Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2,
One International Center,
Senapati Bapat Marg,
Prabhadevi, Mumbai- 400013
IRDAI Reg. No.150, CIN: U66000MH2010PLC269656

CRITICAL CONNECT
PROSPECTUS

Introduction

Life is full of uncertainties, you never know at which stage of life you may be diagnosed with critical illness which will washout all your savings. Thus, connect yourself with our Critical Illness policy for peaceful future.

Note: The information provided herein is only indicative, we request you to refer the Policy document for better understanding of the covers, sum insured, exclusions, terms and conditions applicable.

Eligibility

- Minimum Entry Age : 18 Years for Adults and 5 years for children
- Maximum Entry Age : 65 Years for Adults and 25 years for children
- Renewability: Lifelong
- Policy Tenure: 1/2/3 Years
- Relationships covered: Self, Spouse, Children, Parents, Parents-in-laws, Siblings, Son-in-law, Daughter-in-law, Grand- children, Grand-parents.
- Child/children above 5 years of age can be covered, provided either of the parents are insured under the policy and child above 18 years of age may continue in their existing policy or may opt for a separate policy with continuity benefits.

Key Features

1. **Flexi Policy term:** Option to choose policy term of 1, 2 and 3 years
2. **Refill Feature for Second and Third Events (with Plan A):** Multiple claims after a waiting period of 24 months for unrelated CIs. Maximum of 3 refills over a lifetime.
3. **Health check-up:** you are eligible for a Health check -up on cashless basis after a block of every 2 claim free years.
4. **Pay premium on Installments:** Monthly, quarterly or half yearly.
5. **Second Opinion / Tele-Consult** from our empaneled network providers
6. **Digital Wellness App** (access provided to all policyholders)
7. **Optional Cover(S):** Loan Protector Cover and Option to Waive 30-Day Survival Period
8. **Coverage up to 59 Critical illnesses**
9. **Sum Insured range from 1 lac to 1 crore**
10. **Tax Benefit:** Avail tax benefits under section 80D of Income Tax Act 1961

Scope of Cover

The features and benefits available are as per the relevant plan opted by the Insured Person/s. Please refer the Benefit Schedule in the later part of the Prospectus.

A. Payment of the Benefit Amount for an Insured Condition - We will pay you a lump sum amount for one of the conditions in the Benefit Schedule, as long as it occurs (diagnosed or undergoing surgery) itself during the policy period as a first incidence and you survive the defined Survival Period.

The compensation under more than one event as stated below for the same Policy year shall not exceed the Sum Insured as mentioned in the Policy schedule. Moreover, we will pay only once for the same Critical illness over a lifetime.

For Plan A, the lump sum amount will be 100% of Sum Insured in your Policy Schedule.

For Plan B, we will pay you a lump sum amount that is a percentage of Sum Insured, based on whether a condition is a "Major Condition" or "Minor Condition":

1. For Major Conditions, the policy pays out 100% of the Sum Insured.
2. For Minor Conditions, the policy pays out 25% of the Sum Insured and continues until the policy term. If, during the policy term, you are diagnosed with one of the Major Conditions in that same cover, we will pay out the remaining 75% of the Sum Insured to you.
3. With the Heart and Cancer Protect, you can raise multiple claims under each cover until the total payout for that cover is exhausted. In any case, the total payout in the policy cannot exceed 100% of the Sum Insured.
4. Plan 'B' has an option to choose one or more from the given '*Disease-specific Bundles'* with a Sum Insured applicable to each selected '*Disease-specific Bundle'.*

Please refer to the Benefit Schedule: Plan A & Plan B given at the later part of the document, for a list of insured conditions (illnesses, medical events, and surgical procedures).

B. Continuation for Second and Third Events (for Plan A) - If you have one of the covers in Plan A, we will pay a lump sum benefit for any condition in the Benefit Schedule (corresponding to your cover), provided it occurs itself as a first incidence and you survive the defined Survival Period. After one claim is paid, we will continue to provide coverage, subject to the following:

1. Coverage shall be given for a second and third insured condition, or maximum of 3 conditions over a lifetime
2. 24-month waiting period shall apply between the occurrences of each condition (i.e. between the first and second insured condition, or between the second and third condition)
3. You have maintained or renewed the policy and the second or third event occurs during the policy period
4. Coverage shall not be given for a second or third insured condition that is "Related" to the previous event. For a full list of "Related" conditions that we will not provide continuous coverage for, please see the Table I given below: ***"Related" Conditions not covered by Continuation Feature***

C. Multiple Claims up to Sum Insured Amount (for Plan B)

We will pay you a lump sum amount that is a percentage of Sum Insured, based on whether a condition is a "Major Condition" or "Minor Condition" as listed in the Benefit Schedule.

1. For Major Conditions, the policy pays out 100% of the Sum Insured.
2. For Minor Conditions, the policy pays out 25% of the Sum Insured and continues until the policy term. If, during the policy term or on renewal of the Policy with same benefits, you are diagnosed with one of the Major Conditions in that same cover, we will pay out the remaining 75% of the Sum Insured to you.
3. With the Heart and Cancer Protect, you can raise multiple claims under each cover until the total payout for that cover is exhausted.

In any case, the total payout in the policy cannot exceed 100% of the Sum Insured.

