RELIANCE
General Insurance

Reliance HealthGain Policy Wording

Annexure I

Annexure II

IRDAI Registration No. 103.
Reliance General Insurance Company Limited.
Registered Office: 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400001.
Corporate Office: Reliance Centre, 4th Floor, South Wing, Near Prabhat Colony, Santacruz (East), Mumbai - 400 055.
UIN: IRDA/NL-HLT/RGI/P-H/V.I/318/13-14
Corporate Identity No.: U66603MH2000PLC128300.
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An ISO 9001:2008 Certified Company

reliancegeneral.co.in
1800 3009

Preamble

Whereas the Policyholder designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of this 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 and agreed and undertaken to pay subsequent premiums ,if any, by their due dates and upon the Company receiving all premiums by their due dates, for the Policy 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 to this Policy, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim as per the terms, conditions, coverages and exclusions as set forth in this Policy

Policy Terms And Conditions

The terms defined below have the meanings ascribed to them 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. Definitions

a) **Accident/ Accidental:** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

b) **Age:** The completed age of the Insured Person as on his last birthday.

c) **Ambulance:** A road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

d) **Annexure:** A document attached and marked as Annexure to this Policy.

e) **Anyone Illness:** Continuous period of Illness/Injury and it includes relapse within 45 days from the date of last consultation with the Hospital/Day Care centre where the treatment was taken.

f) **Base Sum Insured:** The sum shown against each Insured Person in the Policy Schedule which represents the Company's maximum liability in aggregate for each Insured Person for any and all claims incurred for that Insured Person during the Policy Period.

g) **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 network provider by the Company to the extent pre-authorization approved

h) **Child:** Means biological or legally adopted son or daughter of the Policyholder whose completed age is less than 21 years as on the Policy Period Start Date.

i) **Claim:** A demand made by the Policyholder or on his behalf, for payment of Medical Expenses under Benefit 1 or under any other Benefit, as covered under the Policy.

j) **Company:** Reliance General Insurance Company Limited.

k) **Congenital Anomaly** refers to a condition which is present since birth and which is abnormal with reference to form, structure or position

I) An external Congenital Anomaly refers to a congenital anomaly which is in the visible and accessible parts of the body.

ii) An internal Congenital Anomaly refers to a congenital anomaly which is not in the visible and accessible parts of the body.

l) **Co-payment**: means a cost sharing requirement under this Policy that provides that the Policyholder/Insured will bear a specified percentage of the assessed claim amount/costs. A co-payment does not reduce the Sum Insured

m) **Cosmetic Surgery:** Surgery/ treatment which is primarily done for the enhancement of appearance through surgical and medical techniques. It concerns with maintaining normal appearance, restoring or enhancing it. Cosmetic Surgery is a multi-disciplinary and comprehensive approach directed to all areas of body and involves specialists in the anatomy, physiology, pathology and/or a physician across disciplines including contributing disciplines like dermatology, general surgery, plastic surgery, otolaryngology, maxillofacial surgery, oculoplastic surgery and others

n) **Cumulative Bonus:** means any increase in Base Sum Insured granted by the Company without an associated increase in premium

o) **Day Care Centre:** means any institution established for Day Care Treatment of illness &/or injuries or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under.

1) has qualified nursing staff under its employment;

2) has qualified Medical Practitioner(s) in-charge;

3) has a fully equipped Operation theatre of its own, where surgical procedures are carried out;

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

p) **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 center in less than 24 hours because of technological advancement, and

ii) which would have otherwise required a Hospitalization of more than 24 consecutive hours.

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

iv) Day Care Treatment shall only include procedures listed in Annexure "1".

q) **Dependant**: means financially dependant on the Policyholder and does not have independent source of income

r) **Emergency/Emergency Care:** means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediatecare by a medical practitioner to prevent death or serious long term impairment of the Insured person's health.

s) **Extended Family:** It shall include the relationship of son & daughter who are not dependant, siblings (brother and sister), grandparents, grand children , daughters –in – law and sons –in – law of the Policyholder

t) **Family:** It shall include the Policyholder, his legally wedded spouse, dependant children and parents.

u) **Hospital** means any institution in India established for In-patient care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities, under the Clinical Establishments (Registration & Regulation) Act, 2010 or under the enactments specified under the schedule of section 56(1) of the said Act or complies with all with all minimum criteria as under :

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

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

3) has qualified Medical Practitioner(s) in-charge round the clock;

4) has a fully equipped Operation theatre of its own, where surgical procedures are carried out;

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

v) **Hospitalization:** means admission in a Hospital for a minimum period of 24 (Twenty Four) in-patient care consecutive hours except for Day Care Treatment.

w) **Illness:** A sickness or a disease or a pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment. For the avoidance of doubt, Illness does not mean and this Policy does not cover any mental Illness or sickness or disease (including but not limited to a psychiatric condition, disorganization of personality or mind, or emotions or behavior) even if caused by or aggravated by or related to an Injury or Illness.

x) **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.

y) **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

z) **Insured Person/Insured:** 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.

aa) **Intensive / Critical Care Unit:** An identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.\

bb) **Life Threatening Medical Condition:** A medical condition suffered by the Insured Person which has any of the following characteristics :

i) Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate);or

ii) Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas) ; or

iii) Critical care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or

iv) Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department; and

v) is certified by the attending Medical Practitioner as a Life Threatening Medical Condition.

cc) **Medical Advice:** Any consultation or advice from a Medical Practitioner including the issue of any prescriptions or repeat prescriptions.

dd) **Medical Expenses:** means those expenses that that the Policyholder/Insured Person has necessarily and actually incurred, during the Policy Period, for medical treatment on account of illness or injury on the written Medical 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.

Medical Expenses includes the following:

1) Room Rent of the Hospital where the Insured Person availed medical treatment

2) Intensive Care Unit (ICU) charges

3) Fees of Surgeon, anesthetist, Medical Practitioner

4) Anesthesia, blood, oxygen, operation theatre charges, surgical consumables, medicines and

drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, joint replacement and similar prosthetic devices if implanted internally during a surgical procedure unless specifically excluded

ee) **Medically Necessary** : Any treatment , test , medication or stay in Hospital or part of stay in Hospital which

i) Is required for the medical management of the illness/injury suffered by the Insured Person;

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

ff) **Medical Practitioner:** A person who holds a valid registration from the Medical Council of any state or Medical Council of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

The Medical Practitioner should not be the Policyholder/ Insured or their close family member

gg) **Network/Network Provider:** means Hospitals or other Service /Health Care Providers enlisted by the Company to provide medical services to an Insured Person on payment by a cashless facility. The Network list is available with the Company and is subject to amendment from time to time.

hh) **Nominee:** The person whose name specifically appears as such in the Policy Schedule and is the person to whom the proceeds under this Policy, if any, shall become payable in the event of the death of the Policyholder. Nominee for all other Insured Person(s) shall be the Policyholder himself.

ii) **Non-Network**: Any Hospital/Day Care centre or other provider that is not part of the Network.

jj) **Policy:** 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, which form part of the contract and must be read together.

kk) **Policy Schedule:** The Schedule attached to and forming part of this Policy mentioning apart from other details, Policyholder's details, details of the Insured Person, the Base Sum Insured, the Policy Period, Premium paid (including duties, taxes and levies thereon) and the limits to which benefits under the Policy are subject to.

ll) **Policyholder:** The person who is the Proposer and whose name specifically appears in the Policy Schedule as such.

mm) **Policy Period:** The period commencing from the Policy Period Start Date and ending on the Policy Period End Date and as specifically appearing in the Policy Schedule.

