SECTION-1 PREAMBLE

WHEREAS the policyholder designated in the Schedule to this Group Mediclaim having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the Policy Period as specified in the Schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms conditions and benefits and exclusions and the limit of Sum insured as set forth in this policy.

SECTION-2 DEFINITIONS

The terms defined below have the meanings as ascribed to them below wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

1. **Accident** is a sudden, unforeseen and involuntary event caused by external visible and violent means.
2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **Ambulance** means road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.
5. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **An AYUSH Hospital** is a healthcare facility wherein medical/ surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with inpatient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
7. **AYUSH Day Care Centre:** AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

   (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner" under Chapter I of Guidelines)

   AYUSH Hospitals referred above should also hold either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under national Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).
8. **"Bank Rate"** means Bank Rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claims has fallen due.
9. **"Cashless Facility"** means a facility extended by the company to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre-authorization approved.
10. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    a. **Acute Condition** is a disease, Illness and injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately.
    b. **"Chronic Condition"** is defined as a disease, illness, or injury that has one or more of the following characteristics
       i. it needs ongoing or long term monitoring through

consultation, examination, check-ups, and /or tests

ii. it needs ongoing or long-term control or relief of symptoms

iii. it requires insured rehabilitation or for you to be specially trained to cope with it

iv. it continues indefinitely

v. it recurs or is likely to recur.

11. **"Congenital Anomaly"** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital anomaly "Internal Congenital Anomaly" means Congenital anomaly which is not in the visible and accessible parts of the body.

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

12. **"Co-Payment"** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured

13. **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

14. **"Day Care Treatment"** refers to medical treatment, and /or surgical procedure which is:

i. Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hours because of technological advancement, and

ii. Which would have otherwise required a hospitalisation of more than 24 hours.

a. Internal Congenital anomaly "Internal Congenital Anomaly" means Congenital anomaly which is not in the visible and accessible parts of the body.

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

iv. Day Care Treatment shall only include procedures listed in Annexure D.

15. **"Day care centre"** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

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

16. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured. (Insurers to define whether the deductible is applicable per year, per life or per event and the manner of applicability of the specific deductible)

17. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

18. **"Domicilliary hospitalisation"** means medical treatment for an illness/disease/injury which in the normal course require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a. the condition of the patient is such that he/she cannot be removed to Hospital/or

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

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

20. **"Family"** means as defined in the policy schedule

21. **"Hospital"** means any institution established for inpatient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said ACT or complies with all minimum criteria as under:

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

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

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

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

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

22. **"Hospitalisation"** means admission in a hospital for a minimum period of 24 Inpatient care consecutive hours except for specified procedures/treatments where such admission could be for a period of less than 24 consecutive hours.

23. **"Injury"** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

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

25. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

26. **Maternity expenses**

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) expenses towards lawful medical termination of pregnancy during the policy period.

27. **"In-patient care"** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

28. **"Insurer/Company"** means i.e Reliance General Insurance Company Limited.

29. **Insured/Insured Person/Insured beneficiary:** A person accepted by the Company to be insured under this Policy and who meets and continues to meet all the eligibility requirements and whose name specifically appears under Insured (Insured Person) in the Policy Schedule and with respect to whom the premium has been received by the Company.

30. **"Medical Advice"** means any consultation or advice from a medical practitioner including the issuance of any prescription or repeat prescription.

31. **"Medical Expenses"** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or Medical Practitioners in the same locality would have charged for the same medical treatment.

32. **"Medical Practitioner"** is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy Set up by the Govt of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017. The registered practitioner should not be the Policyholder/Insured or their close family member. Physician', wherever mentioned under this Policy shall also satisfy the definition of a Medical Practitioner

33. **"Medically necessary treatment"** is defined as any treatment, tests, medication, or stay in hospital or part of stay in a hospital which
    i. Is required for the medical management of the illness or injury suffered by the insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. Must have been prescribed by a medical practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

34. **"Network Provider"** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

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

36. **"New Born Baby"** means baby born during the policy period and is aged upto 90 days.

37. **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

38. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

39. **"Policy"** is the Company's contract of insurance with the policyholder providing cover as detailed in this Policy Terms & conditions, the Proposal Form, Policy Schedule, Endorsements, if any and Annexures, form part of the contract and must be read together.