D. Second Medical Opinion / Tele-Consult - We will arrange and pay for a second opinion through our empaneled network providers. This is on the condition that you suffer one of the insured conditions during the Policy Period, and decide to avail this benefit. The medical specialist will directly send you the e-opinion. Please note that this benefit can be claimed only once in a policy year.

The Second Opinion shall not be construed as medical advice. Second Opinion should not be used as a substitute to medical professional advice or visit or call consultation of your choice and any reliance on any opinion, advice, statement, memorandum, or information available on the Second Opinion, otherwise, shall be at your sole risk and responsibility. Second Opinion from a Medical professional on our panel shall be that person's independent assessment of information that you share. We do not warrant the accuracy or completeness of the information, materials, services or the reliability of any Second Opinion. We and our affiliates, subsidiaries, employees, officers, directors and agents, expressly disclaim any liability for or arising out of any deficiency in the Second Opinion obtained by you.

E. Health Checkups Every 2 Years – If you are above 18 years of age, you are entitled to a health check-up on cashless basis for the list of investigations given below at our specified Network providers after a block of every 2 claim free continuous Policy years with Us. This is available if you was insured with Us for the above specified period and continue to be insured in the subsequent Policy Year.

If the Health checkup reports are abnormal and you succeeds to bring it to normal, you can earn Wellness Rewards as mentioned under Section 'Health 360°-Table 1 'Wellness Reward'.

Sum Insured	List of Investigation
1 Lac to 1 Crore	Complete blood Count, , Fasting Blood Sugar, S. Cholesterol, S. Creatinine, ECG

F. Health 360°

We covers below listed benefits to ensure your Health & Wellness under this Policy by offering services & incentivizing rewards as mentioned below

G. Ayush cover #-AYUSH treatment" refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

#Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.

A. Delight Healthcare

You can avail discounts on outpatient consultation, pharmaceuticals and Diagnostic tests through our empaneled Network Providers. The list of such Network Providers will be updated from time to time and can be obtained from Our website, mobile application or by calling Our call centre. We will assist in scheduling appointments for consultation and diagnostic tests at a time convenient to you. Alternatively you may also schedule your own appointment by contacting the Network Provider or through the mobile application. You may avail these facilities as many number of times as wishes to avail.

1. OPD consultation-

We will arrange a family physician as well as specialist consultations at discounted rates from the Network Providers. You can also store the prescription letters and bills in the electronic health portal system.

2. Diagnostic services-

We will arrange diagnostic facilities at discounted rates from the Network Providers. You can avail this facility as many number of times as you wishes to avail.

3. Pharmacies

If you want to obtain medicines and consumables prescribed by a Medical practitioners, you can avail home delivery facilities through our web portal or mobile application. These medicines and consumables are available at discounted rates subject to a valid prescription.

B. Concierge Healthcare-

The Company offers integrated healthcare services inculcating the advancement in technology and with a member centric approach. You will be provided an individual access to our health portal which will be available at our website and Mobile application where you can perform various healthcare activities.

1. Health Risk Assessment (HRA)

   Step 1 - Health questionnaire-

   Once the Profile of the Insured Persons is created on the Health Portal or Mobile application, this questionnaire will be available for doing own Health Risk assessment. We will aid the Insured Person/s to complete the questionnaire whenever required.

   Step 2- Electronic Health records-

   Insured Person/s can store the medical tests reports, prescriptions and other consultation papers in the personalized portal and which gets digitalized to help create a complete health profile of the Insured person/s. These medical test reports along with HRA as specified above, will provide a health score to depict the health status of the Insured Person/s.

   The Health score will be driven basis the information provided in areas of Medical history, stress, diet and lifestyle which ranges from 1 to 100 enabling us to identify the need of Step 3 as mentioned hereunder.

Step 3 -Health Screening-

If the health scores depicts healthy status, there will be no trigger for medical screening. But if the score depicts unhealthy status, medical screening is advised to the Insured Person/s which he will have to get it done at his own cost or focus on 'Target Risk Assessment' post identification of the risk factor for improving his/hers overall well-being.

"Targeted Risk Assessment", which basically takes a deep dive in the identified risk areas to establish the focus points in that particular risk area. This is based on the Health screening done subsequently after the HRA. It's a specific tracking if the client suffers from any of the Non Communicable Diseases like Diabetes, Blood Pressure, Thyroid or any other diseases which in turn call for a Health coach who will prompt for the next steps which is a 'Targeted Risk Assessment.

Step 4- Disease management program-

The Insured Person/s also gets further triggers for disease management program as specified hereunder pertaining to the current health status if required.

2. Disease Management Program-

Those who get detected or get assessed as high risk in the health risk assessment or are already suffering from chronic diseases, the Company offers variety of disease management programs. This service aims to help the Insured Person/s cope with their disease and to show them ways of dealing with them in everyday life. The Disease management Program aim to improve the Insured Person/s quality of life.

Following are the names of Disease Management programs.

- Asthma Management
- Pre-Diabetes / Diabetes Management
- Hypertension
- Heart Related Management
- Maternity Management
- Tropical Disease Management

Based on the Disease Management Program identified, we will assign a Health Coach for online Diet consultation & tracking mechanism, indulging the Insured Person/s into physical activities, encouraging for meditation & breathing techniques at home or online counselling through our health portal/mobile application.