However where the Policy is issued for a Tenure of 2 years "Policy Period" shall mean a period of 12 consecutive months commencing from the Policy Period Start Date and ending on the Policy Period End Date. The subsequent "Policy Period" shall mean a period of 12 consecutive months commencing from the date following the end of the previous Policy Period and ending before Renewable Date.

nn) **Policy Period End Date**: The date on which the Policy expires, as specifically appearing in the Policy Schedule.

oo) **Policy Period Start Date**: The date on which the Policy commences, as specifically appearing in the Policy Schedule.

pp) **Post Hospitalization Medical Expenses**: means medical expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

1) Such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and

2) The inpatient hospitalization claim for such Hospitalization is admissible by the Company

qq) **Portability** : Portability means transfer by an individual health insurance policyholder (including floater) of the credit gained of pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another

rr) **Pre-existing Disease:** Any condition, ailment or Injury or related condition(s) for which the Insured Person had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first Policy issued by the Company under which he was covered.

ss) **Pre-hospitalization Medical Expenses**: means medical expenses incurred immediately before the Insured Person is hospitalized provided that:

1) Such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and

2) The inpatient hospitalization claim for such Hospitalization is admissible by the Company

tt) **Qualified Nurse:** A person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

uu) **Reasonable & 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

vv) **Rehabilitation:** Assisting an Insured Person who, following a medical condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

ww) Room Rent means the amount charged by a Hospital for the occupancy of a bed on per day (24 hrs) basis and shall include associated medical expenses

xx) Surgery / Surgical Procedure / Surgical Operation : 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.

yy) Unproven/ Experimental Treatments: Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

2. Scope of Cover

Benefit 1: Hospitalization Expenses

If any of the Insured Person, during the Policy Period, is diagnosed with any Illness or suffers any Injury that requires In-patient Care/Treatment or Day Care Treatment, , then the Company will pay, subject to the conditions mentioned below, exclusions and other terms and conditions as mentioned in this Policy, for:

a. In-patient Treatment

If during the Policy Period, any of the Insured Person undergoes Hospitalization on the written advice of a Medical Practitioner, then the Company will indemnify the Medical Expenses, which are Reasonable and Customary Charges, so incurred by the Policyholder/Insured Person subject to the available Base Sum Insured.

b. Day Care Treatment

If during the Policy Period, any of the Insured Person undergoes a Day Care Treatment on the written advice of a Medical Practitioner, then the Company will indemnify the Policyholder for the Medical Expenses, which are Reasonable and Customary Charges, so incurred by the Policyholder/Insured Person subject to the available Base Sum Insured

The pre-condition for admissibility and the basis for payment of Claim under the following Benefits 2 to 6 shall be as under:

No.	Description	Basis of Claim*	Basis of Payment	Precondition-Admissibility of Claim under Benefit 1 (Yes / No)
Benefit 2	Pre-hospitalization & Post-hospitalization Expenses	Individual	Indemnity	Yes
Benefit 3	Domestic Road Ambulance	Individual	Indemnity	Yes
Benefit 4	Donor Expenses	Floater	Indemnity	Yes
Benefit 5	Domiciliary Hospitalization	Floater	Indemnity	No
Benefit 6	Wellness			

**Wherever the Cover Type is Individual, Claim under all Benefits 2-5 shall be assessed on Individual basis.*

If the Cover type as mentioned in the Schedule is Individual, then the total liability of the Company under Benefit 1 to 6 for payment of all Claims in aggregate in relation to each Insured Person incurred during the Policy Period shall not exceed the Base Sum Insured as stated in the Policy Schedule for that Insured Person.

If the Cover type as mentioned in the Schedule is Floater, then the total liability of the Company under Benefit 1 to 6 for payment of all Claims in relation to all Insured Person(s) incurred during the Policy Period shall not exceed in aggregate the Base Sum Insured as stated in the Policy Schedule.

General Conditions applicable to all Benefits 2 to 6

a. Where the admissibility of Claim under Benefit 1 is not a pre-condition, then cause of action and / or expenses incurred, for the Claim to be admissible, under Benefit 2 to 6 should be during the Policy Period.

b. Where the admissibility of Claim under Benefit 1 is a pre-condition then Claim under Benefit 1 as defined in Clause 2 of Policy Terms and Conditions should be payable for a Claim under Benefit 2 o 5 to become admissible

c. Cashless Facility shall not be available for Benefit 2 to 6 unless specified otherwise.

Benefit 2: Pre-hospitalization and Post - hospitalization Expenses

The Company will indemnify the Policyholder subject to the available Base Sum Insured of the Insured Person for the Medical Expenses incurred, during the Policy Period, for the Insured Person in relation to:

1. Pre-hospitalization Medical Expenses incurred during a period of 60 days immediately prior to the Insured Person's date of admission to the Hospital; and

2. Post-hospitalization Medical Expenses incurred during a period of 60 days immediately following the Insured Person's date of discharge from Hospital,

   Provided that, the Medical Expenses relate to the same Illness/ Injury for which the Company has accepted the Insured Person's Claim under Benefit

   For any Post Hospitalization claim under re-imbursement the following wordings under Clause 4.2.2 of the Policy “not later than 15 days of discharge from the Hospital “ shall stand modified as “not later than 15 days of completion of Post hospitalization period “

Benefit 3: Domestic Road Ambulance

The Company will indemnify the Policyholder up to an amount of Rs/- per Hospitalization as mentioned against this Benefit in the Policy Schedule, subject to the available Base Sum Insured, for the reasonable expenses incurred on availing ambulance services offered by a Hospital or by an ambulance service provider for the Insured Person's necessary transportation to the nearest Hospital in case of an emergency Life Threatening Medical condition as certified by the treating Medical Practitioner.

Clause 3.3.18 of the Policy Terms and Conditions stands superseded to the extent covered under this Benefit.

Benefit 4: Donor Expenses

The Company will indemnify the Policyholder up to 50% of Base Sum Insured as mentioned in the Policy Schedule subject to a maximum of Rs 5 lacs, subject to the balance Base Sum Insured for the Medical Expenses incurred, during hospitalization, in respect of the donor for any organ transplant surgery conducted during the Policy Period, provided:

- The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.
- The Company has admitted the Insured Person's claim under the Policy.
- The organ donated is for the Insured Person's use.

The Company will not pay the donor's Pre-hospitalization and Post-hospitalization expenses or any other Medical Expenses for the donor consequent to the harvesting.

Clause 3.3.19 of the Policy Terms and Conditions stands superseded to the extent covered under this Benefit.

Benefit 5: Domiciliary Hospitalization

"Domiciliary Hospitalization" means medical treatment for an illness/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the Insured Person is such that he/she is not in a condition to be removed to a Hospital
- The Insured Person takes treatment at home on account of non-availability of room in a Hospital.

The Company will indemnify the Policyholder for the Medical Expenses incurred during the Policy Period on the written advice of a Medical Practitioner, for "Domiciliary Hospitalization" of the Insured Person up to 10% of Base Sum Insured subject to a maximum of Rs 50,000 in aggregate during the Policy Period, subject to the available base Sum Insured, as specified against this Benefit in the Policy Schedule subject to the following:

The medical treatment should exceed 3 consecutive days

Medical Expenses arising out of the following shall not be payable under this Benefit:

1. Any Pre-hospitalization and Post-hospitalization Expenses of such Domiciliary Hospitalization
2. Treatment of any of the following diseases:
   a. Asthma
   b. Bronchitis
   c. Chronic Nephritis and Chronic Nephritic Syndrome
   d. Diarrhoea and all types of Dysenteries including Gastro-enteritis
   e. Diabetes Mellitus and Insipidus
   f. Epilepsy
   g. Hypertension
   h. Influenza, Cough and Cold
   i. All Psychiatric or Psychosomatic Disorders
   j. Pyrexia of unknown origin
   k. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
   l. Arthritis, Gout and Rheumatism

Clause 3.3.23 of the Policy Terms and Conditions stands superseded to the extent covered under this Benefit.

It is a condition paramount for a claim to be admissible under this Benefit the Policyholder/ Insured Person, must notify the Company either at the call center or in writing at least 48 hours prior to the commencement of Domiciliary Hospitalization as per process mentioned under Clause 4.1 of Policy Terms & conditions

For any claim under this Benefit the following wordings under Clause 4.2.2 of the Policy

"not later than 15 days of discharge from the Hospital " shall stand modified as "not later than 15 days of completion of Domiciliary Hospitalization "

Benefit 6: Wellness

i. Wellness Services:

   Subject to the Policy Terms and Conditions, the Company shall provide the following Services under this Benefit either on its own or through a Service Provider:

   a. *Doctor Anytime /Free Health Helpline:* The Insured Person shall have the option of seeking medical advice from a Medical Practitioner through the telephonic or online mode.

   b. *Health Portal:* The Insured Person shall have the option to access health related information and services through the Company's/designated website.

ii. General Conditions applicable to this Benefit :

   1.1. In case the Services are availed over phone or through online mode, the Insured Person will be required to provide the details as sought by the Company/ Service Provider in order to establish authenticity and validity prior to availing such services.