40. **Policyholder:** The person who is the Proposer and whose name specifically appears in the Policy Schedule as policy holder

41. **"Policy period"** means the period between the inception date/ date of joining and the expiry date/date of exit as specified in the Schedule to this Policy or the cancellation of this policy, whichever is earlier.

42. **"Pre-existing Disease"** "Pre-existing disease (PED)" means any condition, ailment, injury or disease:
    a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy

43. **"Pre-hospitalisation medical expenses"** means Medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required, and
    ii. The in-patient hospitalisation claims for such hospitalisation is admissible by the Insurance Company.

44. **"Post hospitalisation medical expenses"** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required, and
    ii. The in-patient hospitalisation claims for such hospitalisation is admissible by the Company.

45. **"Qualified Nurse"** is a person who holds a valid registration from the Nursing council of India or the Nursing council of any state in India.

46. **"Reasonable and customary charges"** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.

47. **"Room Rent"** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

48. **"Schedule"** means the document attached name so and to and the forming part of this Policy mentioning the details of the Insured/ Insured Person/s, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

49. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during

the Policy Period

50. **"Surgery or Surgical Procedure"** Surgery or Surgical procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

51. **Third party administrator (TPA):** Third party administrator or TPA means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company to service this policy, for the purposes of providing health services.

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

53. **Proposal Form** means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

    Explanation: "Material Information" shall mean all important, essential and relevant information sought by the Company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk.

54. **Prospect** means any person who is potential customer of an insurer and is likely to enter into an insurance contract either directly with the insurer or through a Distribution Channel.

55. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.

56. **Senior citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

57. **Telemedicine** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

58. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

59. **"Portability"** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

60. **"Migration"** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

61. **Complainant** means a policyholder or prospect or any beneficiary of an insurance policy who has filed a Complaint or Grievance against the Company or a Distribution Channel.

62. **Complaint or Grievance:** Complaint or Grievance means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer, Distribution Channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, Distribution Channels, intermediaries, insurance intermediaries or other regulated entities.

63. **Disclosure to information norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact

64. **Renewal:** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for preexisting diseases, time-bound exclusions and for all waiting periods.

65. **Break in policy:** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

66. **Grace Period:** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage is not be available during the period for which no premium is received, except in case of instalments, where coverage shall be available during the grace period.

SECTION-3 SCOPE OF COVER

The Policy Schedule and all Endorsement Schedules shall be as per terms and conditions accepted and agreed with the Policyholder.

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed in the Policy, to compensate the Insured Person as per the covers and limits specified in the Policy Schedule.

In addition to the terms laid out herein, liability arising due to any treatment relating to Mental Illness shall be assessed in accordance with the relevant provisions of The Mental Healthcare Act, 2017.

The total payment under all benefits under the Policy shall not exceed the Sum Insured mentioned in the Policy Schedule

1. **InPatient Treatment**

    If during the Policy Period any of the Insured Person undergoes Hospitalization for Inpatient Treatment on the written advice of a Medical Practitioner, then the Company will indemnify the Policyholder/Insured Person for the below incurred Medical Expenses:

    - Room Rent
    - Nursing
    - Intensive care Unit (ICU),
    - Medical Practitioner(s),

- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances,
- Medicines, drugs and Consumables
- Diagnostic procedures
- The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

2. Pre- Hospitalization

The Company will indemnify the Policyholder/ Insured Person for the Pre- Hospitalisation Expenses upto 30 days, provided that:

i. such **Medical Expenses** are incurred in respect of the same condition for which **Insured Person** has taken Inpatient Treatment, and

ii. **Company** has accepted the **Claim** for these Inpatient Treatment expenses under Benefit 1 **InPatient Treatment**

3. Post Hospitalization

The Company will indemnify the Policyholder/ Insured Person for the Post Hospitalisation Expenses upto 60 days, provided that:

i. Such costs are incurred in respect of the same condition for which the **Insured Person** has taken Inpatient Treatment, and

ii. **Company** has accepted the **Claim** for these Inpatient Treatment expenses under Benefit 1 **InPatient Treatment**

4. Day Care Treatment

The Company will indemnify the Policyholder/ Insured Person for the Medical Expenses on the written advice of the Medical Practitioner, if during the Policy Period, any of the Insured Person undergoes a Day Care Treatment as defined and listed under this Policy

