from pregnancy.

11. Any Critical Illness based on a Diagnosis made by the Insured or his/her Immediate Family Member or anyone who is living in the same household as the Insured or by a herbalists, acupuncturist or other non-traditional health care provider.

12. Critical Illness when the Insured Person dies within 30 days from the date of the Diagnosis.

13. Any expenses towards test, visits, fees etc. relating to the Diagnosis.

14. Any illness/disease/injury/condition arising out of use/misuse or abuse of alcohol, solvents, substance or drugs (whether prescribed or not) and tobacco (in any form).

15. Any condition, illness, sickness or disease arising out of self medication or any treatment that is not scientifically recognized.

16. Any condition, illness, sickness or disease due to involvement in any activities resulting in any breach of law with criminal intent.

17. Any condition, illness, sickness or disease arising out of any experimental or unproven treatment, diagnostic tests and treatment not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury.

18. Unreasonable failure to seek or follow medical advice.

Critical Illness Claims Procedure

The Claims Procedure is as follows:

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/burns and name and address of the attending Medical Practitioner/Hospital/Nursing Home should be given to Us within seven days from the date of Diagnosis, 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.

1. Certificate from the attending Doctor of the Insured Person confirming, inter alia,
   a. name of the Insured person;
   b. name, date of occurrence and medical details of the Insured Event.
   c. Confirmation that the Insured Event does not relate to any Pre-Existing Illness or any Illness or Injury which existed within the first 90 days of commencement of Period of Insurance.
2. Duly completed and signed claim form.
3. Case history/Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
4. Test reports and prescriptions relating to First/Previous consultations for the same or related illness.
5. Death summary in case of death of the insured person at the hospital.
6. FIR/MLC in the case of burns and English translation of the same, if in any other language.
7. 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.

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 Service Helpline Number 1860 425 0000.

- Insured/Insured Person must give Us at his expense, all the information We ask for about the claim and he 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.

Payment of Claim

- All claims under this Policy shall be payable in Indian Currency.
- Any claim intimated after 90 days from the date of Diagnosis shall not be entertained.
- If a claim is settled for an insured, cover for other insured members under the policy shall continue.
- 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.
- At the time of claim settlement, Company may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.

4. Dental Care (Extended on payment of additional premium as evidenced in the schedule of the policy)

The Insured is eligible for a maximum of Rs.15,000/-, on completion of two consecutive years under this policy with us towards the following

a. Fillings and Crowns.
b. Emergency Tooth Replacement.
c. Non-cosmetic Oral Surgeries.
d. Dental x-rays.

Provided that the above are prescribed by a Medical Practitioner and does not include anything of cosmetic in nature.

i) The benefit under this section is subject to a co payment of 25% of the expenses incurred by the insured person.

ii) Under a Family Floater cover, the limits are per policy. .

iii) The prescription of the medical practitioner and the bills/ receipts/invoices are necessary for making a claim.

iv) This benefit is payable once in 2 years only.

5. Health Checkup

Reimbursement of expenses, subject to a maximum of Rs. 2,500/- under Silver and Gold Plan, Rs. 3,500/- under Platinum Plan and Rs.5000/- under Super Platinum Plan per Insured Person, towards Master Health Check up for the Insured Person, after each 2 consecutive claim free years. This is payable once in 2 claim free years.

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

6. Maternity Benefit (not applicable for Silver Plan)

1. The maximum amount payable under this Benefit is 10% of the Sum Insured subject to maximum of Rs.50,000/- 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.
2. This Benefit is admissible only if the expenses are incurred in Hospital/Nursing Home as In-Patient in India.

3. Expenses incurred towards Maternity Treatment shall not be payable during the first 24 months from the Commencement Date of the cover for the insured person. The waiting period may be relaxed only in case of delivery /miscarriage/abortion induced by accident or other medical emergency.

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

5. 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. Hospitalization expenses incurred up to 3 days after a regular delivery and 5 days after a cesarean delivery shall be covered. Any extended stay,shall be covered only if medically necessary.

Riders:

7. Convalescence/Recovery Benefits (Extended on payment of additional premium and as evidenced in the schedule of the policy)

A lump sum of Rs.15,000/- is payable, if the period of hospitalization exceeds 15 days. This benefit is payable once for each Insured Person per year per illness, irrespective of number of policies. The benefit under this section is payable in addition to the hospitalization expenses only if a valid claim for hospitalization is admitted under this policy.

8. Hospital Cash (Extended on payment of additional premium and as evidenced in the schedule of the policy)

For each completed 24 hours of hospitalization the daily benefit of Rs.2000/- will be payable. This benefit follows admitted liability under hospitalization cash benefit.