   1.2. It is entirely for the Policyholder/Insured Person to decide whether to obtain these Services and also to decide the use (if any) to which these Services is to be put for.

   1.3. The Service is intended for additional information purpose only and does not substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

   1.4. The Company will have no liability on the availability and quality of the Services.

The pre-condition for the basis of Sum Insured and for admissibility and payment of Claim under Benefits 7 to 13 shall be as under:

No.	Description	Basis of Claim Insured *	Basis of Payment	Precondition - Admissibility of Claim under Benefit 1 (Yes / No)
Benefit 7	Cumulative Bonus	Floater	Indemnity	Yes
Benefit 8	Re-instatement of Base Sum Insured	Floater	Indemnity	Yes
Benefit 9	Call option	Floater	Indemnity	No
Benefit 10	Claim Service Guarantee	Individual	Indemnity	Yes
Benefit 11	Policy Service Guarantee	Floater	Indemnity	No
Benefit 12	Accidental Death Cover for No Claim Renewal	NA	Benefit	No
Benefit 13	Insurance Renewal	NA	NA	Yes

**Wherever the Cover Type is Individual, Claim under Benefits 7 to 11shall be assessed on Individual basis.*

General Condition applicable to Benefits 7 to 13

Where the admissibility of Claim under Benefit 1 is a pre-condition then Claim under Benefit 1 as defined in Clause 2 of Policy Terms and Conditions should be payable for a Claim under Benefit 7-13 to become admissible

Benefit 7 – Cumulative Bonus

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, at the end of each Policy Period, the Company will provide 33.33% (one third) of the expiring Policy Period Base Sum Insured on a cumulative basis as Cumulative Bonus for each completed and continuous Policy Year, provided that there is no Claim in the expiring Policy Year. This is subject to the following:

1. In any Policy Period, the accrued Cumulative Bonus, including the one credited under portability if any, shall not exceed 100% of the of Base Sum Insured available in this renewed Policy.
2. The Cumulative Bonus shall not enhance the available Room Category limit and other such limits which are a function of Sum Insured which shall always be applicable on the Base Sum Insured.
3. In relation to a Floater, the Cumulative Bonus, shall be available on Floater basis. The Cumulative Bonus which accrued during a claim-free Policy Year will only be available to those Insured Person(s) who were insured in such claim-free Policy Period and continue to be insured in the subsequent Policy Period.
4. The Cumulative Bonus is provisional and is subject to revision in case of Claim being reported under the expiring Policy Year.
5. Entire Cumulative Bonus will be lost if Policy is not continued / renewed on or before Policy Period End Date/Renewable Date or grace period end date whichever is later.
6. Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy.
7. In case of a claim in any given Policy Period the Cumulative Bonus shall be decreased by 33 1/3 % (one third) of the Base Sum Insured in the subsequent year. However this reduction shall not reduce the Base Sum Insured
8. This clause does not alter the Company's right to decline renewal or cancellation of the Policy.
9. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit 1.

Benefit 8 Re-instatement of Base Sum Insured

It is agreed that one re-instatement of upto the Base Sum Insured, during the Policy Period, will be automatically done after the Base Sum Insured and Cumulative Bonus have been utilized completely for claims incurred under the Policy for the particular Policy Period, provided that:

- For a claim to be admissible under Re-instated Sum Insured it should be admissible under the Benefit 1.
- The payment of claims in aggregate under Re-instated Sum Insured during a Policy Period shall be as per follows:
  - -- Upto 20% of Base Sum Insured
  - -- for the same claim, which is payable under the Base Sum Insured &/or Cumulative Bonus, during a single hospitalization or;
  - -- for a claim which has arisen out or is a consequence of or its related to or is a complication of an illness/injury for which a claim has already been admitted under the current or any previous Policy in relation to an Insured Person.
  - -- Upto 100% of Base Sum Insured
  - -- for all other claims not falling under the category as defined above
- The Re-instated Sum Insured for a particular Policy Period can be utilized only after the Base Sum Insured, Cumulative Bonus and Policy Service Guarantee Sum Insured applicable to that Policy Period have been completely exhausted in that Policy Period.
- The Company's overall liability for all claims, in aggregate, within a Policy Period under the Re-instated Sum Insured shall not exceed the Base Sum Insured
- While calculating Cumulative Bonus, Re-instated Sum Insured shall not be considered.
- If the Policy is issued on Individual Basis then The Re-instated Sum Insured will only be applied once for an Insured Person during the Policy Period and the sublimit of 20% as defined above shall be applicable on individual basis.
- If the Policy is on Floater basis, then the Re-instated Sum Insured will be available on Floater basis and shall be applied once for the Policy Period and the sublimit of 20% as defined above shall also be applicable on floater basis
- The unutilized Re-instated Sum Insured cannot be carried forward to any subsequent Policy Period.
- During a Policy Period, the aggregate of all Claims payable under the Policy, shall not exceed the sum of:
  - -- Base Sum Insured
  - -- Cumulative Bonus

-- Policy Service Guarantee Sum Insured

-- Re-instated Sum Insured

For better understanding of this Benefit refer Annexure 2.

Benefit 9 – Call option for Enhancement of Base Sum Insured

For the purpose of this Clause:

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that at the end of every 4 consecutive claim free Policy Periods of the Policy with the Company, the Company will provide a Call option for enhancement of Base Sum Insured by an amount equal to the accumulated Cumulative Bonus (which shall not exceed 100% of expiring Policy Base Sum Insured)

This is subject to the following:

a. The sum total of Base Sum Insured and Cumulative Bonus on exercising the call option shall not exceed four times the Base Sum Insured under the first Policy Period with the Company or Rs 50 lacs whichever is lower;

b. The enhancement of Base Sum Insured on exercising the call option shall not enhance the available Room Category limit and other such limits which are a function of Sum Insured which shall always be applicable on the Base Sum Insured.

c. This Benefit shall cease to apply:

   i. In relation to an individual cover, once the Insured Person attains the Age of 60 years;

   ii. In relation to a floater cover, once the eldest Insured Person attains the Age of 60 years.

d. In relation to a Floater, the enhanced Base Sum Insured after exercising the Call option shall be available on Floater basis.

e. Under a Floater Policy the Call option shall be available only if all the Insured Person(s) who are to be insured under the enhanced Base Sum Insured were also continuously covered in the immediate preceding 4 Policy Periods without any claim and continue to be insured under the current/subsequent Policy Period. However if a new member is to be added at the time of renewal the company shall cover him under the renewed Policy subject to receipt of appropriate premium , underwriting and applicability of waiting periods as defined under clause 3.1.1, 3.1.2 & 3.1.3 of the Policy

f. Under an Individual Policy the Call option shall be available only if the Insured Person(s) who is to be insured under the enhanced Base Sum Insured was also continuously covered in the immediate preceding 4 Policy Periods without any claim and continue to be insured in the current/subsequent Policy Period.

g. Call Option shall not be available if Policy is not renewed on or before Policy Period End Date, Renewable Date or Grace Period, whichever is later.

h. In case the Insured Person(s) in the expiring 4 consecutive claim free Policy Periods are covered on individual basis and desire to renew such expiring policy with the Company on a Floater basis, and are eligible for Call option then the amount available for call option shall be the least of the Base Sum Insured amongst all the Insured Person(s).