5. Domiciliary Hospitalisation

Domiciliary Hospitalisation means medical treatment for a period exceeding three days for disease/ injury which in the normal course would require care and treatment at a hospital/ nursing home but is actually taken whilst confined at home in India under any of the following circumstances namely

1. The condition of the patient is such that he/she cannot be removed to Hospital/Nursing home, or
2. The patient cannot be admitted to Hospital/ Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the Sum Insured as specified in the Schedule, and shall, in no case cover expenses incurred for:

Treatment of any of the following diseases/illness/injury:

i. Asthma
ii. Bronchitis
iii. Chronic nephritis and nephritic syndrome
iv. Diarrhea & all types of dysenteries including gastroenteritis.
v. Diabetes mellitus and insipidus
vi. Epilepsy
vii. Hypertension
viii. Influenza, cough and cold
ix. All psychiatric or psychosomatic disorders
x. Pyrexia of unknown origin for less than 10 days
xi. Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
xii. Arthritis, gout and rheumatism.

6. Ayush Treatment

The Company will indemnify the Policyholder /Insured Person against the Medical Expenses which are incurred on treatment under AYUSH up to the Sum Insured under the Policy. The AYUSH treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.

The Company shall not be liable for payment of any Claim under this Benefit directly or indirectly arising out of or relating to:

i. Treatment other than **Inpatient Treatment** or **Day Care Treatment**
ii. Medical Expenses incurred for evaluation, Investigation only.
iii. Treatment availed outside India.
iv. Treatment at a healthcare facility which is NOT an **AYUSH Hospital** or **AYUSH Day Care Centre.**
v. **Pre-Post Hospitalization** expenses
vi. All preventive and rejuvenation treatments (noncurative in nature), or treatments that are not **Medically Necessary**. This includes but not limited to treatments at Spa, Massages and Health Rejuvenation Procedure.

7. Modern Treatment

The Company will indemnify the **Insured Person** up to 50% of **Base Sum Insured** for the **Medical Expenses** incurred during the **Policy period** on Inpatient Treatment or Day Care Treatment or Domiciliary Treatment of below mentioned Modern Treatment Methods

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Immunotherapy-Monoclonal Antibody to be given as injection
- Oral Chemotherapy
- Deep Brain Stimulation
- Intra Vitreal injections
- Robot surgeries
- Stereotactic radio surgeries
- Bronchial Thermoplasty
- Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
- IONM- (Intra Operative Neutro Monitoring)
- Stem Cell therapy: Including Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

The claim under this benefit shall be subject to all other terms under Benefits 1 to 6

SECTION-4 WAITING PERIOD

The Waiting Periods as defined in Section 3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1. Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a preexisting Disease

(PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

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 the extent of prior coverage.

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by 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 12 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 f stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures in respect of which 12 months waiting period is imposed is mentioned below:

- Cataract,
- Benign prostatic hypertrophy
- Hysterectomy or menorrhagia or fibromyoma
- Hernia,
- Hydrocele
- Internal congenital diseases/anomalies
- Fistula in anus
- Piles
- Sinusitis

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.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

SECTION-5 GENERAL EXCLUSIONS

The Company shall have no liability and no Claim shall be admissible in respect of any Insured Person under any benefit(s) where such liability or Claim arises directly or indirectly due to any of the following:

1. Investigation & Evaluation (Code:Excl04)

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

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

2. 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.

3. Obesity/ Weight Control (Code:Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a) Surgery to be conducted is upon the advice of the Doctor

b) The surgery/Procedure conducted should be supported by clinical protocols

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. 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:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type2 Diabetes

4. 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.

5. 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.

6. 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, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. Breach of law (Code: Excl10): Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with

criminal intent.

8. **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. (For updated and detailed list of Excluded Providers refer website - www.reliancegeneral.co.in)

9. **Substance Abuse and Alcohol (Code: Excl12):** Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

10. **Wellness and Rejuvenation (Code:Excl13):** Treatments received in heath 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.

11. **Dietary Supplements & Substances (Code: Excl14):** 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.

12. **Refractive Error (Code: Excl15):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

13. **Unproven Treatments-Code (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.