This benefit is not applicable in case of an admitted liability under hospitalization benefit for day care procedures where no inpatient treatment is involved.

The daily benefit as mentioned in the Schedule of the policy is payable for a maximum period of 30 days per annum.

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 Any heart, kidney and circulatory disorders in respect of Insured Persons caused by Hypertension/Diabetes.

1.3 All exclusions flowing from base policy (except Pre Existing Disease).

Hospital Cash Claims procedure

1. Preliminary notice of claim with particulars relating to Policy number, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name, address Hospital/ Nursing Home etc. should be given to Us 24 hours prior to admission in case of planned. hospitalisation and not later than 24 hours after admission in case of an emergency hospitalisation.

2. The claim form duly completed in all respects along with all documents listed below should be submitted within 30 days from the date of discharge.

   a) Photo copy of bills, receipt and discharge certificate/card from the Hospital.

   b) Photocopy of FIR. copy in case of an accident.

   c) Complete set of Hospital/medical records if specifically sought by Us.

   d) If required, the Insured/Insured Person must give consent to obtain Medical Report from any Medical Practitioner at Our expense.

   e) If required, the Insured/Insured Person must agree to be examined by a Medical Practitioner of Our choice at Our expense.

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.

9. Accidental Death and dismemberment Benefit (Extended on payment of additional premium and as mentioned in the schedule of the policy)

If at any time during the currency of this policy, the Insured person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means any where in the world then the Company shall pay to the Insured or his legal Personal representative(s) as the case may be, the sum or sums hereinafter set forth, that is to say:

a) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the death of the Insured, the Sum Insured stated in the schedule hereto.

b) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of (i) sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand or one entire foot, or such loss of sight of one eye and such loss of one entire hand or one entire foot, the Sum Insured stated in the schedule hereto (ii) use of two hands or two feet or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot, the Sum Insured stated in the schedule hereto.

c) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of (i) the sight of one eye, or of the actual loss by physical separation of one entire hand or of one entire foot, fifty percent (50%) of the Sum Insured stated in the schedule hereto (ii) total and irrecoverable loss of use of a hand or a foot without physical separation, fifty percent (50%) of the sum insured stated in the schedule hereto.

NOTE: For the purpose of Clause (b) and Clause (c) above, 'physical separation' of a hand means separation at or above the wrist and of the foot at or above the ankle.

d) If such injury shall, as a direct consequence thereof, immediately, permanently totally and absolutely, disable the insured person from engaging in any employment or occupation of any description, whatsoever, then a lump sum equal to hundred percent (100%) of the Sum Insured.

e) If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and/or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the percentage of the Sum Insured as indicated below shall be payable:

Sl. No		Percentage of Sum Insured
1.	Loss of toes – all	20%
	Great – both phalanges	5%
	Great –one phalanx	2%
	Other than great, if more than one toe lost each	1%

2.	Loss of hearing – both ears	75%
3.	Loss of hearing – One ear	30%
4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%
6.	Loss of thumb – both phalanges	25%
	- one phalanx	10%
7.	Loss of index Finger – three Phalanges	10%
	- two phalanges	
	- one phalanx	
8.	Loss of middle finger – three phalanges	6%
	- two Phalanges	
	One phalanx	
9.	Loss of ring finger – three phalanges	5%
	- two phalanges	
	- one phalanx	
10.	Loss of little finger – three phalanges	4%
	- two phalanges	
	- one phalanx	
11.	Loss of metacarpals – first or second (additional) third, fourth or fifth (addnl)	3%
12.	Any other permanent	percentage as partial disablement assessed by the panel doctor of the Company

Exclusions for Personal Accident Benefit:

The Company shall not be liable to make any payment under this Benefit in connection with or in respect of any expenses whatsoever incurred by the Insured in connection with or in respect of:

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance.

2. Payment of compensation in respect of death, injury or disablement of the Insured Person.

   (a) from intentional self injury, suicide or attempted suicide.

   (b) whilst under the influence of intoxicating liquor or drugs.

   (c) whilst engaging in aviation, whilst mounting into or dismounting from or travelling in any aircraft other than as passenger (fare paying or otherwise) in any duly licensed Standard type of Aircraft anywhere in the world. ("Standard type of Aircraft" means an aircraft duly licensed to carry passenger (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine).

   (d) directly or indirectly caused by venereal diseases, AIDS or insanity.

   (e) arising or resulting from the Insured/Insured Persons committing any breach of law with criminal intent.

