RELIANCE GENERAL INSURANCE

RELIANCE HEALTH GAIN

POLICY WORDINGS

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IRDAI Registration No. 103.
Reliance General Insurance Company Limited.
Registered and Corporate Office: Reliance Center, South Wing, 4th Floor, Santacruz (East), Off. Western Express Highway, Mumbai 400 055.
Corporate Indentity No. U66603MH2000PLC128300.
Reliance Health Gain Policy - UIN-RELHLIP21514V022021

RGI/MCOM/CO/RELIANCE-HGP-PW/Ver. 1.0/25112020
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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

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

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

3) **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.

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

5) **Any one Illness:** means Continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home centre where treatment was taken.

6) **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

7) **AYUSH Treatment** means the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

8) **AYUSH Day Care Centre** means and includes Community Health Centre (CHC) , Primary Health Centre (PHC) ,Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner(s) in charge,

b. Having dedicated AYUSH therapy sections as required and /or has equipped operation theatre where surgical procedures are to be carried out;

c. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative

AYUSH Day Care Centres referred above should also hold either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under national Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

9) **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment and procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching Hospital attached to AYUSH colleges recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following with all the following criterion:

- Having at-least 05 in-patient beds;
- Having qualified AYUSH Medical Practitioner in charge round the clock;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedure are to be carried out;
- Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative.

AYUSH Hospitals referred above should also hold either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under national Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

10) **Bank Rate:** means bank rate fixed by the Reserve Bank of India(RBI) at the beginning of the financial year in which claim has fallen due.

11) **Base Sum Insured:** means the amount specified as Base Sum Insured in the Policy Schedule. Calculation of bonus and sub-limits mentioned under the Policy shall be on basis of the Base Sum Insured.

12) **Break in policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

13) **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 is approved.

14) **Child:** means biological or legally adopted son or daughter of the Policyholder whose completed Age is less than 25 years as on the Policy Period Start Date.

15) **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.

16) **Company:** means Reliance General Insurance Company Limited.

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

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

Explanation: An inquiry or request would not fall within the definition of the "Complaint" or "Grievance".

19) **Condition Precedent:** means a Policy term or condition upon which the Company's liability under the policy is conditional upon.

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

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

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

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

The Policyholder/Insured Person shall bear a co-payment of 20% on the Assessed Claim Amount if age at first entry under the policy is >=61 years (under floater policies the age of Senior most member will be considered). If all the Insured persons at the time of first enrolment are below the age of 61 years then no co-pay shall be applicable even on renewals.

22) **Cosmetic Surgery/Treatment:** 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.

23) **Cumulative Bonus:** means any increase or addition in Sum Insured granted by the Company without an associated increase in premium.

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

a. has qualified nursing staff under its employment;

b. has qualified Medical Practitioner/s incharge;

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

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

25) **Day Care Treatment:** means medical treatment, and/ or surgical procedure which is:

a. undertaken under general or local anesthesia in a Hospital/ Day Care center in less than 24 hours because of technological advancement, and

b. which would have otherwise required Hospitalization of more than 24 consecutive hours.

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

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

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

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

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

29) **Distribution Channels** means persons and entities authorised by the Authority to involve in sale and service of insurance products . For the purpose of this Policy it means the Distribution Channels who is an Intermediary of the Company.

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

a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

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

31) **Emergency/Emergency Care:** means management for an illness orinjury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical practitioner to prevent death or serious long term impairment of the Insured person's health .

32) **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.

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

34) **Grace period:** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

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

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

c. has qualified Medical Practitioner(s) incharge round the clock;

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

e. maintains daily records of patients and makes these accessible to theInsurance company's authorized personnel.

36) **Hospitalization:** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours (Day Care Treatment).

37) **Illness:** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a. Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

b. Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests"
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
- it continues indefinitely
- it recurs or is likely to recur

38) **Injury:** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

39) **In-patient Care/In-patient Treatment:** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

40) **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.

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

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

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

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

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

c. 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

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

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

44) **Maternity expenses:** means

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b. expenses towards lawful medical termination of pregnancy during the Policy Period.