14. **Sterility and Infertility (Code: Excl17):** Expenses related to sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization

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

16. **Circumcision** unless necessary for treatment of a disease not excluded here in above or as may be necessitated due to an accident.

17. **Cost of spectacles**, contact lenses and hearing aids.

18. **Dental treatment** or surgery of any kind unless requiring hospitalisation.

19. **Convalescence**, general debility, 'run-down' condition venereal disease.

20. **All expenses** arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

21. **Disease or injury** directly or indirectly caused by or contributed to by nuclear weapons/materials.

22. **Non-medical expenses:** Any non-medical expenses mentioned in Annexure A

23. **War (whether declared or not)** and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

24. **Permanent Exclusions**

    A permanent exclusion will be applied on **Pre-Existing** medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule. This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this **Policy** to such **Insured Person**. The list of such diseases/ conditions or treatments are enclosed as an Annexure-F.

SECTION-6 CLAIM PROCEDURE

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

6.1. CLAIMS INTIMATION

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the Policyholder/ Insured Person, must notify to the TPA/Company either at the call center or in writing immediately.

In the event of

- Planned Hospitalization, the Policyholder /Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization, the Policyholder /Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to the TPA/ Company at the time of intimation of Claim:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by the Company

6.2. CLAIMS PROCEDURE

6.2.1 Cashless: Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

a. Pre-authorization: Prior to Hospitalization, the Policyholder/ Insured Person must call the call center of the TPA/Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.

b. The TPA/Company will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the TPA/Company will confirm such Cashless authorization / rejection in writing or by other means.

c. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

d. The Company/TPA (On behalf of Company) reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.

e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.

f. There can be instances where the TPA/Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/Company which will be considered subject to the Policy Terms & Conditions.

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 4.4 with the Network Hospital.

Note: Under Cashless facility, the TPA/Company may authorize upon the Policyholder's / Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/ Company. In such cases, the TPA/Company will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website.

6.2.2. RE-IMBURSEMENT:

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in clause 4.4 shall be provided by the Policyholder/Insured Person, to TPA/ Company immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

6.3. POLICYHOLDER'S / INSURED PERSON'S DUTY AT THE TIME OF CLAIM

a. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.

b. Forthwith intimate / file / submit a Claim in accordance with Clause 4 of this Policy.

c. If so requested by the TPA/Company, the Insured Person will have to submit himself for a medical examination by the TPA/Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.

d. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the TPA/ Company's website or call center before availing the Cashless services.

e. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder/ Insured Person shall:

- Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

6.4. CLAIM DOCUMENTS

The Policyholder / Insured Person shall submit to the TPA/ Company/ Network Hospital (as applicable) the following documents for or in support of the Claim:

- Duly completed and signed Claim Form, in original
- Medical Practitioner's referral letter advising Hospitalization
- Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- Original bills, receipts and discharge card from the Hospital/ Medical Practitioner
- Original bills from pharmacy / chemists
- Original pathological / diagnostic test reports and payment receipts
- Indoor case papers
- Ambulance receipt and bill
- First Information Report/ Final Police Report, if applicable
- Post mortem report, if available

- Any other document as required by the Company to assess the Claim

When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Note:

- Claim once paid under one Benefit cannot be paid again under any other Benefit.
- All invoices / bills should be in Insured Person's name.

6.5. PROPORTIONATE DEDUCTION

Subject to the other Terms and Conditions of this Policy The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- The **Insured Person** chooses a higher room category than the category that is eligible as per the terms and conditions of the **Policy**. In this case, higher room category means a room category in which the room rent expenses charged by the **Hospital** is more expensive than the eligible room category as per the terms and conditions of the **Policy**.
- The **Insured Person** chooses a room category in which the room rent charges are more than the applicable **Sum Insured** sub-limit (in percentage or Rupee terms) on the room rent as per the **Policy** terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit 1 (i.e. Inpatient Treatment) barring the below mentioned expense break ups:

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table:

Sr. No.	Header	Explanation
A	Actual Medical Bills Incurred	As per submitted documents
B	Covered Medical Expenses	A – Any expense not covered under Policy Benefits
C	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
D	Covered Medical Expenses which shall be subject to Proportionate Deduction	B - cost of Pharmacy and consumables, implants and medical devices and diagnostics
E	Claim after Proportionate Deduction	D * Eligible Room Rent Limit ÷ Actual Room Rent (If Actual Room Rent is within eligibility, then no deduction to be applied [E=D])
F	Ground up claim amount	E + cost of Pharmacy and consumables, implants and medical devices and diagnostics
G	Amount after Co-pay	F - Co-payment, if any on account of age
H	Payable claim amount	G – Deductions for Policy Deductibles and Limits

Proportionate Deduction is subject to the following:

- Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced
- If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Insurer shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Insurer.
- ICU charges shall not be proportionately reduced in all cases.