Health coach-

The Insured Person/s will be assigned a dedicated health coach who will take care of the complete wellbeing of the Insured person. This service will offer immediate and complete assistance to the person looking after his/her day-to- day health care. Post the complete profile building of the Insured Person/s done on online portal, health coach will interact with the Insured Person/s as per health requirements.

3. Dedicated Health Professional

The Company offers 24/7 live Health Chat via online Health portal and telephonic call service to discuss health and other various lifestyle related issues from expert panel of empaneled doctors and health professionals. The below services may be availed anytime during the policy period and there are no restrictions on the number of times the facility can be utilized.

- Ask Doctor – for basic health related conditions and medications
- Ask Nutritionist – for diet and nutrition considerations depending on lifestyle

- Ask Counselor – confidential counseling by professionals, crisis intervention etc.

4. Wellness Rewards :
   The Company has kept a provision to Earn & Burn Rewards individually by way of 'Wellness Reward Program'. The Rewards can be earned by performing various activities as listed below 'Table 1. Wellness Reward' upto the maximum limits as specified under every category during every continuous Policy year and Burn it whenever required without any waiting period against array of our facilities provided as mentioned hereunder which would help you to improve your overall Health status whilst using the Rewards earned by you as follow.

   a. The earning of Wellness Rewards shall be considered up to the maximum limits as specified under every category or sum of all Rewards earned by you maximum up to 10% of premium paid in the current Policy Period whichever less.
   b. We will specify the Wellness Rewards-Earn & Burn categories as well as Earned but non-utilized Rewards in the Policy Schedule. The details of Wellness Reward also would be available at our Health portal or Mobile application using personalized security access.
   c. All Rewards earned under this Section of the Policy are valid upto four Policy years of renewal of this Policy including the Grace Period applicable to the preceding Policy and would not be carried forwarded thereafter. However, in case the policy gets lapsed or ceased, the earned rewards can be utilized for maximum up to 3 months of the policy expiry date.

   d. Each Reward earned by the Insured Person will be equivalent to 0.50 INR.

   e. The Wellness Reward can be Earned in the following ways as mentioned under Table 1. Wellness Reward: Earn.

Table 1 Wellness Reward: Earn

Sr. No.	Activities for Earning Wellness Rewards			Rewards/ unit earned by Individual	Max Rewards earned by Individual Per Policy Year
I	Solution to Sedentary Lifestyle	HRA outcome without any adverse report	Cover 2.5 to 3.5 lakhs steps in a month	100/month	500
		HRA Outcome of having Large waist size (> 40 inches)	Cover minimum 2 lakhs steps in a month	100/month	500
			Cover above 2 lakh steps in a month	150/month	1000
		Blood pressure for a known case of Hypertension	Blood Pressure is below or equal to - SBP:120-140 mm/Hg	150/month	500

			DBP: 80-90 mm/Hg SBP- Systolic Blood Pressure; DBP – Diastolic Blood Pressure		
		Blood sugar levels for a known case of Diabetes	HBA1C within normal limits ≤ 5.6	150/quarterly	500
		Lipid profile Level for a known case of Dyslipidemia	Lipid level are normal within range as applicable to the Laboratory	150/quarterly	500
		Body Mass Index (BMI) for a known case of High BMI Insured Person /s >=30 optimum BMI	BMI between 31 to 35 and reduce your BMI to the Optimum range	100/quarterly	200
			BMI between 35 to 39 and reduce your BMI to the optimum range	150/quarterly	300
			BMI between 40 to 42 and reduce your BMI to the optimum range	250/quarterly	500
II	Get active Rewards: Participate in professional sport events like Marathon/Cyclothon/Swimathon and Earn the Rewards by providing medal/trophies/BIB number (as applicable) from the respective facility provider.			100 /event	500
III	Online Screening : On completion of HRA on Health Portal/Mobile application within a month from Policy Inception Date			200	200
IV	Prophylactic Screening	The Insured person (s) can earn wellness reward by undergoing the below listed medical tests at his own cost, irrespective of the results of screen tests performed.			
		Heart Related Monitoring	a. ECG	50/quarterly	100
			b. 2D echo/ TMT	100/ quarterly	200
		Blood Sugar Monitoring	a. FBS & PPBS	50/ quarterly	100
			b. HbA1C	75/ quarterly	200
		Thyroid/Lipid Monitoring	a. TFT (Thyroid Function Test)	100/ quarterly	200
			b. Lipid Profile	100/ quarterly	200

		Tests for Female Insured Person	a. PAP Smear	200/ quarterly	300
			b. USG Abdomen & Pelvis	150/ quarterly	300
			c. Mammogram	250/ quarterly	500
		Test For Male	a. Prostate Specific Antigen (PSA)	150/ quarterly	300
			b. Any other test as suggested in Health Screening by Us.	150/ quarterly	300
V	Family Rewards	Fit Kid (Age: 5-18 years): It is an additional criteria of earning Reward available for a child participating in the Sports at multiple levels. Can be availed by providing Sports Certificate provided by the School/State/National Sports authorities.	a. School level	20/sport	50
			b. State level	50/sport	100
			c. National level	100/sport	200

f. The Insured Person can Burn these accumulated Rewards without any Waiting period against categories as mentioned in Table 2 Wellness Reward: Burn.