45) **Medical Advice:** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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

47) **Medically Necessary Treatment:** means any treatment , tests , medication or stay in Hospital or part of a stay in Hospital which

a. Is required for the medical management of the illness/injury suffered by the Insured;

b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

c. Must have been prescribed by a Medical Practitioner ;

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India

48) **Medical Practitioner:** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for

Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017.

The registered practitioner should not be the Policyholder /Insured or their close family member.

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

50 **MIgration means**, the right accorded to health insurance Policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

51) **Network/Network Provider:** means Hospitals or health Care providers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a cashless facility. The Network list is available with the Company and is subject to amendment from time to time.

52) **Newborn baby:** means baby born during the Policy Period and is aged upto 90 days.

53) **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.

54) **Non-Network Provider/Hospital:** means any Hospital, Day Care centre or other provider that is not part of the Network.

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

56) **OPD treatment:** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or In-patient.

57) **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, form part of the contract and must be read together.

58) **Policy Schedule/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.

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

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

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

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

63) **Policy Year** means a period of every 12 consecutive months of the Policy Period commencing from the Policy Period Start Date.

64) **Post Hospitalization Medical Expenses:** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

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

b. The In-patient hospitalization claim for such Hospitalization is admissible by the Company

65) **Portability:** Portability means the right accorded to individual health insurance Policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer.

66) **Pre-existing Disease:** means any condition, ailment, Injury or disease:

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

67) **Pre-hospitalization Medical Expenses:** means Medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's hospitalization was required and

b. The In-patient hospitalization claim for such Hospitalization is admissible by the Company

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

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

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

70) **Prospectus** means a document either in physical or electronic

or any other format issued by the insurer to sell or promote the insurance products

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

72) **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

73) **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.

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

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

76) **Senior citizen** means any person who has completed sixty or more years of Age as on the date of commencement or renewal of the Policy.

77) **Sum Insured** means the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year. Sum Insured is the sum of:

a. Base Sum Insured
b. Cumulative Bonus
c. Policy Service Guarantee Sum Insured
d. Re-instated Sum Insured

78) **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.

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

80) **Unproven/Experimental Treatments:** means the 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 is diagnosed with any Illness or suffers any Injury that requires Hospitalization, (including Hospitalization under AYUSH Treatment) during the Policy Period, then the Company will pay, subject to the conditions mentioned below, exclusions and other terms and conditions as mentioned in this Policy, for room category up to Single Private Room or equivalent, for:

i. **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 Sum Insured.

ii. **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 Sum Insured.

Medical Expenses as mentioned under Benefit 1 includes the following:

a. Room Rent
b. Nursing expenses
c. Intensive Care Unit (ICU) Charges
d. Fees of Medical Practitioner including Surgeon and anesthetist
e. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances,
f. Medicines, drugs and consumables,
g. Diagnostics procedures,
h. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure unless specifically excluded

The pre-condition for admissibility and the basis for payment of Claim under the following Benefits 1 to 14 shall be as under:

No.	Description	Basis of Payment	Precondition - Admissibility of Claim under Benefit 1 (Yes / No)
Benefit 1	Hospitalization Expenses	Indemnity	Not Applicable
Benefit 2	Pre-hospitalization & Post-hospitalization Expenses	Indemnity	Yes
Benefit 3	Domestic Road Ambulance	Indemnity	Yes
Benefit 4	Donor Expenses	Indemnity	Yes
Benefit 5	Domiciliary Hospitalization	Indemnity	Yes*
Benefit 6	Wellness	Not applicable	No
Benefit 7	Cumulative Bonus	Indemnity	Yes
Benefit 8	Re-instatement of Base Sum Insured	Indemnity	Yes

Benefit 9	Call option	Indemnity	No
Benefit 10	Claim Service Guarantee	Indemnity	Yes
Benefit 11	Policy Service Guarantee	Indemnity	No
Benefit 12	Accidental Death Cover for No Claim Renewal	Benefit	No
Benefit 13	Insurance Renewal	NA	Yes
Benefit 14	Modern Treatment	Indemnity	Yes*

*Claims under Benefits 5 and 14 should have normally resulted in Hospitalization under Benefit 1, except for special circumstances specified under the respective benefits.

