



TERMS & CONDITIONS OF MEDICLAIM POLICY

1.1 Policy witness that subject to the terms, conditions, exclusions and definitions contained herein or endorsed, or otherwise expressed here on the Company undertakes that, if during the period stated in the Schedule or during the continuance of this policy by renewal, any insured person shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalization expenses for medical/surgical treatment at any Nursing Home/Hospital/Day Care Centre in India as herein defined (hereinafter called HOSPITAL) as an inpatient, the Company will pay through Third Party Administrator (hereinafter called TPA) to the Hospital / Nursing Home or the Insured Person the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate in any one period of insurance stated in the schedule hereto.

1.2 In the event of any claim(s) becoming admissible under the scheme, the Insurance company shall pay in time to the concerned Hospital / Nursing Home or the insured person. Intimation will be given by VIL. the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate mentioned in the schedule hereto.

A. Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing Home upto 1% of Sum Insured per day. This also includes Nursing Care, RMO charges, IV Fluids/Blood Transfusion/Injection administration charges and similar expenses.

B. If admitted in IC Unit, the Company will pay up to 2% of Sum Insured per day or actual amount whichever is less.

C. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees

D. Anesthetist, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, relevant laboratory diagnostic tests, etc. and such similar expenses.

E. Hospitalization Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant to the insured.

Note: 1. the amount payable under 1.2 C & D above shall be at the rate applicable to the entitled room category. In case the Insured person opts for a room with rent higher than the entitled category as in 1.2 A above, the charges payable under 1.2 C & D shall be limited to the charges applicable to the entitled category. This will not be applicable in respect of medicines & drugs and implants.

2. No payment shall be made under 1.2 C other than as part of the hospitalization bill

1.2.1 Expenses in respect of the following specified surgeries will be restricted as detailed below:

Hospitalisation Benefits	LIMITS per surgery RESTRICTED TO
A. Cataract, Hernia Hysterectomy B. Major surgeries*	A. Actual expenses incurred or 25% of the sum insured whichever is less B. Actual expenses incurred or 70% of the sum insured whichever is less

*Major surgeries include Cardiac surgeries, Brain Tumour surgeries, Pacemaker implantation for sick sinus syndrome, Cancer surgeries, Hip Knee joint replacement surgery, Organ Transplant.

* The above limits specified are applicable per hospitalisation/ surgery.

1.3 Pre & Post Hospitalisation in respect of each hospitalisation shall be the actual expenses incurred subject to maximum of 10% of Sum Insured.

1.4 In addition to the above, the following would apply to claims arising out of persons aged more than 60 years

EXPENSES ON MAJOR ILLNESSES CHARGED AS A TOTAL PACKAGE	TO BE SETTLED WITH A CO-PAY ON 80:20 BASIS. The co-pay of 20% will be applicable on the admissible claim amount
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(N.B: Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the sum INSURED per person as mentioned in the schedule)

2. DEFINITIONS:

2.1 HOSPITAL/ NURSING HOME means any institution in India established for indoor care and treatment of sickness and injuries and which

Either

1. Has been registered as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner.

Or

2. Should comply with minimum criteria as under: -
 - i. It should have at least 15 inpatient beds.
 - ii. Fully equipped operation Theatre of its own wherever surgical operations are carried out.
 - iii. Full qualified Nursing staff under its employment round the clock.
 - iv. Fully qualified Doctor's should be in charge round the clock.
 - v. Maintains a daily record for each of its patient.

N.B.:1. In class C towns condition 2.1b (i) in respect of number of beds reduced to 10.

2. for Ayurvedic/Homeopathic/Unani Treatment. Hospitalization expenses are admissible only when the treatment is taken as in patient in a Government Hospital/Medical college Hospital.

2.1. 1 The term Hospital/Nursing Home shall not include an establishment which is a place of rest, a place for the aged, a place for the drug-addicts or place for Alcoholics a hotel or a similar place.

2.2 'Surgical operation' means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.

2.3 Hospitalization means admission in a Hospital/Nursing Home in India upon the written advice of a Medical Practitioner for a minimum period of 24 consecutive hours. However, this time limit is not applied to specific treatments, such as.