Table 2 Wellness Reward: Burn

Sr. No	Categories to Burn the Rewards
a.	The Insured Person (s) may redeem the reward points (as available) while paying the applicable discounted rates to the Network Provider for the facilities as mentioned under 'Health 360°: Delight Healthcare'.
b.	Dental Care except cosmetic treatment
c.	Cost of Vaccinations
d.	Cost of Spectacle Lenses
e.	Laser surgery for correction of refractory errors
f.	You can also redeem your Rewards against Claim of yours/your Family member/s who are insured with Us under any retail Health Indemnity product against any Non admissible expenses.
g.	Discount on premium while renewing your Policy. For more details, please refer clause Health 360° (B) (4)(a).

H. Critical Illnesses Related due to HIV/AIDS:

Any insured condition or critical illness resulting due to HIV infection and / or AIDS is payable under the policy subject to following conditions:

i. The payout will be limited to 10% of the Sum Insured for a Policy year up to 100% of the Sum Insured in a lifetime for a Critical illness related to HIV/AIDS as specified in the Table , *Part C: "Related" Conditions not Covered by Continuation Feature'*

ii. 24-months waiting period shall apply between the occurrences of the Insured condition i.e. between the first and second insured condition, or between the second and third Insured condition and so on Related to HIV/ AIDS until 100% of the Sum Insured fully exhausted in a lifetime.

iii. 36-months Waiting Period shall apply for the Insured condition Related due to HIV / AIDS and its complications, from policy commencement date.

iv. In case of occurrence of the Insured condition which is not related to HIV/ AIDS, the claim shall be payable up to the Sum Insured as specified in the Policy Schedule less the amount paid during a Policy year.

v. Total payout in a policy year cannot exceed 100% of the Sum Insured.

vi. 'Maximum 3 no. of claims in a lifetime' as mentioned under Section 2.B. **Continuation for Second and Third Events (for Plan A)** is not applicable for a valid claim related to HIV/AIDS.

vii. 'The policy shall be renewable as specified under Part C with coverage of ***"Related"*** *Conditions mentioned against HIV/AIDS*

Optional Cover (s)

The Optional Covers as stated below shall be available only if the same is specifically mentioned in the Policy Schedule and available on payment of additional premium as applicable.

a) Loan Protector Cover

After the first diagnosis of one of the conditions in the Benefit Schedule, we will pay once during the Policy period, the lower of either:

i. the Equated Monthly Installment (EMI) of a loan obtained through a Financial Institution/Bank, for 12 months; or

ii. the lump sum amount as specified in the Policy Schedule (3 percentage of Sum Insured amount) and

iii. after the commencement of the Insured Event till the Principal Outstanding loan amount or expiry of Policy Period, whichever is earlier/lower.

This is subject to submission of sanction letter, repayment track record, and bank account statement reflecting EMI or Loan account statement.

b) Option to Waive 30-Day Survival Period

If you specify that you would like opt this cover for *waiving* the Survival Period from the date of diagnosis, we will apply an additional pricing to the premium payable. If you opt for this Optional feature, and you submit a duly filled claim form along with specified documents, a claim can be valid and payable without completion of the Survival Period.

We will not pay you for any claim directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy.

Commented [MF1]: Swati - As discussed, these definitions are all not as per standard definition. Request you to please modify.

Commented [MF2R1]: These need to be further segregated into standard and specific

Commented [RS3R1]: done

EXCLUSIONS

We will not pay you for any claim directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy.

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

The Company shall bear no liability to make the payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

1. **Pre- Existing Diseases – Code –Excl01**
   a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded as per the Plan mentioned in the Policy schedule i.e. Until the expiry of 36 months or 24 months of continuous coverage after the date of inception of the first policy with Us.
   b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to be extent of prior coverage.
   d. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-exiting Disease is subject to the same being declared at the time of application and accepted by the Insurer.

2. **Specified disease/procedure waiting period- *Code- Excl02***

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of below mentioned months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

3. **30-day waiting period- *Code- Excl03***

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

The within referred waiting period is made applicable to the enhanced sum insured in the

event of granting higher sum insured subsequently.

4. **Investigation & Evaluation – Code-Excl04**

   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. **Rest Cure, rehabilitation and respite care- *Code- Excl05***

   Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. **Obesity/ Weight Control: *Code- Excl06***

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

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

7. **Change-of-Gender treatments:** *Code- Excl07*

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

8. **Cosmetic or plastic Surgery:** *Code- Excl08*

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

9. **Hazardous or Adventure sports: Code- Excl09**

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

10. **Breach of law:** *Code- Excl 10*
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. **Excluded Providers : Code-Excl11**
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl 12

13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code - Excl 13**

14. Dietary supplements and substances that can be purchased without prescription including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code-Excl 14**

15. Refractive error: **Code – Excl15**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. Unproven Treatments: *Code- Excl16*
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility: Code- Excl17**
    Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

18. **Maternity: Code Excl18**
    ii. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    iii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

ii. Specific Exclusions (Exclusions other than those mentioned under E(i) above)

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, 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 dental treatment or surgery unless requiring hospitalization arising out of an accident.

3. 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.

4. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.

5. 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.

6. External Congenital Anomaly.

7. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

8. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.

9. Treatment received outside India unless specifically mentioned in your policy schedule.

10. 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.

11. 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.

12. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

13. 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.

14. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head.

15. 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.

16. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

17. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.

18. 36- months Waiting Period for Insured conditions Related to HIV/AIDS, shall apply from the policy commencement date.