I. In case where the Insured Person(s) in the expiring 4 consecutive claim free Policy Periods are covered on a floater basis and desire to renew such expiring policy with the Company on an Individual/floater basis and are eligible for Call option then the Base Sum Insured available as call option shall be split into 2 or more Floater / individual covers in the proportion of the number of lives insured under such renewed policies

j. Call option for enhancement of Base Sum Insured is an option which the Policyholder can avail by paying the premium as applicable for the revised Sum Insured, which shall become the Base Sum Insured for the renewed Policy on exercising the Call Option, at the time of renewal in the year in which the Policy becomes eligible for enhancement.

k. The Policyholder can exercise this option only at the end of every 4 consecutive claim free Policy Periods. If the Policyholder chooses to forgo this option then the same would be available after expiry of further four claim free consecutive Policy Periods

l. In case of multiple insured persons covered under individual base sum insured under the same policy then all those who become eligible for Call option would have to opt for or forgo the Call option without selection.

m. On exercising of call option and the company increasing the Sum Insured the Pre-existing Disease Coverage shall be available for the entire enhanced Sum Insured

n. If Call Option is exercised then the entire Cumulative Bonus shall be forgone and reduced to zero

Benefit 10 – Claim Service Guarantee

I) Cashless Intimation

If the Insured Person notifies a request for Cashless facility as per clause 4.1, along with complete set of documents & information then the Company will respond within 6 business hours of receipt of such information with either

a. Approval ; or

b. Rejection ; or

c. Query seeking further information

In the event that the Company fails to respond within 6 business hours then the Company shall be liable to pay the Insured Person for the delay in the following manner:

- For delay beyond 6 business hours and upto 12 hours– 1% of Delayed Claim Amount. For delay beyond 12 hours additional 1% for every additional delay of 6 business hours. The total liability under this clause shall be subject to a maximum of 6% of Delayed Claim Amount.

II) Reimbursement Intimation

The Company shall process the Claim within 21 days of the actual receipt of complete information and all documents as specified in Clause 4 (“Claims Intimation, Assessment and Management”)

In the event that the Company fails to send a response within 21 days then the Company shall be liable to pay the Insured Person for the delay in the following manner:

- For delay beyond 21 days and upto 42 days – 1% of Delayed Claim amount. For delay beyond 42 days, 1% for every additional delay of 21 days. The total liability under this clause shall be subject to a maximum of 6% of Delayed Claim Amount.

Delayed Claim Amount for the purposes of this clause shall mean the minimum of authorization request amount or authorization amount issued, final claim amount or balance Base Sum Insured

The Company will not be liable to pay under I) and II) above in case of any force majeure, natural event or manmade disturbances which impedes the Company's ability to make a decision or to communicate such decision to the Policyholder/Insured Person

Any amount paid under I) and II) will not affect the Base Sum Insured as specified in the Schedule. The Company's liability to make payments under I) and II) shall at all times be restricted to the amounts specified under I) and II) including the maximum amount specified therein and the Policyholder/Insured Person shall not be entitled to any sum whatsoever in excess of those amounts.

The payment under this clause is over and above Protection of Policyholder's Interest Regulations 2002

Benefit -11 – Policy Service Guarantee

In the event of delay in the process of issuing a Policy beyond 10 Working days from the date of receipt of all completed documents (including Medical reports, as applicable) and premium, the Company shall provide an one time additional amount of Sum Insured of *Rs.* as mentioned in Policy Schedule which will be applicable only for 1 year Policy Period and shall not be applicable for renewals/auto-renewals. This Sum Insured shall not be taken into consideration for calculating the Cumulative Bonus &/or the Re-instatement Sum Insured

Benefit -12 –Accidental Death Cover for No Claim Renewal

It is hereby declared and agreed that at the end of every claim free Policy Period with the Company, the Company will provide a Personal Accident cover to the Policyholder provided he is also an Insured Person in the Policy for an amount of Rs. 1 Lac for one Year starting from Policy Start Date of the renewed Policy.

This Benefit would pay an amount of Rs 1 Lac to the nominee/legal heir of the Policyholder, in the unfortunate event of the Death of the Policyholder (who is also an Insured Person) within a period of twelve months from the date of Injury, and such Injury, which is sustained during the Policy Period, is the sole and direct cause of the death of the Policyholder

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

1. Any pre-existing injury or physical condition
2. An Insured Person operating or learning to operate any aircraft or performing duties as a member of a crew on any aircraft or Scheduled Airline or any airline personnel.
3. An Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline.

4. Any intentional self-inflicted Injury, suicide or attempted suicide, sexually transmitted conditions, mental and nervous, insanity, disorder, anxiety, stress or depression.
5. Influence of drugs, alcohols or other intoxications or hallucinogens
6. Insured Person engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports, unless declared beforehand and agreed by the Company subject to additional premium being paid and incorporated accordingly in the Policy.
7. Insured Person serving in any branch of the Military, Navy or Air-force or any branch of Armed Forces or any paramilitary forces
8. Insured person working in/with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs work or ship crew services or as jockeys or circus personnel or aerial photography or engaged in Hazardous Activities
9. Results from pregnancy or child-birth
10. Impairment of an Insured's intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance.

This Benefit shall only be applicable if the Policy is renewed with us without any break and with atleast the same Insured Person(s) who were insured under the expiring Policy.

Benefit -13 – Insurance Renewal

It is hereby declared and agreed that if the Policyholder (who is also an Insured Person) is diagnosed or undergoes for the first time, with any of the below named Critical illness which is admissible and payable under the policy, the cover under the Policy shall be automatically extended for a tenure of 1 year.

This benefit is provided once in the lifetime to the Policyholder.

For the purpose of this Benefit, Critical illness is as defined below:-

"Critical Illness" means disease / illness / surgery limited to the following

Cancer of specified severity

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

The following are excluded

- Tumors showing the malignant changes of carcinoma in situ & tumors which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CI N-1, CIN-2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumors of the prostrate unless histologically classified as having a Gleason score greater than 6 or having progressed to atleast clinical TNM classification T2N0M0
- Papilary Micro-carcinoma of the thyroid less than 1 cm in diameter

- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumors in the presence of HIV infection

Open chest Coronary Artery Bypass Graft

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

II. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser surgery

Stroke resulting in permanent symptoms

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

The following are excluded:

I) Transient ischemic attacks (TIA)

ii) Traumatic injury of the brain

iii) Vascular disease affecting only the eye or optic nerve vestibular functions

Multiple Sclerosis with persisting symptoms

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

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

ii) There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months, and

iii) Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

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

3. Exclusions

3.1 Waiting Period:

3.1.1 30-Day waiting period

Claim for any Medical Expenses incurred for treatment of any Illness which began within 30 days of Policy Period Start Date shall not be admissible, except those incurred as a result of an Injury.

This exclusion shall not be applicable on subsequent Policy Period provided there is no break in insurance and the Policy is renewed with the Company on time upto the same or lower Base Sum Insured.

3.1.2 2 year waiting period

Claims will not be admissible for any Medical Expenses incurred for diagnosis / treatment of the following Illnesses / Surgeries during the first two consecutive years of coverage by the Company from the first Policy Period Start Date:

- Arthritis if non-infective, Osteoarthritis and Osteoporosis, Gout, Rheumatism & all vertebrae Disorders including but not limited to Spondylitis, Spondylosis, Spondylolisthesis & Intervertebral Disc Prolapse, Joint Replacement Surgery
- Benign ear, nose and throat (ENT) Disorders and Surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
- Benign Prostatic Hypertrophy
- Cataract
- Dilatation and Curettage
- Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, any abscess related to Anal region, Gastric and Duodenal Ulcers
- Surgery of Genito urinary system unless necessitated by malignancy
- All types of Hernia, Hydrocele
- Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy and Myomectomy for fibroids
- Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
- Kidney Stone/ Ureteric Stone/ Lithotripsy / Gall Bladder Stone
- Varicose veins and varicose ulcers

In case the above Illness / conditions are Pre-existing disease/ conditions at the time of commencement of first policy with the Company, these shall not be covered until 36 months of continuous coverage has elapsed, since the first Policy Period Start Date with the Company.

3.1.3 Pre-existing Disease: Claims will not be admissible for any Medical Expenses incurred for diagnosis / treatment of any Pre-existing Disease until 36 months of continuous coverage has elapsed, counting from the inception of the first Policy with the Company.