1. Adenoidectomy	19. FESS
2. Appendectomy	20. Haemo dialysis
3. Ascitic/Pleural tapping	21. Fissurectomy/Fistulectomy
4. Auroplasty	22. Mastoidectomy
5. Coronary angiography	23. Hydrocele
6. Coronary angioplasty	24. Hysterectomy
7. Dental Surgery	25. Inguinal/ventral/umbilical/Femoral hernia
8. D&C	26. Parenteral Chemotherapy
9. Endoscopies	27. Polypectomy
10. Excision of Cyst/Granuloma/lump	28. Septoplasty
11. Eye Surgery	29. Piles/fistula
12. Fracture/dislocation excluding hairline fracture	30. Prostate
13. Radiotherapy	31. Sinusitis
14. Lithotripsy	32. Tonsilectomy
15. Incision and drainage of abscess	33. Liver aspiration
16. Colonoscopy	34. Sclerotherapy
17. Varicocoelectomy	35. Varicose Vein Ligation
18. Wound suturing	

OR any other surgeries/procedures agreed by the TPA/Co. which require less than 24 hours Hospitalization and for which prior approval from TPA is a mandatory.

Further if the Treatment/Procedure/Surgeries of the above diseases are carried out, in day care centers which is fully equipped with advanced technology and specialized infrastructure where the insured is discharged on the same day, the requirement of minimum beds will be overlooked provided following conditions are met: The operation theatre is fully equipped for the surgical operation required in

Respect Of.sickness/ailment/injury covered under the policy.

ii Day Care nursing staff is fully qualified.

iii The doctor performing the surgery or procedure as well as post operative attending doctors are also fully qualified for the specific surgery/procedure.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours.

2.4 DOMICILIARY HOSPITALISATION BENEFIT: means medical treatment for a period exceeding three days for such illness/disease/injury which in the normal course would require care and treatment at a hospital/Nursing Home but actually taken while confined at home under any of the following circumstancesnamely :

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

Subject however the domiciliary Hospitalization benefits shall not cover:

- i. Expenses incurred for pre and post Hospital treatment and .
- ii. Expenses incurred for treatment for any of the following diseases.

Asthma, Bronchitis, Chronic, Nephritis and Nephritic Syndrome, Diarrhea and all types of dysenteries including gastro enteritis, diabetes, mellitus and insipid us, Epilepsy, Hypertension, Influenza, Cough and Cold, All Psychiatric OR Psychosomatic disorders, Pyrexia of unknown horizon for less than 10 days, Tonsillitis and upper respiratory tract infection including laryngitis and pharangitis, Arthritis, Gout and Rheumatism.

Note: When treatment such as dialysis, Chemotherapy, Radiotherapy. etc is taken in the hospital / nursing home/Day-care centre and the insured is discharged on the same day the treatment will be considered to be taken under hospitalization benefit section.

3.0 ANY ONE ILLNESS

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken. Occurrence of the same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

3.1 PRE – HOSPITALISATION:

Relevant medical expenses incurred immediately 30 days prior to Hospitalization on disease/illness/injuries sustained will be considered as part of claim as mentioned under item 1.2 above.

3.2 POST HOSPITALISATION:

Relevant medical expenses incurred immediately 60 days after to Hospitalization and disease/illness/injuries sustained will be considered as part of claim as mentioned under item 1.2 above.

3.3 MEDICAL PRACTITIONER

A Medical Practitioner means a person who holds a degree/diploma of a recognized Institution and is registered by Medical Council of respective state of India. The term Medical Practitioner would include Physician, Specialist and Surgeon.

3.4 QUALIFIED NURSE

QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India and who is employed on recommendation of the attending Medical Practitioner.

3.5 MATERNITY EXPENSES BENEFIT means treatment taken in Hospital/Nursing Home arising from or traceable to pregnancy/child birth including normal/caesarean section. This is an optional benefit available on payment of additional premium. When maternity expenses benefit is opted for in the policy, exclusion 4.12 of the policy stands deleted. The Hospitalization expenses in respect of the New born child are covered within the mother's maternity expenses subject to an overall limit of Rs.50000/-

3.6 "THIRD PARTY ADMINISTRATOR"

TPA means a Third Party Administrator who holds a valid License from Insurance Regulatory and Development Authority to act as a THIRD PARTY ADMINISTRATOR and is engaged by the Company for the provision of health services as specified in the agreement between the Company and TPA.