6.6. PAYMENT TERMS

6.6.1 This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.

6.6.2 Claims shall not be admissible under this Policy unless the TPA/ Company has been provided with the complete documentation/ information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.

6.6.3 The Company shall not indemnify the Policyholder /Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure D (List of Day Care Treatments).

6.6.4 The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.

6.6.5 For Cashless Claims, the payment shall be made to the Network Hospital / TPA whose discharge would be complete and final.

6.6.6 For the Reimbursement Claims, the TPA/Company will pay the Policyholder/Insured Person.

6.6.7 The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form.

6.6.8 The Company shall settle the claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion it 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 document. In such cases, Company shall settle the claim within 45 days from the date of receipt of last necessary document.

SECTION-7 GENERAL TERMS & CONDITION

1. Disclosure of Information

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

Policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

2. Claim Settlement (provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it 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 document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

3. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

4. Reasonable Care

The Policyholder/ Insured Person shall take all reasonable steps to safeguard the interests against any Illness / Injury that may give rise to a Claim.

5. Material Change

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

6. Records to be maintained

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

7. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in possession of the Company and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

8. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

9. Multiple Policies

a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

b. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / Policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.

c. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured Person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

d. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

10. Fraud

If any claim made by the **Insured Person**, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the **Insured Person** or anyone acting on his/her behalf to obtain any benefit under this **Policy**, all benefits under this **Policy** and the premium paid shall be forfeited.

Any amount already paid against claims made under this **Policy** but which are found fraudulent later shall be repaid by all recipient(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the **Hospital**/ doctor/any other party acting on behalf of the **Insured Person**, with intent to deceive the insurer or to induce the insurer to issue an Insurance Policy:

a. the suggestion, as a fact of that which is not true and which the **Insured Person** does not believe to be true;

b. the active concealment of a fact by the **Insured Person** having knowledge or belief of the fact;

c. any other act fitted to deceive; and

d. any such act or omission as the law specially declares to be fraudulent.

The **Company** shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the **Insured Person**/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

11. Policy Disputes

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

12. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 4 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

13. 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 IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

For Detailed Guidelines on migration, kindly refer the www.irdai.gov.in (Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020)

14. 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 45 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 benefits in Waiting Periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the **www.irdai.gov.in** (Circular-IRDA/HLT/REG/CIR/003/012020, dated 01012020)

15. Free Look Period

The Free Look Period shall be applicable on new health insurance policies and not on renewals or at the time of porting/ migrating the policy.

The Insured Person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to

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

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

16. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy

17. Cancellation (other than Free Look Period)

The Policyholder may cancel this policy by giving 7 days 'written notice to the Company and in such an event, the Company shall refund the premium as detailed below:

- In case of no claim in the policy In the event of cancellation by the insured the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

  Calculation of Pro-Rata refund:

  Return Premium=Total Policy Premium*(1-((Number of Policy days expired)/(Total Policy Days)))

  For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = 10000* (1- (243 / 365)) = Rs. 3342.47.

- In case of claim in the policy

  Where any claim has been admitted or has been lodged by the person under the Policy, there shall be no refund of premium

  For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000. Considering the claim year is 1st Year (200 days), then no refund shall be made for the Policy Year

  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 7 days' written notice. There would be no refund of premium on cancellation on grounds of fraud.

18. Grace Period

a) The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.

b) 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. The same is applicable for both Indemnity and Benefit products

19. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

a. The Company shall endeavour to give notice for renewal.

However, the Company is not under obligation to give any notice for renewal.

b. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding Policy periods.

c. Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

d. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without break in policy.

e. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

f. Coverage is not available during the grace period, except in case where the premium is paid in instalment.

g. Renewal premium may vary and shall be as per the respective master policy issued by Reliance General Insurance to the group at the time of renewal.