3.1.4 The Waiting Periods as defined in Clause 3.1.1, 3.1.2 &3.1.3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

If there is any break in insurance cover then the waiting periods including that for Pre-existing Disease shall be applicable afresh and the look-back period of 4 years for Pre-existing Disease shall be counted from the fresh Policy Period Start Date

3.2 Portability:

3.2.1 If the Policyholder/ Insured Person renews with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDA, then the Waiting Period as defined in Clause 3.1.1, 3.1.2 and 3.1.3 of this Policy shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s). However the company's maximum liability for payment of any claim on account of any

illness/injuries/surgeries/disease as excluded under Clause 3.1.1, 3.1.2 and 3.1.3 of this Policy shall be capped to the limits as defined in Clause 3.2.2 below subject to Base Sum Insured and completion of waiting periods as mentioned under the respective Clause 3.1.1, 3.1.2 and 3.1.3

3.2.2 For portability in case of individual to individual or floater to floater the limits applicable for payments of claim under the Policy on account of reduction of Waiting Periods as defined above in 3.1.1, 3.1.2 & 3.1.3 shall be available as per the following criteria:

a. Base Sum Insured opted with the Company is lower than the expiring policy sum insured then the limit shall be available upto the Base Sum Insured opted with the Company

b. Base Sum Insured opted with the Company is equal to the expiring policy sum insured then the limit shall be available upto the Base Sum Insured opted with the Company. The accrued cumulative bonus if any shall be credited as Cumulative Bonus

c. Base Sum Insured opted with the Company is higher than the sum of expiring policy sum insured and cumulative bonus then the limit shall be available upto the sum of expiring policy sum insured and the accrued cumulative bonus as mentioned in the schedule.

d. In case where cover type is floater then Sum Insured Limit for Portability as defined in the Schedule shall also be on floater basis

e. Waiting Periods shall apply afresh to the amount which is equal to the difference between the Base Sum Insured opted with the Company and the expiring policy sum insured as mentioned in the schedule.

f. The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum Insured Limit for Portability with a capping upto Applicable Sub-limit for Portability for each Insured Person as defined in Policy Schedule

3.2.3 The Waiting Periods as defined in Clause 3.1.1, 3.1.2 & 3.1.3 and this clause shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

3.3 Permanent Exclusions:

Claim in respect of any Insured Person arising directly or indirectly due to any of the following shall not be admissible, unless expressly stated to the contrary in the Policy:

3.3.1 Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

3.3.2 Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. However, this exclusion will not apply to ectopic pregnancy, which is proved by diagnostic means and certification by a gynecologist that it is life threatening.

3.3.3 Any treatment arising from or traceable to any fertility, infertility, sub-fertility or assisted conception procedure or sterilization, birth control procedures, hormone replacement therapy, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

3.3.4 Any dental treatment or surgery unless necessitated due to an Injury and requiring Hospitalization.

3.3.5 Treatment taken from anyone not falling within the scope of definition of Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

3.3.6 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, cochlear implants, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

3.3.7 Unproven/Experimental treatments, investigational, devices and pharmacological regimens or unproven treatments or treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment. Any diagnosis/treatment of an Illness/ Injury which does not require Hospitalization.

3.3.8 Any expenses incurred on injection bevacizumab or similar injections, organ transplant surgery involving organs not harvested from a human body, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/ thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition.

3.3.9 Weight management services and treatment, services and supplies including treatment of obesity (including morbid obesity).

3.3.10 Any treatment related to sleep disorder or sleep apnea syndrome, general debility, convalescence, rest home, health hydros, remodeling/ nature cure clinics or similar institutions, sanatorium treatment, Rehabilitation measures, convalescent homes for de-addiction/detoxification centers, private duty nursing, respite care, long-term nursing care, home for aged, mentally disturbed, custodial care or any treatment in an establishment that is not a Hospital.

3.3.11 Treatment of all Congenital Anomaly / Illness or defects or anomalies or treatment relating to birth defects.

3.3.12 Treatment of mental illness, stress, Parkinsonism, Alzheimer, psychiatric or psychological disorders.

3.3.13 Aesthetic treatment, Cosmetic Surgery and plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury.

3.3.14 Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.

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

3.3.16 All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment), vitamins & tonics.

3.3.17 Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

3.3.18 Any travel or transportation expenses including Ambulance charges.

3.3.19 All expenses related to donor screening, treatment, including surgery to remove organ(s) from the donor, in case of transplant surgery.

3.3.20 Non-allopathic treatment.

3.3.21 Out-patient treatment.

3.3.22 Treatment received outside India or any robotic/remote surgery performed by medical

practitioners from outside the geographical territory of India.

3.3.23 Domiciliary hospitalization/ treatment.

3.3.24 Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/ Day Care Treatment is required.

3.3.25 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.

3.3.26 Any Illness / Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.

3.3.27 Act of self-destruction or self-inflicted Injury or any form of organ donation by Insured Person, attempted suicide or suicide while sane or insane or Illness/ Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol.

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

3.3.29 Personal comfort & convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls(wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body / baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

3.3.30 Stem Cell implantation, harvesting, storage or any kind of treatment using stem cells.

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

3.3.32 Nuclear, Chemical or Biological attack/ weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this Clause :

a. Nuclear attack/ weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack/ weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably

distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack/ weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Also excluded herein is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above.

3.3.33 Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.

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

3.3.35 Any genetic disorder resulting from defect in the genes including but not limited to Muscular Dystrophy, Marfan syndrome etc.

3.3.36 Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule or any non-medical charges as mentioned in "List of Medical Expenses Excluded" as appended

3.3.37 All expenses incurred by the Policyholder/ Insured Person at the Hospital or any institution about which the Company has expressly notified that the Claim incurred at such Hospital/institution shall not be payable. The updated list of such Hospitals can be obtained through the Company's website or Call Center.

4 Claims Intimation, Assessment and Management

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:

4.1 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 the 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 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

4.2 Claims Procedure

4.2.1 **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 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 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 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 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 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 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 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 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 Company. In such cases, the 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.

4.2.2 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, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

4.3 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 Company, the Insured Person will have to submit himself for a medical examination by the 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 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.

4.4 Claim Documents

The Policyholder / Insured Person shall submit to the 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.

4.5 Claim Assessment for Benefit 1

The Claim under this Policy shall be assessed in the following progressive order:

a) Aggregate of all covered Medical Expenses incurred in the hospital shall be derived

b) Assessed Claim Amount

In case the room category is not violated,

Assessed Claim Amount = amount as derived at a) above

In case the Insured Person opts for a Room whose category is higher than the eligible limit as specified in the Policy, then all the Medical Expenses shall be prorated as per following and the Company's liability for further assessment of claim shall be restricted to

$$\text{Assessed Claim Amount} = \frac{\text{Room Rent of the entitled room category} \times \text{covered Medical Expenses}}{\text{Room Rent actually incurred}}$$

c) Final Claim Amount shall be derived after deducting Co-payment, if any on account of age. Such Co-payment shall be applicable in aggregate on the Assessed Claim Amount as derived above.

d) The Final Claim amount would be deducted, in the following progressive order, from:

i) Base Sum Insured

ii) Cumulative Bonus

iii) Policy Service Guarantee Sum Insured

iv) Reinstated Sum Insured

e) In case the Contribution Clause is invoked, the Company's liability shall be apportioned accordingly.

f) The company's total liability shall not exceed at any point of time the aggregate of the balance of Base Sum Insured, Cumulative Bonus, Policy Service Guarantee Sum Insured & Re-instated Sum Insured , wherever applicable.

g) Wherever there is an applicable limit/sublimit to any illness/injury/surgery etc on account of but not limited to portability/sublimits etc then the application of re-instatement of base sum insured or cumulative bonus or policy serviced guarantee sum insured shall not alter them and the company's aggregate liability under a policy for payment of such claims shall be restricted to such limit/sublimit

4.6 Payment Terms

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

4.6.2. Claims shall not be admissible under this Policy unless the 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.

4.6.3. 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 1 (List of Day Care Treatments).

4.6.4. The amount payable under Benefits is part of the Base Sum Insured, unless specifically provided in the Policy Schedule.

4.6.5. The Base 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.

4.6.6. The claim under Benefit 2 to 5 shall be admissible provided a Claim under the Benefit 1 is admissible, unless specifically provided for.

4.6.7. The Company shall have no liability under the Benefits 1 to 6 in respect of an Insured Person, once the Base Sum Insured or the limit mentioned against the Benefit as stated against such Insured Person is exhausted.

4.6.8. The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

4.6.9. If the Policyholder/ Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any one Illness under this Policy shall be applied as if they were under a single Claim.

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

4.6.11. For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.

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

5. General Terms and Conditions

5.1 Duty of disclosure

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

In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or device being used by the Policyholder/ Insured Person or any one acting on his/ their behalf to obtain a benefit under this Policy, the Company may cancel this Policy at its sole

discretion and the premium paid shall be forfeited in its favor.