3.7 Network Hospital means the hospital/nursing home or health such other medical aid provider that has agreed with the TPA to provide cashless access services to policy holders. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

3.8 CASHLESS FACILITY

Cashless facility means facility whereby the TPA agrees on the insured's request to settle the admissible claim directly to the Network Hospital.

3.9 ID CARD

ID card means the identity card issued to the insured person by the TPA to avail cashless facility in network hospitals.

3.10 DAY CARE PROCEDURES means the course of Medical treatment/surgical procedure in specialized day care centers which enables the insured to be discharged on the same day

3.11 Pre-existing condition/Disease – Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment, within 48 months prior to his/her first policy with the company.

3.12 REASONABLE AND NECESSARY EXPENSES: For a networked hospital, it shall mean the rate agreed between Networked Hospital and the TPA for surgical/medical treatment that is necessary, customary and reasonable for treating the condition for which insured person was hospitalized to the extent relatable to such condition.

4. Exclusions

The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his/her first Policy with the Company.

4.2 Any disease other than those stated in clause 4.3, below, contracted by the Insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however, apply in case of the Insured person having been covered under any Health Insurance Policy or Group Insurance Scheme with the Company for a continuous period of preceding 12 months without any break.

4.3 During the first two years of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout & Rheumatism, Calculus Diseases, Joint Replacement due to Degenerative Condition and age-related Osteoarthritis & Osteoporosis are not payable.

4.4 During the first 4 years of the operation of the policy, the expenses related to treatment of joint replacement due to degenerative condition and age related Osteoarthritis and Osteoporosis are not payable.

If these diseases mentioned in exclusion No.4.3 & 4.4 (other than congenital internal diseases) are pre-existing at the time of proposal they will not be covered even during subsequent period of renewal subject to the pre-existing disease exclusion clause. If the insured is aware of the existence of congenital internal disease before inception of the policy, the same will be treated as pre-existing.

4.5 Injury / disease directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not)

4.6 a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.

b. vaccination or inoculation.

c. change of life or cosmetic or aesthetic treatment of any description such as correction of eyesight, etc.

d. plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.7 Cost of spectacles, contact lenses and hearing aids.

4.8 Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization.

4.9 Convalescence, general debility; run-down condition or rest cure, obesity treatment, Congenital external disease or defects or anomalies, Sterility, Venereal disease, intentional self injury and use of intoxication drugs / alcohol

4.10 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.11 Charges incurred at Hospital or Nursing Home primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and

treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home

4.12 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician

- 4.13 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials
- 4.14 Treatment arising from or traceable to pregnancy (including voluntary Termination of pregnancy) and childbirth (including caesarean section).
- 4.15 Naturopathy Treatment, acupressure, acupuncture, magnetic and such other therapies.
- 4.16 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including CPAP, CAPD, Infusion pump, Oxygen concentrator etc., Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, etc. of any kind, Diabetic foot wear, Glucometer/Thermometer, and similar related items etc. and also any medical equipment, which are subsequently used at home.
- 4.17 Genetic disorders & Stem cell implantation/surgery.
- 4.18 Change of treatment from one system of medicine to another unless documented by the consultant/Hospital under whom the treatment is taken.
- 4.19 Treatment for aged related macular degeneration(ARMD), treatment such as rotational field quantum magnetic resonance(RFQMR), enhanced external counter pulsation(EECP), etc.,
- 4.20 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, ayah or private nursing/barber or beauty services, died charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses.
- 4.21 Any kind of Service charges, Surcharges, Admission Fees/Registration Charges levied by the hospital.

5. CONDITIONS:

- 5.1 CONTRACT: The Proposal form, Prospectus, Pre-acceptance Health check-up and the Policy issued shall constitute complete Contract of Insurance.
- 5.2 Every notice or communication regarding hospitalization or claim under this policy shall be delivered in writing at the address of the TPA office as shown in the Schedule. Other matters with regard to the policy may be communicated to the Police Issuing Office.
- 5.3 The premium payable under this Policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.
- 5.4 Notice of communication: - Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the TPA named in the schedule immediately and in case of emergency Hospitalization, within 24 hours from the time of Hospitalization.
- 5.5 All supporting documents relating to the claim must be filed with TPA within 15 days from the date of discharge from the hospital. In case of post-hospitalization, treatment (limited to 60

days), all claim documents should be submitted within 7 days after completion of such treatment.
Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it



was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

5.6 The Insured Person shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim.

5.7 Any medical practitioner authorized by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalization if so required. 5.8 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.9 If at the time when any claim arises under this Policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society), whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its ratable proportion of any loss, liability, compensation costs or expenses. The benefits under this Policy shall be in excess of the benefits available under Cancer Insurance Policy.