20. Withdrawal of Policy

a. 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.

b. 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

21. 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.

22. Premium Payment in Instalments (wherever applicable)

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

i. Grace Period as (as agreed at the time of issuance of the Policy) would be given to pay the instalment premium due for the Policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods' 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period

iv. No interest will be charged If the instalment premium is not paid on due date.

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.

23. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

24. Communication

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.

Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

25. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.

26. Cause of Action

Claims shall be payable under this Policy only if the cause of action arises in India.

27. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

28. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

29. Revision/ Modification of the Product

The Company reserves the right to revise or modify this product / policy in future. The revision/modification may be in respect of Benefits, coverage, premiums, policy terms and conditions &/ or exclusions.

In the event of any revision or modification of the product the company will notify the policyholder in advance of such changes.

30. Redressal of Grievances

In case of any grievance the Insured Person may contact the Company through

Website	:	https://reliancegeneral.co.in
Dedicated Senior Citizen helpline	:	022 3383 4185 (paid line)
e-mail	:	rgicl.services@relianceada.com
Fax	:	+91 22 3303 4662
Post/Courier	:	Any branch office, the correspondence address, during normal business hours
Write to us at	:	Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301 302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:

Grievance Redressal Officer
The Grievance Cell,
Reliance General Insurance Co. Limited
No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad – 500 081

Grievance Redressal officer email ID:
rgicl.headgrievances@relianceada.com
(For updated details of grievance officer, kindly refer the link. https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B

Grievance may also be lodged at IRDAI Integrated Grievance Management System https://igms.irdai.qov.in / our website www.reliancegeneral.co.in

IRDAI Registration No. 103. UIN: RELHLGP21523V022021

ANNEXURE-A

1. List I - Items for which coverage is not available in the policy

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGING S
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPY ES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZE R KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets

54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT,RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

2. List II - Items that are to be subsumed into Room Charges

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

3. List III - Items that are to be subsumed into Procedure Charges

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

4. List IV - Items that are to be subsumed into costs of treatment

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES

5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

Annexure D – List of Day Care Procedures	
1	**Microsurgical operations on the middle ear**
1.	Stapedotomy to treat various lesions in middle ear
2.	Revision of a stapedectomy
3.	Other operations on the auditory ossicles
4.	Myringoplasty (post-aura/endaural approach as well as simple Type -I Tympanoplasty)
5.	Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
6.	Revision of a tympanoplasty
7.	Other microsurgical operations on the middle ear
2	**Other operations on the middle & internal ear**
9.	Myringotomy
10.	Removal of a tympanic drain
11.	Incision of the mastoid process and middle ear
12.	Mastoidectomy
13.	Reconstruction of the middle ear
14.	Other excisions of the middle and inner ear
15.	Fenestration of the inner ear
16.	Revision of a fenestration of the inner ear
17.	Incision (opening) and destruction (elimination) of the inner ear
18.	Other operations on the middle and inner ear
19.	Removal of Keratosis Obturans
3	**Operations on the nose & the nasal sinuses**
20.	Excision and destruction of diseased tissue of the nose
21.	Operations on the turbinates (nasal concha)
22.	Other operations on the nose
23.	Nasal sinus aspiration Foreign body removal from nose
4	**Operations on the eyes**
24.	Incision of tear glands
25.	Other operations on the tear ducts
26.	Incision of diseased eyelids
27.	Correction of Eyelid Ptosis by Levator Palpebrae Superioris Resection bilateral)
28.	Correction of Eyelid Ptosis by Fascia Lata Graft (bilateral)
29.	Excision and destruction of diseased tissue of the eyelid
30.	Operations on the canthus and epicanthus
31.	Corrective surgery for entropion and ectropion
32.	Corrective surgery for blepharoptosis
33.	Removal of a foreign body from the conjunctiva
34.	Removal of a foreign body from the cornea
35.	Incision of the cornea
36.	Operations for pterygium
37.	Other operations on the cornea
38.	Removal of a foreign body from the lens of the eye
39.	Removal of a foreign body from the posterior chamber of the eye
40.	Removal of a foreign body from the orbit and eyeball
41.	Operation of cataract
42.	Diathermy/Cryotherapy to treat retinal tear
43.	Anterior chamber Paracentesis/Cyclodiathermy/ Cyclocryotherapy/ Goniotomy/Trabeculotomy and Filtering and Allied Operations to treat glaucoma
44.	Enucleation of Eye without Implant
45.	Dacryocystorhinostomy for various lesions of Lacrimal Gland
46.	Laser Photocoagulation to treat Ratinal Tear
5	**Operations on the skin & subcutaneous tissues**
47.	Incision of a pilonidal sinus
48.	Other incisions of the skin and subcutaneous tissues
49.	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50.	Local excision of diseased tissue of the skin and subcutaneous tissues
51.	Other excisions of the skin and subcutaneous tissues
52.	Simple restoration of surface continuity of the skin and subcutaneous tissues
53.	Free skin transplantation, donor site
54.	Free skin transplantation, recipient site
55.	Revision of skin plasty
56.	Other restoration and reconstruction of the skin and subcutaneous tissues.
57.	Chemosurgery to the skin.
58.	Destruction of diseased tissue in the skin and subcutaneous tissues
59.	Reconstruction of Deformity/Defect in Nail Bed
6	**Operations on the tongue**
60.	Incision, excision and destruction of diseased tissue of the tongue