5.2 Observance of Terms and Conditions

The due observance and fulfillment of the Policy Terms & Conditions and Endorsements of this Policy in so far as they relate to anything to be done or complied with by the Policyholder / Insured Person, shall be a condition precedent to any of the Company's liability to make any payment under this Policy.

5.3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 Complete discharge

Payment made by the Company to the Policyholder/ adult Insured Person or the Nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

5.8 Subrogation

Subrogation shall mean the right of the Company to assume the rights of the Insured Person/Policyholder to recover expenses paid out under the Policy that may be recovered from any other source

The Policyholder/ Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is/or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become

necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of effecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on fixed benefit basis.

5.9 Contribution

Contribution: It is essentially the right of an Insurer to call upon other Insurer liable to the same Insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim. This clause shall not apply to any Benefit offered on fixed benefit basis.

5.10 Fraudulent Claims

If a Claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a Claim, or if any fraudulent means or devices are used by the Policyholder / Insured Person or anyone acting on his/ their behalf to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to the Company by the Policyholder / all Insured Persons who shall be jointly liable for such repayment.

5.11 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.

5.12 Free Look Period

The Policyholder would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review the entire Policy. Where the Policyholder disagrees to any of those terms or conditions, the Policyholder has the option to return the Policy stating the reasons for his objection and the Policyholder shall be entitled to a refund of the premium paid, provided no Claim has been incurred under this Policy, subject only to a deduction of the expenses incurred by the Company on medical examination and the stamp duty charges. In cases where the risk has already commenced when the option of returning this Policy is exercised, within the free look period, by the Policyholder, the refund of the premium paid will also be subject to a deduction for proportionate risk premium for the period on cover. Where only part of the risk (e.g. only accidental hospitalization risk) has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

This clause shall not be applicable on renewal of this Policy and Portability cases.

5.13 Renewal Notice

a. This Policy will automatically terminate at the end of the Policy Period. All renewal applications should reach the Company before the end of the Policy Period.

b. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein prior mentioned and that nothing is known to the Policyholder/ Insured Person(s) that may result in enhancing the Company's risk.

c. This Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of this Policy and in any case not later than the expiry of the Grace Period.

   Grace period means a period of 30 days immediately following the premium due date during which a payment can be made to renew or continue this Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Disease. Coverage is not available for the period for which no Premium is received by the Company.

d. The Company shall not be liable for any Claims incurred during such period for which premium is not received by due date and in advance

e. Ordinarily renewals will not be refused by the Company except on ground of fraud, moral hazard or misrepresentation.

f. Renewal premium would be as per the age /Sum Insured /Plan etc selected on the date of renewal.

5.14 Cancellation / Termination

- The Company may at any time, cancel this Policy on grounds as specified in Clause 5.1, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.

- The Policyholder may also give 15days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy by the Policyholder/ Insured Person.

Refund % to be applied on Policy Premium

Policy Tenure	*1 year*	*2 year*
Cancellation date up to (x months) from Policy Period Start Dat	*Refund*	
Up to 1 month	*75.00%*	*87.50%*
Up to 3 month	*50.00%*	*75%*
Up to 6 month	*25.00%*	*62.50%*
Up to 9 month	*0.00%*	*50%*
Up to 12 month	*0.00%*	*25%*
Up to 18 month	*NA*	*12.50%*
Up to 24 month	*NA*	*0%*

No refund of premium shall be made on Policy where premium is paid in installments.

In case of demise of the Policyholder, this Policy shall continue till the end of Policy Period or next premium due whichever is earlier. In case the other Insured Person want to continue with the same Policy, the Company would renew the Policy providing all continuity benefits, subject to there being atleast one adult member as an Insured Person who would then become the Policyholder. This will be subject to the Company receiving a written application in this regard before Policy Period End Date.

5.15 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.

5.16 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.

5.17 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.

5.18 Cause of Action

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

5.19 Withdrawal / Revision / Modification of the Product / Policy

The Company reserves the right to withdraw, revise or modify this Product/Policy in the future. The revision/modification maybe in respect of Benefits, coverage's, premiums, Policy Terms and Condition s and/or exclusions.

In the event of any such withdrawal of Product/Policy, the company will notify in advance to the Policyholder providing him the option to port to the specified existing health products of the company with continuity benefits.

In the event of any revision/modification of the Product/ Terms of Policy/Premium the company will notify the Policyholder of such changes 3 months in advance

5.20 Payment of Interest

In case of delay of seven days or more in payment of claim after the acceptance by the insured, the Company will pay interest on the claim amount at a rate which is 2% above the bank rate for the period of delay

5.21 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.

5.22 Electronic Transactions

The Policyholder/ Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company'sother products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

5.23 Pre-policy health check-up

The prospect whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, the company shall be liable to re-imburse 50% of the cost of such medicals conducted at the Company's designated centre.

5.24 Grievances

If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

Website	: www.reliancegeneral.co.in
e-mail	: rgicl.services@relianceada.com
Telephone	: 1800 3009
Fax	: +91-22-30479650
Post/Courier	: Any branch office, during normal business hours

If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may contact the Company's Head of Customer Service at:

The Grievance Cell, Reliance General Insurance Company Limited Corrospondence Unit, C- 42, Pawane, T.T.C, Industrial Area, M.I.D.C, Turbhe, Navi Mumbai, Maharashtra, INDIA 400705

If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Address of the Ombudsman Offices	Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 22222049 / 22222048 Email: bimalokpal.bengaluru@gbic.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@gbic.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.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@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, 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@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237539 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.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@gbic.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@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.

Address of the Ombudsman Offices	Jurisdiction
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part 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@gbic.co.in	West Bengal, Bihar, Sikkim, Jharkhand, Andaman & Nicobar Islands.
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@gbic.co.in	Uttar Pradesh, Uttaranchal.
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@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council : www.generalinsurancecouncil.org.in,the Company's website www.reliancegeneral.co.in or from any of the Company's offices.

Address and contact number of Governing Body of Insurance Council:

Secretary General
Governing Body of Insurance Council
JeevanSevaAnnexe, 3rd Floor (Above MTNT)
S. V. Road, Santacruz (W), Mumbai – 400 054
Tel: 022-6106889
Fax: 022-6106980, 6106052
Email: inscoun@vsnl.ne0074

ENDORSEMENT

Endorsements are subject otherwise to the Policy Terms and Conditions.

E.1. Floater: Not withstanding anything to the contrary in the policy, It is hereby declared and agreed that the Company's total liability in aggregate, for any and all claims incurred during the policy period, in respect of all insured person, shall not exceed the Base Sum Insured as stated in the Policy Schedule.

E.2. Premium Installment Clause: Notwithstanding anything to the contrary in the Policy,it is hereby declared and agreed that:

- Policyholder shall pay to the Company the premium, applicable taxes & levies, charges etc. as mentioned in the Policy and so long as the Policyholder performs and observes all his obligations hereunder, the Company, as a matter of facility to the Policyholder, agrees to accept payment of premium in installments as mentioned in the Policy.
- Notwithstanding the provisions of the preceding clause, upon non-payment of any installments by the due date thereof, this Policy shall cease to operate from the unpaid installment due date and the Company shall not be liable under this Policy for any Claim occurring thereafter, nor shall any refund of premium become due under the Policy. However, the Company may at its sole discretion re-instate the Policy, subject to the available Sum Insured and underwriting at the time of such re-instatement, from the date and time of receipt of such installment till the Policy Period End Date, provided that the Policyholder makes the payment of the due installment not later than 15 days from the due date of last unpaid installment and further provided that all the other installments payable under the Policy are realized by the Company by the respective due dates and time and without any default.
- Company shall not be liable for any Claims which are incurred from the due date of installment till the date and time of re-instatement of the Policy.
- Additionally in the event of any Claim being lodged under the Policy for any cause whatsoever, all the subsequent premium installments shall immediately become due and payable notwithstanding anything to the contrary herein above contained. The Company shall have the right to recover and deduct any or all the pending installments from the Claim amount due under the Policy.
- No refund of premium shall be made under the policy on account of cancellation of the Policy.