5.10 The Policy may be renewed by mutual consent 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. The company shall not be bound to give notice that such renewal premium is due, provided however that if the insured shall apply for renewal and remit the request premium before the expiry of this policy, renewal shall not normally be refused, unless the company has reasonable justification to do so.

The Company may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending fifteen days notice in writing by Registered A/D to the insured at his last known address in which case the Company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance if no claim has been paid under the policy. The insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate table given below provided no claim has occurred upto the date of cancellation.

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED.
Up to one month	1/4 th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate.

5.11 If any dispute or difference shall arise as to the quantum to be paid under the 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 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 herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

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

5.12 If the TPA, as per terms and conditions of the policy or the company shall this claim liability to the insured for any claim hereunder and if the insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the TPA or company in writing that he does not accept such disclaimer and intends to recover his claim from the TPA/Co., then the claim shall for all purposes be deemed to have been abandoned and shall not there after the recoverable here under.

5.13 All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian Currency. Payment of claim shall be made through TPA to the Hospital/Nursing Home or the insured person as the case may be.

5.14 Low claim ratio discount (Bonus)

Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ratio for the entire group insured under the group med claim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal where the group med claim insurance policy has not been in forced for three completed year, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred claim ratio under the group policy	Discount in %
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	40



5.15 High Claims Ratio Loading (MALUS)

The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the group med claim insurance policy for the preceding year (Immediately preceding the date of renewal).

Incurred claim ratio under the group policy	Loading %
Between 70% & 100%	25
Between 101% & 125%	55
Between 126% & 150%	90
Between 151% & 175%	120
Between 176% & 200%	150
Over 200%	Cover to be reviewed

Note:

1. Low claim Ratio Discount (Bonus) or high claim ratio loading (MALUS) will be applicable to the Premium at renewal of the Policy depending on the incurred claims Ratio for the entire Group Insured.
2. Incurred claim would mean claims paid plus claims outstanding in respect of the entire group insured under the policy during the relevant period.

The insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the insured persons and other relevant details as are normally kept in any institution/ organization. The insured shall declare to the company any addition in the number of insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

It is hereby agreed and understood that, that this insurance being a group policy availed by the insured covering Members, the benefit thereof would not be available to members who cease to be part of the group for any reason whatsoever.

Such members may obtain further individual insurance directly from the company and any claims shall be governed by the terms thereof.

5.16 MATERNITY EXPENSES BENEFIT EXTENSION: (WHEREVER APPLICABLE)

This is an optional cover, which can be obtained on payment of 10% of total basic premium for all the Insured Persons under the Policy.

Option for Maternity Benefits has to be exercised at the inception of the Policy period and no refund is allowable in case Insured's cancellation of this option during currency of the policy.



5.17 The hospitalization expenses in respect of the new born child can be covered within the Mothers Maternity expenses. The maximum benefit allowable under this clause will be up to Rs. 50,000/- or the sum insured opted by the group whichever is lower.

Special Conditions applicable to Maternity expenses Benefit Extension:

1 These benefits are admissible only if the expenses are incurred in Hospital/Nursing Home as in-patients in India.

2 A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.

3 Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any renewal thereof. Those insured persons who are already having two or more living children will not be eligible for this benefit.

4 Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

5 Pre-natal and postnatal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

Note: When group policy is extended to include Maternity Expenses Benefit, the exclusion No.4.14 of the policy stands deleted.

6 REASONABLE AND NECESSARY EXPENSES:

1. For a networked hospital, it shall mean the rate pre-agreed between Networked Hospital and the TPA for surgical/medical treatment that is necessary, customary and reasonable for treating the condition for which the insured person was hospitalized.
- 2 For any other hospital, it shall mean the cost of surgical/medical treatment that is necessary, customary and reasonable for treating the condition for which insured person was hospitalized to the extent relatable to such condition.