19. Survival Period: A claim for an insured condition becomes valid and payable if you survive for 30 days after the insured condition. For an additional price on the premium payable, we will waive this 30-day survival period.

20. 24-months waiting period shall apply between the occurrences of the Insured condition i.e. between the first and second insured condition, or between the second and third Insured condition and so on.

Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would

be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.
Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

Installment payment Option

If the insured person has opted for payment of premium on an installment basis i.e. Half Yearly, Quarterly or Monthly as mentioned in the certificate of insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy). This facility needs to be opted before inception of the policy and opting ECS/SI payment mode.

i. The grace period of fifteen days (where premium is paid in monthly installments) and thirty days (where premium is paid in quarterly/half-yearly/annual installments) is available on the premium due date, is available to the policyholder to pay the premium.
ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.
v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Premium Payment in Installment:

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly or any other specific frequency as mentioned in the policy Schedule/Certificate of Insurance the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. The grace period of fifteen days (where premium is paid in monthly installments) and thirty days (where premium is paid in quarterly/half-yearly/annual installments) is available on the premium due date, is available to the policyholder to pay the premium.
ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Given below are the payment terms applicable on standard premiums in case of installments.

Installment Frequency	% of Annual Premium
Half Yearly	51%
Quarterly	26%
Monthly	8.75%

Discount and Loadings

The following discounts on the premium payable based on the declarations made in proposal form, health status of the insured person(s) and coverage sought.

1. Family Discount: A Family discount of 10% will be given if 2 or more family members are covered. It is available to each member under the policy insured at start date of the Policy. Family members can include: Spouse, Children, Parents & In-laws, Siblings, Son/Daughter-in-law, Grandchildren, and Grandparents.
2. Long Term Policy Discount: A discount of 7.5% and 10% will be given on selection of 2 year or 3 year tenure policies respectively.
3. Employee Discount: 10% discount will be given if you are an employee of the Company at start date of the Policy. This discount is applicable to your family members insured in the same policy.
4. Direct Policy Purchase Discount- 10% discount will be given if you are purchasing this Policy as a New or Renewal Policy through Our Website. (Either of Employee/Direct Discount shall be applied)

Loadings:

Proposals where the Health status is adverse, as revealed in the proposal form or as evidenced in the pre policy check-up may be accepted as per the board approved underwriting policy of the Company.

We **may** apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will not apply any additional loading on your policy premium at renewal based on claim experience.

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the issuance of such counter offer letter. In case You neither accept the counter offer nor revert to Us within 7 days, We shall cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent.

Renewal Benefits

1. **Lifelong** Policy Renewal without any exit Age
2. **Grace Period -** Grace Period of 30 days for renewing the Policy is provided under this Policy
3. **Waiting Period -** The waiting periods of 90 days mentioned in the Policy wording will get waived off automatically on renewal of the policy.

4. **Sum Insured Enhancement -** Sum insured can be enhanced at the time of renewal following approval by the Company
5. **Change in Installment Option:** Change in Installment option or opting for this facility as specified can be done at Renewal.
6. **Continuation for Second and Third Events (for Plan A)** – 24-months waiting period between the occurrences of each condition (i.e. between the first and second insured condition, or between the second and third condition) shall be reduced

Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to you at least 90 days in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the revisions or modifications affected, and the changes in premium, if any, 90 days prior to expiry of the policy.

Cancellation/Termination

(i) The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall
a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.
(ii) The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

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.

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

Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port
the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60
days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently
covered and has been continuously covered without any lapses under any health insurance policy with an Indian
General/Health insurer, the proposed insured person will get the accrued continuity benefit in waiting periods
as per IRDA guidelines on portability.
For Detailed Guidelines on Portability, kindly refer the link https://www.libertyinsurance.in/

Withdrawal of Product

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

Pre-Policy Health Check Up

The Pre-policy check up is required as per the PPC grid mentioned below. This product has PPC grids based on the Sum Insured, Plan and age band. This grid may be subject to change based on the company policy in future. The result of these tests will be valid for a period of 3 months from the date of tests. The Pre-Policy Check Up will be carried out at our network list of diagnostic centres as available on our website

The Company reserves its right to require any individual to undergo such medical tests or any further additional tests, as per the Board approved Underwriting Guidelines of the Company to determine the acceptance of a Proposal.

If the proposal is accepted the Company to refund 50% of the health check-up cost.

Plan A

<table>
<tr><th>Age Band</th><th>1 to 5lakhs</th><th>7.5 to 10lakhs</th><th>15 to 40Lakhs</th><th>50lakhs to 1cr</th></tr>
<tr><td>5-18</td><td rowspan="7">Nil</td><td colspan="2" rowspan="5">Nil</td><td rowspan="4">Nil</td></tr>
<tr><td>18-25</td></tr>
<tr><td>26-30</td></tr>
<tr><td>31-35</td></tr>
<tr><td>36-40</td></tr>
<tr><td>41-45</td><td colspan="2" rowspan="2">MER, RUA, FBS, CBC, Lipid Profile & Sr. creatinine</td><td rowspan="2">MER, RUA, FBS, CBC, Lipid Profile & Sr. creatinine</td></tr>
<tr><td>46-50</td></tr>
<tr><td>51-55</td><td colspan="2" rowspan="3">MER, RUA, CBC, Lipid Profile, HbA1c, RFT, ECG & PSA (for male)</td><td colspan="2" rowspan="3">MER, RUA, FBS, CBC, Lipid Profile, HbA1c, LFT, RFT, TMT, Chest X-Ray, USG, PSA (for male), PAP smear (for female)</td></tr>
<tr><td>56-60</td></tr>
<tr><td>61-65</td></tr>
</table>