E.3. Co-Payment: Not withstanding anything to the contrary in the policy, It is hereby declared and agreed that the Policyholder/Insured Person shall bear 20% of the Assessed Claim Amount, as mentioned in the table below, and the Company's liability shall be restricted to the balance amount, subject to the available Base Sum Insured.

Cover Type	Entry age* of Insured Person or Eldest Insured Person (in case of Floater)	Applicable to
Individual	>= 61 years	Individual Insured Person

Floater	>= 61 years	All Insured Persons

*Entry age means the age of the Insured Person at the time of coverage under the first policy with the company.

The Co-payment shall be applicable to each and every claim for each Insured Person.

E.4. Room Category: Not withstanding anything to the contrary in the policy, It is hereby declared and agreed that the Insured Person's Hospital accommodation for In-patient care shall be limited Upto Single Private Room.

For the Purpose of this clause, Single Private Room means a Hospital room where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room may have the provision for accommodating an attendant. Such room shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

In the event of Insured Person getting admitted in higher category of accommodation than the entitled category, as mentioned above, the policyholder/ Insured Person shall bear the ratable proportion of the Medical Expenses in proportion of the

$$\left[\frac{\text{Room Rent actually incurred-Room Rent of the entitled room category}}{\text{Room Rent actually incurred}}\right]$$

This shall be applicable to all the Medical Expenses incurred during the stay in Hospital.

List Of Medical Expenses Excluded Reliance HealthGain Policy

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
1	Hair Removal Cream Charges	Not payable
2	Baby charges (unless specified/ indicated)	Not Payable
3	Baby food	Not payable
4	Baby utilites charges	Not payable
5	Baby set	Not payable
6	Baby bottles	Not payable
7	Brush	Not payable
8	Cosy towel	Not payable
9	Hand wash	Not payable
10	Moisturiser paste brush	Not payable
11	Powder	Not payable
12	Razor	Payable
13	Shoe cover	Not payable
14	Beauty services	Not payable
15	Belts/ braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
16	Buds	Not payable
17	Barber charges	Not payable
18	Caps	Not payable
19	Cold pack/hot pack	Not payable
20	Carry bags	Not payable
21	Cradle charges	Not payable
22	Comb	Not payable
23	Disposables razors charges (for site preparations)	Payable
24	Eau-de-cologne/room fresheners	Not payable
25	Eye pad	Not payable
26	Eye sheild	Not payable
27	Email / internet charges	Not payable
28	Food charges (other than patient's diet provided by hospital)	Not payable
29	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
30	Foot cover	Not payable
31	Gown	Not payable
32	Laundry charges	Not payable
33	Mineral water	Not payable
34	Oil charges	Not payable
35	Sanitary pad	Not payable

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
36	Slippers	Not payable
37	Telephone charges	Not payable
38	Tissue paper	Not payable
39	Tooth paste	Not payable
40	Tooth brush	Not payable
41	Guest services	Not payable
42	Bed pan	Not payable
43	Bed under pad charges	Not payable
44	Camera cover	Not payable
45	Cliniplast	Not payable
46	Crepe bandage	Not Payable/ Payable by the patient
47	Curapore	Not payable
48	Diaper of any type	Not payable
49	DVD, CD charges	Not payable (however if cd is specifically sought by insurer)
50	Eyelet collar	Not payable
51	Face mask	Not payable
52	Flexi mask	Not payable
53	Gause soft	Not payable
54	Gauze	Not payable
55	Hand holder	Not payable
56	Hansaplast/ adhesive bandages	Not payable
57	Infant food	Not payable
58	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

Items Specifically Excluded In The Policies

59	Weight control programs/ supplies/ services	Exclusion in policy unless otherwise specified
60	Cost of spectacles/ contact lenses/ hearing aids etc.,	Exclusion in policy unless otherwise specified
61	Dental treatment expenses that do not require hospitalisation	Exclusion in policy unless otherwise specified
62	Hormone replacement therapy	Exclusion in policy unless otherwise specified
63	Home visit charges	Exclusion in policy unless otherwise specified
64	Infertility/ subfertility/ assisted conception procedure	Exclusion in policy unless otherwise specified
65	Obesity (including morbid obesity) treatment	Exclusion in policy unless otherwise specified

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
66	Psychiatric & psychosomatic disorders	Exclusion in policy unless otherwise specified
67	Corrective surgery for refractive error	Exclusion in policy unless otherwise specified
68	Treatment of sexually transmitted diseases	Exclusion in policy unless otherwise specified
69	Donor screening charges	Exclusion in policy unless otherwise specified
70	Admission/registration charges	Exclusion in policy unless otherwise specified
71	Hospitalisation for evaluation/ diagnostic purpose	Exclusion in policy unless otherwise specified
72	Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed	Not payable - exclusion in policy unless otherwise specified
73	Any expenses when the patient is diagnosed with retro virus + or suffering from/HIV/AIDS etc is detected/directly or indirectly	Not payable as per HIV/AIDS exclusion
74	Stem cell implantation/ surgery and storage	Not payable except bone marrow transplantation where covered by policy

Items Which Form Part Of Hospital Services Where Separate5consumables Are Not Payable But The Service Is

75	Ward and theatre booking charges	Payable under OT charges, not payable separately
76	Arthroscopy & endoscopy instruments	Rental charged by the hospital payable. Purchase of instruments not payable.
77	Microscope cover	Payable under OT charges, not separately
78	Surgical blades,harmonic scalpel,shaver	Payable under OT charges, not separately
79	Surgical drill	Payable under OT charges, not separately
80	Eye kit	Payable under OT charges, not separately

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
81	Eye drape	Payable under OT charges, not separately
82	Boyles apparatus charges	Part of OT charges, not separately
83	X-ray film	Payable under radiology charges, not as consumable
84	Sputum cup	Payable under investigation charges, not as consumable
85	Blood grouping and cross matching of donors samples	Part of cost of blood, not payable
86	Antiseptic or disinfectant lotion	Not payable - part of dressing charges
87	Band aids, bandages, sterlile injections, needles, syringes	Not payable - part of dressing charges
88	Cotton	Not payable - part of dressing charges
89	Cotton bandage	Not payable - part of dressing charges
90	Micropore/ surgical tape	Not payable-payable by the patient when prescribed, otherwise included as dressing charges
91	Blade	Not payable
92	Apron	Not payable-part of hospital services/ disposable linen to be part of ot/icu charges
93	Torniquet	Not payable (service is charged by hospitals, consumables cannot be separately charged)
94	Orthobundle, gynaec bundle	Part of dressing charges
95	Urine container	Not payable

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses

Elements of Room Charge

96	Luxury tax	Actual tax levied by government is payable. Part of room charge for sub limits
97	Hvac	Part of room charge not payable separately
98	House keeping charges	Part of room charge not payable separately
99	Service charges where nursing charge also charged	Part of room charge not payable separately
100	Television & air conditioner charges	Payable under room charges not if separately levied
101	Surcharges	Part of room charge, not payable separately
102	Attendant charges	Not payable - part of room charges
103	Im IV injection charges	Part of nursing charges, not payable
104	Clean sheet	Part of laundry/ housekeeping not payable separately
105	Extra diet of patient(other than that which forms part of bed charge)	Patient diet provided by hospital is payable
106	Blanket/warmer blanket	Not payable - part of room charges

Administrative Or Non-medical Charge

107	Admission kit	Not payable
108	Birth certificate	Not payable
109	Blood reservation charges and ante natal booking charges	Not payable
110	Certificate charges	Not payable
111	Courier charges	Not payable
112	Convenyance charges	Not payable
113	Diabetic chart charges	Not payable
114	Documentation charges / administrative expenses	Not payable

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
115	Discharge procedure charges	Not payable
116	Daily chart charges	Not payable
117	Entrance pass / visitors pass charges	Not payable
118	Expenses related to prescription on discharge	To be claimed by patient under post hosp where admissible
119	File opening charges	Not payable
120	Incidental expenses / misc. Charges (not explained)	Not payable
121	Medical certificate	Not payable
122	Maintainance charges	Not payable
123	Medical records	Not payable
124	Preparation charges	Not payable
125	Photocopies charges	Not payable
126	Patient identification band / name tag	Not payable
127	Washing charges	Not payable
128	Medicine box	Not payable
129	Mortuary charges	Payable upto 24hrs, shifting charges not payable
130	Medico legal case charges (mlc charges)	Not payable