61.	Partial glossectomy
62.	Glossectomy
63.	Reconstruction of the tongue
64.	Other operations on the tongue
7	**Operations on the salivary glands & salivary ducts**
65.	Incision and lancing of a salivary gland and a salivary duct
66.	Excision of diseased tissue of a salivary gland and a salivary duct
67.	Resection of a salivary gland
68.	Reconstruction of a salivary gland and a salivary duct
69.	Other operations on the salivary glands and salivary ducts
8	**Other operations on the mouth & face**
70.	External incision and drainage in the region of the mouth, jaw and face
71.	Incision of the hard and soft palate
72.	Excision and destruction of diseased hard and soft palate
73.	Incision, excision and destruction in the mouth
74.	Palatoplasty
75.	Other operations in the mouth
9	**Operations on the tonsils & adenoids**
76.	Transoral incision and drainage of a pharyngeal abscess
77.	Tonsillectomy without adenoidectomy
78.	Tonsillectomy with adenoidectomy
79.	Excision and destruction of a lingual tonsil
80.	Other operations on the tonsils and adenoids
81.	Trauma surgery and orthopaedics
82.	Incision on bone, septic and aseptic
83.	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84.	Suture and other operations on tendons and tendon sheath
85.	Reduction of dislocation under GA
86.	Arthroscopic knee aspiration
87.	Adenoidectomy
10	**Operations on the breast**
88.	Incision of the breast abscess
89.	Operations on the nipple
90.	Excision of single breast lump
11	**Operations on the digestive tract,Kidney and Bladder**
91.	Incision and excision of tissue in the perianal region
92.	Surgical treatment of anal fistulas
93.	Surgical treatment of hemorrhoids
94.	Division of the anal sphincter (sphincterotomy)
95.	Other operations on the anus
96.	Ultrasound guided aspirations
97.	Sclerotherapy, etc.
98.	Laparotomy for grading Lymphoma with Splenectomy/ Liver/Lymph Node Biopsy
99.	Therapeutic Laparoscopy with Laser
100.	Cholecystectomy and Choledocho-Jejunostomy/ Duodenostomy/Gastrostomy/Exploration Common Bile Duct
101.	Esophagoscopy, gastroscopy, duodenoscopy with polypectomy / removal of foreign body/diathermy of bleeding lesions
102.	Lithotripsy/Nephrolithotomy for renal calculus
103.	Excision of renal cyst
104.	Drainage of Pyonephrosis/Perinephric Abscess
105.	Appendicectomy with/without Drainage
12	**Operations on the female sexual organs**
106.	Incision of the ovary
107.	Insufflations of the Fallopian tubes
108.	Other operations on the Fallopian tube
109.	Dilatation of the cervical canal
110.	Conisation of the uterine cervix
112.	Therapeutic curettage with Colposcopy/Biopsy/ Diathermy/Cryosurgery/
113.	Laser Therapy of Cervix for Various lesions of Uterus
114.	Other operations on the uterine cervix
115.	Incision of the uterus (hysterectomy)
116.	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
117.	Incision of vagina
118.	Incision of vulva
119.	Culdotomy
120.	Operations on Bartholin's glands (cyst)
121.	Salpingo-Oophorectomy via Laparotomy
13	**Operations on the prostate & seminal vesicles**
122.	Incision of the prostate
123.	Transurethral excision and destruction of prostate tissue
124.	Transurethral and percutaneous destruction of prostate tissue
125.	Open surgical excision and destruction of prostate tissue
126.	Radical prostatovesiculectomy
127.	Other excision and destruction of prostate tissue
128.	Operations on the seminal vesicles
129.	Incision and excision of periprostatic tissue
130.	Other operations on the prostate
14	**Operations on the scrotum & tunica vaginalis testis**
131.	Incision of the scrotum and tunica vaginalis testis
132.	Operation on a testicular hydrocele
133.	Excision and destruction of diseased scrotal tissue