Plan B

1) **Heart Protect**

<table>
<tr><th>Age Band</th><th>1 to 5lakhs</th><th>7.5 to 10lakhs</th><th>15 to 40Lakhs</th><th>50lakhs to 1cr</th></tr>
<tr><td>5-18</td><td rowspan="7">Nil</td><td colspan="3" rowspan="6">Nil</td></tr>
<tr><td>18-25</td></tr>
<tr><td>26-30</td></tr>
<tr><td>31-35</td></tr>
<tr><td>36-40</td></tr>
<tr><td>41-45</td></tr>
<tr><td>46-50</td><td colspan="3">MER, RUA, CBC, Lipid Profile, HbA1c, Chest X-Ray</td></tr>
<tr><td>51-55</td><td colspan="4">MER, RUA, CBC, Lipid Profile, HbA1c, Chest X-Ray</td></tr>
<tr><td>56-60</td><td colspan="4" rowspan="2">MER, RUA, CBC, Lipid Profile, HbA1c, Chest X-Ray, TMT</td></tr>
<tr><td>61-65</td></tr>
</table>

2) **Cancer Protect**

<table>
<tr><th>Age Band</th><th>1 to 5lakhs</th><th>7.5 to 10lakhs</th><th>15 to 40Lakhs</th><th>50lakhs to 1cr</th></tr>
<tr><td>5-18</td><td colspan="4" rowspan="8">Nil</td></tr>
<tr><td>18-25</td></tr>
<tr><td>26-30</td></tr>
<tr><td>31-35</td></tr>
<tr><td>36-40</td></tr>
<tr><td>41-45</td></tr>
<tr><td>46-50</td></tr>
<tr><td>51-55</td></tr>
<tr><td>56-60</td><td colspan="4" rowspan="2">MER, CBC, PSA (for male), PAP smear (for female), USG, Chest X-Ray</td></tr>
<tr><td>61-65</td></tr>
</table>

3) **RenoLiv Protect**

<table>
<tr><th>Age Band</th><th>1 to 5lakhs</th><th>7.5 to 10lakhs</th><th>15 to 40Lakhs</th><th>50lakhs to 1cr</th></tr>
<tr><td>5-18</td><td colspan="4" rowspan="8">Nil</td></tr>
<tr><td>18-25</td></tr>
<tr><td>26-30</td></tr>
<tr><td>31-35</td></tr>
<tr><td>36-40</td></tr>
<tr><td>41-45</td></tr>
<tr><td>46-50</td></tr>
<tr><td>51-55</td></tr>
<tr><td>56-60</td><td colspan="4" rowspan="2">MER, RUA, CBC, LFT, RFT, USG</td></tr>
<tr><td>61-65</td></tr>
</table>

4) Brain Protect

Age Band	1 to 5lakhs	7.5 to 10lakhs	15 to 40Lakhs	50lakhs to 1cr
5-18	Nil			Nil
18-25				
26-30				
31-35				
36-40				
41-45				
46-50				
51-55				
56-60				MER
61-65				

MER – Medical Examination Report, RUA (Routine Urine Analysis), FBS (Fasting Blood Sugar), CBC (Complete Blood Count), Lipid profile, ECG (Electrocardiogram), TMT (Tread Mill Test), LFT (Liver Function Test), RFT (Renal Function Test), HbA1c, PSA (Prostate Specific Antigen for Males), PAP Smear (females only), USG Abdomen -males & females (Ultrasonogram).,

Claim process and Management

a) **Summary of Claim Procedure**:

- You, or someone claiming on your behalf, must inform us in writing immediately within 48 hours of diagnosis of any of the listed insured conditions / critical illnesses. See "**How Do I Notify You of a Claim?**" below.
- You must immediately consult a Doctor / Medical Practitioner and follow the advice and treatment that he/she recommends.
- You or someone claiming on your behalf must promptly, within 30 days of diagnosis of any of the listed insured conditions (or discharge from the hospital, if admitted), give us the following documents specified in "**Supporting Documentation**" below.
- You must have yourself examined by our medical advisors, if we ask of this, and as often as we consider this to be necessary (at our cost). See "**Examination**" below.

b) **How Do I Notify You of a Claim?**

- You must immediately inform us of any event or occurrence that may give rise to a claim under this Policy within 30 days of the diagnosis of the first occurrence of the insured condition.
- You can intimate us through letter, email, fax or telephone. The details of it have been given on the Health Card provided to you.
- Please include the details below:
  - Policy Number / Health Card Number
  - Your name (i.e. the Insured person availing treatment)
  - Details of the insured condition / critical illness (see **Supporting Documentation**, below) and any other relevant information

c) **Supporting Documentation**:

- You, or someone acting on your behalf, must provide us with all documentation, information and medical records. We may request to establish the circumstances of the claim, its quantum or our liability for the claim within 45 days of completion of survival period (if applicable) for the insured condition against which the claim is made. In the event of any request by us for specific information, you must submit the same within 15 days of our request.
- In case you are covered under multiple policies which provide fixed benefits, on the occurrence of the insured condition, we shall make the claim payments as per terms and conditions of this policy, independent of payments received by you under other similar polices.
- We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond your control. Such documentation are as following:
    - Our claim form duly completed and signed by / on behalf of you
    - Original Discharge Summary / Discharge Certificate
    - Copy of Final Hospital Bill
    - A medical certificate confirming the diagnosis of critical illness from a specialist doctor as mentioned under each Critical illness.
    - Medical certificate for the duration of illness.
    - An Investigation reports / other related documents reflecting the critical illness diagnosis
    - First consultation letter and subsequent prescription
    - Original cancelled cheque with payee name printed on the cheque. If the name of the payee is not printed on the cheque please provide copy of first page of bank passbook
    - A precise diagnosis of the treatment for which a claim is made
    - Certificate from treating doctors regarding the duration & etiology (i.e. the cause, set of causes or manner of causation of the disease or condition)
    - KYC documents

    Second Medical Opinion (Additional documents required)

    - Request for seeking second Medical opinion
    - All medical records and investigation reports done for the ailment

    Loan Protection Cover (Additional documents required)

    - Submission of sanction letter from the Financial Institute or Bank from where loan is applied
    - Repayment track record from the Financial Institute or Bank
    - Bank account statement reflecting EMI for the loan
    - Loan account statement

d) **Examination**:

- You will have to undergo medical examination by our authorized Medical Practitioner, as and when we may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such a medical examination of you (at the specified location).

e) **Payment of Claims**:

- You agree that we only need to make payment when you or someone claiming on your behalf has provided us with necessary documentation and information.
- We will make payment to you or your Nominee or Assignee. If there is no nominee or assignee and you are incapacitated or deceased, we will pay your heir, executor or validly appointed legal representative and any payment we make in this way will be a complete and final discharge of our liability to make payment.
- All claims will be processed as per relevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time.. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, we shall offer within a period of 30 days a settlement of the claim to you. In the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate. 'bank rate' means 'Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due"
- However, where the circumstances of a claim warrants an investigation in the Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary documents. In such cases, We shall settle/reject the claim within 45 days from the date of receipt of last necessary documents. In case of delay beyond stipulated 45 days, We shall be liable to pay interest at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment of claim.
- If we, for any reasons, decide to reject the claim under the policy, the reasons regarding the rejection shall be communicated to you in writing within 30 days of the receipt of complete set of documents, in accordance with the provisions of applicable Circulars and Regulations issued by IRDAI from time to time . You may take recourse to the Grievance Redressal procedure stated in Section 5.

f) **Currency of Payment**:

- All claims shall be payable in India and in Indian Rupees only.

g) **Dishonest or Fraudulent Claims**:

- If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices (whether by you or anyone acting on your behalf), then this policy will be:
    - Cancelled ab-initio from inception date or the renewal date (as the case may be), or modified by us, as per the board approved underwriting policy of the Company , upon 30 day notice by sending an endorsement to your address show in the schedule without refunding the premium amount; and
    - All benefits payable, if any, under such policy shall be forfeited with respect to such clai

Commented [FM4]: Please check this may have to be modified as per cancellation clause

Commented [RS5R4]: Cancellation clause modified

Cancellation/Termination

(i) The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall

a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.
c. In case of Installment policy, Policy will be cancelled with proportionate premium refund for unexpired policy period if there is no claim made during the policy period.

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

Cancellation Grid	Time period	Claim Status	One Year - Single payment /Instalment policy	2/3 Years Policy tenure -Single payment /Instalment policy
Free Look Period (Risk not commenced)	Upto30 days	Nil	Full refund less medical examination of insured person and the stamp duty charges	
Free Look Period (Risk commenced)	Upto30 days	Nil	Proportionate refund for unexpired policy period	
Pro rate (Risk commenced)	Beyond 30 days	Nil	Proportionate refund for unexpired policy period	

Table I. "Related" Conditions not Covered by Continuation Feature

On payment of the insured condition, the following are a list of "Related" conditions that we will not provide continuous coverage over the lifetime of the Insured person/s. Thus, the product offers renewal of the policy excluding the conditions which are 'Related' as given in the below Table, in case of a claim which is reported and paid to the Insured. However, all other listed Critical illnesses would be treated as 'Un-related' and will be covered in the policy. For the ease of understanding purpose, the 'Related' insured conditions/critical illnesses are categorized as specified below:
We will pay only once for the same Critical illness over a lifetime.

Important note: Below Table is applicable only for 'Plan A' providing feature of 'Continuation for Second and Third Events' as mentioned under Section 2.B.