   (f) as a result of, or which is contributed to by, the Insured person suffering from any pre- existing condition or pre-existing physical or mental defect or infirmity.

   Complications arising from the pre-existing physical or mental defect or infirmity will be considered as part of the pre-existing condition.

3. Payment of compensation in respect of Death, Injury or Disablement of the Insured person due to or arising out of or directly or indirectly connected with or traceable to: War, Invasion, Act of foreign enemy, Hostilities (whether war be declared or not), Civil War, Rebellion, Revolution, Insurrection, Mutiny, Military action or Usurped Power, Seizure, Capture, Arrests, Restraints and Detainments.

4. Payment of Compensation in respect of Death of or bodily Injury or disablement or any disease or illness to the Insured person

   - directly or indirectly caused by or contributed to by or arising from ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception, combustion shall include any self–sustaining process of nuclear fission.
   - directly or indirectly caused by or contributed to by or arising from nuclear weapons material.

5. Pregnancy Exclusion Clause: The Insurance under this Policy shall not extend to cover Death, Injury or Disablement resulting directly or indirectly, caused by or contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.

6. Payment of compensation in the event of a rail accident except if the accident is directly caused/occurring while

   - Boarding/travelling/alighting from a train.
   - Within the railway area to which a public has got right of access.

7. Persons whilst working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high tension supply, Jockeys, Circus personnel, engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, rock climbing, potholing, bungee jumping, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons whilst engaged in occupation/activities of similar hazard. Persons while engaged in the following occupations are excluded:

   Aircraft pilots and crew, Armed Forces personnel, Artistes engaged in hazardous performances, Aerial crop sprayer, Bookmaker (for gambling), Demolition contractor, Explosives users, Fisherman (seagoing) Jockey, Marine salvager, Miner and other occupations underground, Off-shore oil or gas rig worker, Policeman (Full time), Pop Musicians, Professional sports person, Roofing contractors and all construction, maintenance and repair workers at heights in excess of 50ft/15m, Saw miller, Scaffold Worker, Scrap metal merchant, Security guard (armed), Steeplejack, Stevedore, Structural steelworker, Tower crane operator, Tree feller, Ship crew.

8. Nuclear, Chemical, Biological Terrorism Exclusion Clause: The Insurance under this Policy shall not extend to cover Death, disablement or injury resulting directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

   For the purpose of this endorsement "Nuclear, chemical, biological terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or

reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

"Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

"Biological" agent shall mean any pathogenic (disease producing) microorganism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

If the Company allege that by reason of this exclusion any loss is not covered by this insurance the burden of proving the contrary shall be upon the Insured Person.

Personal Accident Claims Procedure

Preliminary Notice: Upon the happening of any event, which may give rise to a claim under the policy, a preliminary notice with all particulars shall be given to the Company, Immediately, in any case, not later than 30 days after the occurrence of the event.

Claims for insurance benefits must be submitted to the Company not later than one (1) month after the completion of the treatment or after transportation of the mortal remains/ burial in the event of death.

Claim Documentation

Death Claim

Submit the duly filled in claim form with the following documents:

- Original Death Certificate.
- Post Mortem Report.
- Inquest report.
- Accident report.
- FIR/MLC copy.
- Hospital records.
- News Paper cuttings if any and any other relevant records.
- Chemical Analysis Report if available.
- English Translation of vernacular documents.
- Succession Order/legal heir certificate/legal documents to establish identification of legal heir in the absence of nomination under the policy or if the nominee is not alive at the time of claim.
- Any other document as may be required by the Company.

Disablement Claim

Submit the duly filled in Claim form with the following documents

- Disability Certificate issued by attending physician.
- Accident report.
- FIR/MLC copy.
- Hospital Records.
- News Paper cuttings if any and any other relevant records.
- English Translation of vernacular documents.
- Latest IT return to show Proof of annual income (at the option of the Company).
- Any other document as may be required by the Company.

Claim documents may be submitted 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.

Claims Settlement/Rejection

All admissible claims under this policy shall be offered for settlement within 30 days from the receipt of last necessary document. Wherever settlement offer has been made and accepted by Insured Person/Nominee/Legal heir as the case may be, the company shall pay the offered claim amount within 7 days from the date of such acceptance, failing which the Company shall be liable to pay interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

10. Indexation

The Sum Insured under this Policy shall be progressively increased by slabs of 10% of the Sum Insured under Silver, Gold and Platinum Plans and 20% of the Sum Insured under Super Platinum Plan 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 main benefit 1 `Hospitalisation Benefit.'

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