134.	Other operations on the scrotum and tunica vaginalis testis
15	**Operations on the testes**
135.	Incision of the testes
136.	Excision and destruction of diseased tissue of the testes
137.	Unilateral orchidectomy
138.	Bilateral orchidectomy
139.	Orchidopexy
140.	Abdominal exploration in cryptorchidism
141.	Surgical repositioning of an abdominal testis
142.	Reconstruction of the testis
143.	Implantation, exchange and removal of a testicular prosthesis
144.	Other operations on the testis
16	**Operations on the spermatic cord, epididymis and ductus deferens**
145.	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
146.	Excision in the area of the epididymis
147.	Epididymectomy
17	**Operations on the penis**
148.	Operations on the foreskin
149.	Local excision and destruction of diseased tissue of the penis
150.	Amputation of the penis
151.	Other operations on the penis
18	**Operations on the urinary system**
152.	Cystoscopical removal of stones
153.	Catheterisation of Bladder
19	**Other Operations**
154.	Lithotripsy
155.	Coronary angiography
156.	Biopsy ofTemporal Artery for Various Lesions
157.	External Arterio-venous Shunt
158.	Haemodialysis
159.	Radiotherapy for Cancer
160.	Cancer Chemotherapy
161.	Endoscopic polypectomy
20	**Operations of bones and joints**
162.	Surgery for ligament tear
163.	Surgery for meniscus tear
164.	Surgery for hemoarthrosis/pyoarthrosis
165.	Removal of fracture pins/nails
166.	Removal of metal wire
167.	Closed reduction on fracture, luxation
168.	Reduction of dislocation under GA
169.	Epiphyseolysis with osteosynthesis
170.	Excision of Bursirtis
171.	Tennis Elbow Release
172.	Excision of Various Lesions in Coccyx

Annexure F

Below mentioned Diseases maybe permanently excluded under the **Policy** in the case where such Diseases are **Pre-Existing** at the time of first proposal of this Product with the **Company**

Sr. No.	Disease	ICD Code
1.	Sarcoidosis	D86.0-D86.9
2.	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3.	Epilepsy	G40 Epilepsy
4.	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy;

		I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5.	Cerebrovas-cular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6.	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 - Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7.	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.- Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8.	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9.	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0
		- Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10.	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11.	Alzheimer's Disease, Parkinson's Disease	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12.	Demyelinating disease	G.35 to G 37
13.t	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14.	Papulosqua-mous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

OMBUDSMAN OFFICE			
Office of the Ombudsman	**Address**	**Contact Details**	**Areas of Jurisdiction**
AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 001.	Tel.: 079 - 27546150/27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078.	Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.: 0755 - 2769201, 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009.	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneshwar@cioins.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@cioins.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar Over Bridge, S.S. Road, Guwahati – 781001 (ASSAM).	Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, LIC OF INDIA, 10th Floor, 'Jeevan Prakash', Divisional Office, M. G. Road, Ernakulam, Kochi – 682011.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072.	Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, UT of Andaman & Nicobar Islands, Sikkim

LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkar Nagar, Sultanpur, Maharajgang, Sant Kabir Nagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharath Nagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist: Gautam Buddh Nagar, U.P. - 201301.	Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Budha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006.	Tel.: 0612 - 2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020 - 41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on IRDAI website: **www.irdai.gov.in**, on the website of General Insurance Council: **www.giccouncil.in**, our website **www.reliancegeneral.co.in**

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