Sr. No.	Category	"Related" Conditions Not Covered under Continuation
1.	HEART	a) Cardiomyopathy b) Heart Transplant

		c) Open Chest CABG d) Open Heart Replacement or Repair of Heart Valves e) Myocardial Infraction (First Heart Attack of Specified Severity) f) Primary (Idiopathic) Pulmonary Hypertension g) Pulmonary Artery Graft Surgery h) Surgery to Aorta / Aorta Graft Surgery i) Angioplasty j) Balloon Valvotomyor Valvuloplasty k) Carotid Artery Surgery l) Implantable Cardioverter Defibrillator m) Implantation of Pacemaker of Heart n) Infective Endocarditis o) Minimally Invasive Surgery of Aorta p) Pericardiectomy q) Pulmonary Thromboembolism r) Surgery for Cardiac Arrhythmia s) Surgery to Place Ventricular Assist Devices or Total Artificial Hearts t) Primary (Idiopathic) Pulmonary Hypertension
2.	CANCER	a) Cancer of Specified Severity b) Early-Stage Cancers c) Carcinoma in-Situ d) Related Major organ transplant e) Related End stage organ failure (Lung/Liver/Kidney)
3.	BRAIN	a) Apallic Syndrome b) Benign Brain Tumor c) Brain Surgery d) Coma of Specified Severity e) Creutzfeldt-Jakob disease (CJD) f) Encephalitis g) Stroke Resulting In Permanent Symptoms
4.	LUNG	a) Pneumonectomy b) Pulmonary Artery Graft Surgery c) Pulmonary-Renal Syndrome d) End-Stage Lung Failure
5.	LIVER	a) End-Stage Liver Failure b) Liver transplant c) Fulminant Viral Hepatitis
6.	KIDNEY	a) Kidney Failure Requiring Regular Dialysis b) Kidney transplant c) Goodpasture's Syndrome d) Pulmonary-Renal Syndrome e) Medullary Cystic Disease
7.	TRAUMA	a) Major Head Trauma

		b) Loss of Speech arising due to Trauma c) Loss of Limbs arising due to Trauma d) Blindness arising due to Trauma e) Deafness arising due to Trauma f) Stroke Resulting In Permanent Symptoms arising due to Trauma g) Permanent Paralysis of Limbs arising due to Trauma
8.	BURNS	a) Third-Degree Burns (Major Burns) b) Deafness arising due to Burn c) Blindness arising due to Burn d) Loss of Speech arising due to Burn
9.	ANEMIA	a) Aplastic Anaemia b) Major Organ / Bone Marrow Transplant
10.	OTHER DISORDERS	a) Progressive Scleroderma b) Systemic Lupus Erythematosus c) Parkinson's Disease d) Alzheimer's Disease e) Severe Rheumatoid Arthritis
11.	HIV/AIDS	Critical illnesses resulting from complications of HIV/AIDS: a) Tumors b) Encephalitis c) SLE d) Chronic constrictive pericarditis e) Cancer f) Pulmonary Hypertension g) Pulmonary renal syndrome h) Organ Transplant i) Related conditions as specified above under ' Lung', 'Liver', & ' Kidney' The Policy shall be ordinarily renewable for the 'Related' critical illnesses mentioned under HIV/AIDS unlike other Related Critical illnesses specified in this Table.

Claim Illustration

Commented [FM6]: Swati - Please check for modifications

Commented [RS7R6]: NA

Illustration I: HIV/AIDS related payable amount and Critical illness diagnosis which is unrelated to HIV/AIDS

Sum Insured		INR 1000000	
Plan		A, 43 CI's	
Claim 1	CI diagnosed	Pulmonary renal syndrome resulting from HIV complication	
	Claim Payable	Yes	

	Amount Payable	INR 100000 (10% of SI)	The amount paid here is 10% of the SI as per the Policy TnC's.
	Total claim amount paid	INR 100000	
	Balance SI	INR 900000	
Claim 2	CI diagnosed	Multiple Sclerosis resulting from HIV complication	
	Claim Payable	No	
	Amount Payable	0	HIV/AIDS related CI is payable max. upto 10% of SI in a year.
	Total claim amount paid	0	
	Balance SI	900000	
Claim 3	CI diagnosed within the same Policy Year	Myocardial Infarction (First Heart Attack)	
	Claim Payable	Yes	
	Amount Payable	900000	The amount paid here is less the amount paid in 'Claim 1' and treated as ' Unrelated to HIV/AIDS
	Total claim amount paid	1000000	Paid 100% during the Year & 10% for HIV/AIDS
	Balance SI	0	
Above illustration has been provided assuming a valid claim payable as per the Terms and conditions mentioned in the Policy.			

Illustration II: Insured is getting diagnosed with Multiple CI's in presence of HIV/AIDS

Sum Insured		INR 1000000	
Plan		B, Heart Protect	
Claim 1	CI diagnosed	Implantation of Pacemaker of Heart	
	Claim Payable	Yes	
	Amount Payable	INR 250000 (25% of SI)	The amount paid here is 25% of the SI payable for a 'Minor condition' as per the Policy TnC's
	Total claim amount paid	INR 250000	
	Balance SI	INR 750000	
Claim 2	CI diagnosed within the same Policy Year	Angioplasty in presence of HIV/AIDS	
	Claim Payable	Yes	
	Amount Payable	250000	The amount paid here is less the amount paid in 'Claim 1' and up to 25% of the SI for a 'Minor

			condition'. The Critical illness is considered as unrelated to HIV/AIDS
	Total claim amount paid	500000	Claim1+Claim2
	Balance SI	500000	
Claim 3	CI diagnosed within the same Policy Year	Open Chest CABG	
	Claim Payable	Yes	
	Amount Payable	500000	The amount paid here is less the amount paid in 'Claim 1' & 'Claim 2' and up to 75% of the SI for a 'Major condition'. The Critical illness is considered as unrelated to HIV/AIDS
	Total claim amount paid	1000000	
	Balance SI	0	
Above illustration has been provided assuming a valid claim payable as per the Terms and conditions mentioned in the Policy.			