External Durable Devices

131	walking aids charges	Not payable
132	Bipap machine	Not payable
133	Commode	Not payable
134	Cpap/capd equipments	Device not payable
135	Infusion pump - cost	Device not payable
136	Oxygen cylinder (for usage outside the hospital)	Not payable
137	Pulseoxymeter charges	Device not payable
138	Spacer	Not payable
139	Spirometre	Device not payable
140	Spo2 probe	Not payable
141	Nebulizer kit	Not payable
142	Steam inhaler	Not payable
143	Armsling	Not payable
144	Thermometer	Not payable (paid by patient)
145	Cervical collar	Not payable

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
146	Splint	Not payable
147	Diabetic foot wear	Not payable
148	Knee immobilizer/shoulder immobilizer	Not payable
149	Knee braces (long/ short/ hinged)	Not payable
150	Lumbo sacral belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
151	Nimbus bed or water or air bed charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ Quadriplegia for any reason
152	Ambulance collar	Not payable
153	Ambulance equipment	Not payable
154	Microshield	Not payable
155	abdominal binder	Essential and should be paid at least in post Surgery patients of major abdominal surgery including tah, lscs, incisional Hernia repair, explorator laparotomy for intestinal obstruction, liver transplant etc.

Items Payable If Supported By A Prescription

156	Betadine/hydrogen peroxide/ spirit/dettol/savlon/disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	Private nurses	Post hospitalization nursing
158	Nutrition planning charges - dietician charges-diet charges	Patient diet provided by hospital is payable
159	Sugar free tablet	Payable -sugar free variants of admissable medicines are not excluded

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses
160	Creams powders lotions (toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digene gel/antacid gel	Payable when prescribed
162	Ecg electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in icu, may require a change and at least one set every second day must be payable.
163	Gloves	Sterilized gloves payable / unsterilized gloves not payable
164	Hiv kit	Payable - payable pre operative screening
165	Listerine/ antiseptic mouthwash	Payable when prescribed
166	Lozenges	Payable when prescribed
167	Mouth paint	Payable when prescribed
168	Nebulisation kit	If used during hospitalization is payable reasonably
169	Novarapid	Payable when prescribed
170	Volini gel/ analgesic gel	Payable when prescribed
171	Zytee gel	Payable when prescribed
172	Vaccination charges	Routine vaccination not payable / post bite vaccination payable

Part Of Hospital's Own Costs And Not Payable

173	Ahd	Not payable - part of hospital's internal cost
174	Alcohol swabes	Not payable - part of hospital's internal cost
175	Scrub solution/sterillium	Not payable - part of hospital's internal cost

Sr. No.	List of excluded expenses (“non-medical”) under indemnity policy	Expenses

Others

176	Vaccine charges for baby	Not payable
177	Aesthetic treatment / surgery	Not payable
178	Tpa charges	Not payable
179	Visco belt charges	Not payable
180	Any kit with no details mentioned [delivery kit, orthokit, recovery kit, etc]	Not payable
181	Examination gloves	Not payable
182	Kidney tray	Not payable
183	Mask	Not payable
184	Ounce glass	Not payable
185	Outstation consultant's/ surgeon's fees	Not payable, except for telemedicine consulations where covered by plicy
186	Oxygen mask	Not payable
187	Paper gloves	Not payable
188	Pelvic traction belt	Should be payable in case of PIVD requiring traction as this is generally not reused
189	Referal doctor's fees	Not payable
190	Accu check (glucometery/ strips)	Not payable pre hospitilasation or post hospitalisation /reports and charts required/device not payable
191	Pan can	Not payable
192	Sofnet	Not payable
193	Trolly cover	Not payable
194	Urometer, urine jug	Not payable
195	Ambulance	Payable- ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
196	Tegaderm / vasofix safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	Urine bag	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	Softovac	Not payable
199	Stockings	Essential for case like cabg etc. Where it should be paid

Annexure 1 – 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

111.

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 und 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

The list above is indicative. The Company reserves the right to modify the list from time to time. However any deletion in the list of surgeries would be after IRDA approval

Annexure 2- Illustration - How the policy will operate in a Policy Year^						
All amounts in ₹	Base Sum Insured	Cumulative Bonus	Policy Servicing Guarantee	Re-instatement Benefit for unrelated Claims*	Re-instatement Benefit for all Claims*	Total Sum Insured
Policy 1- Insured A	₹ 300,000	₹ 100,000	₹ 10,000	₹ 240,000	₹ 60,000	₹ 710,000
Policy 2- Insured B	₹ 300,000	₹ 100,000	₹ 10,000	₹ 240,000	₹ 60,000	₹ 710,000
Policy 3- Insured C	₹ 300,000	₹ 100,000	₹ 10,000	₹ 240,000	₹ 60,000	₹ 710,000
First Claim : Hospitalisation for "Myocardial Infarction- Heart Attack"						
Policy I - Claim amount			₹ 200,000			
Policy 2 - Claim amount			₹ 340,000			
Policy 3 - Claim amount			₹ 500,000			
Amount of claim paid from respective Sum Insureds						Total Sum Insured
Policy 1- Insured A	₹ 200,000					₹ 200,000
Policy 2- Insured B	₹ 300,000	₹ 40,000				₹ 340,000
Policy 3- Insured C	₹ 300,000	₹ 100,000	₹ 10,000		₹ 60,000	₹ 470,000
Post Payment of Claim Balance Sum Insured						Balance Sum Insured
Policy 1- Insured A	₹ 100,000	₹ 100,000	₹ 10,000	₹ 240,000	₹ 60,000	₹ 510,000
Policy 2- Insured B	Nil	₹ 60,000	₹ 10,000	₹ 240,000	₹ 60,000	₹ 370,000
Policy 3- Insured C	Nil	Nil	Nil	₹ 240,000	Nil	₹ 240,000
Second Claim : Hospitalisation for "Coronary Artery Bypass Graft" which is a related ailment						
Policy 1- Claim amount			₹ 200,000			
Policy 2- Claim amount			₹ 200,000			
Policy 3- Claim amount			₹ 200,000			
Amount of claim paid from respective Sum Insureds						Total Claim Paid
Policy 1- Insured A	₹ 100,000	₹ 100,000				₹ 200,000
Policy 2- Insured B		₹ 60,000	₹ 10,000		₹ 60,000	₹ 130,000
Policy 3- Insured C						₹ 0
Post Payment of Claim Balance Sum Insured						Balance Sum Insured
Policy 1- Insured A			₹ 10,000	₹ 240,000	₹ 60,000	₹ 310,000
Policy 2- Insured B				₹ 240,000		₹ 240,000
Policy 3- Insured C				₹ 240,000		₹ 240,000
Third Claim : Hospitalisation for "Injury because of accident" which is an unrelated illness/injury						
Policy I - Claim amount			₹ 200,000			
Policy 2 - Claim amount			₹ 200,000			
Policy 3 - Claim amount			₹ 240,000			
Amount of claim paid from respective Sum Insureds						Total Claim Paid
Policy 1- Insured A			₹ 10,000	₹ 190,000		₹ 200,000
Policy 2- Insured B				₹ 200,000		₹ 200,000
Policy 3- Insured C				₹ 240,000		₹ 240,000
Post Payment of Claim Balance Sum Insured						Balance Sum Insured
Policy 1- Insured A				₹ 50,000	₹ 60,000	₹ 110,000
Policy 2- Insured B				₹ 40,000		₹ 40,000
Policy 3- Insured C				₹ 0		₹ 0

^ In this illustration it is assumed that it's the 2nd Year of policy with first year being claim free covering a healthy individual (41 years) with no history of any pre-existing disease. The Policy Guarantee sum insured has been considered for illustration only

Please Note:

1. This example is for illustration purposes only subject to Policy wordings and Terms & Conditions shall prevail
2. It is assumed in the above illustration that the claim is admissible as per Policy Terms & Conditions and is not arising out of Pre-Existing Disease and no co-pay, contribution etc is applicable
3. In case of any discrepancy Policy Terms & Conditions will prevail
4. *Applicable only on exhaustion of Base Sum Insured , Cumulative Bonus and Policy Service Guarantee Sum Insured