Note:Basis of Sum Insured Coverage (Individual/Floater) under Benefits 1-14 will be as opted by the Policyholder and printed in the Policy Schedule.

If the Cover type as mentioned in the Schedule is Individual, then the total liability of the Company under Benefit 1 to 14 for payment of all Claims in aggregate in relation to each Insured Person incurred during the Policy Year shall not exceed the Sum Insured 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 14 for payment of all Claims in relation to all Insured Person(s) incurred during the Policy Year shall not exceed in aggregate the Sum Insured.

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.

General Conditions applicable to all Benefits 2 to 14

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 14 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 to 14 to become admissible

c. Cashless Facility shall not be available for Benefit 2 to 14 unless specified otherwise.

Benefit 2: Pre-hospitalization and Post-hospitalization Expenses

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

i. 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

ii. 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 1.

For any Post Hospitalization claim under re-imbursement the following wordings under Clause 5.2(ii) 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 Sum Insured, for the Reasonable and Customary Charges incurred on availing Ambulance services offered by a Hospital or by anAmbulance 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 4.1(xxvi)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 Sum Insured for the Medical Expenses incurred, during Hospitalization, in respect of the donor for any organ transplant surgery conducted during the Policy Year, provided:

i. The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

ii. The Company has admitted the Insured Person's claim under the Policy.

iii. 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 4.1(xxvii) of the Policy Terms and Conditions stands superseded to the extent covered under this Benefit.

Benefit 5: Domiciliary Hospitalization

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 Year, subject to the available 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:

i. 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 4.1(xxxii) 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 5.1 of Policy Terms & conditions.

For any claim under this Benefit the following wordings under Clause 5.2(ii) 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 :

a. 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.

b. 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.

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

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

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 Year, the Company will provide 33.33 % (one third) of the expiring Policy Year 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:

i. In any Policy Year, 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.

ii. 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.

iii. 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 Year and continue to be insured in the subsequent Policy Year.

iv. The Cumulative Bonus is provisional and is subject to revision in case of Claim being reported under the expiring Policy Year.

v. Entire Cumulative Bonus will be lost if Policy is not continued / renewed on or before Grace period end date.

vi. Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy.

vii. In case of a claim in any given Policy Year the Cumulative Bonus shall be decreased by 33.33% (one third) of the Base Sum Insured in the subsequent year. However this reduction shall not reduce the Base Sum Insured

viii. This clause does not alter the Company's right to decline renewal or cancellation of the Policy.

ix. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit 1, 5 or 14.

Benefit 8: Re-instatement of Base Sum Insured

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

i. For a claim to be admissible under Re-instated Sum Insured it should be admissible under the Benefit 1.

ii. The payment of claims in aggregate under Re-instated Sum Insured during a Policy Year shall be as per follows:

a. 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.

b. Upto 100% of Base Sum Insured

- for all other claims not falling under the category as defined above

iii. The Re-instated Sum Insured for a particular Policy Year can be utilized only after the Base Sum Insured , Cumulative Bonus and Policy Service Guarantee Sum Insured applicable to that Policy Year have been completely exhausted in that Policy Year.

iv. The Company's overall liability for all claims, in aggregate, within a Policy Year under the Re-instated Sum Insured shall not exceed the Base Sum Insured

v. While calculating Cumulative Bonus, Re-instated Sum Insured shall not be considered.

vi. 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 Year and the sublimit of 20% as defined above shall be applicable on individual basis.

vii. If the Policy is on Floater basis, then the Re-instated Sum Insured will also be available on Floater basis and shall be applied once for the Policy Year and the sublimit of 20% as defined above shall also be applicable on floater basis

viii. The unutilized Re-instated Sum Insured cannot be carried forward to any subsequent Policy Year.

ix. During a Policy Year, the aggregate of all Claims payable under the Policy, shall not exceed the sum of:

a. Base Sum Insured

b. Cumulative Bonus
c. Policy Service Guarantee Sum Insured
d. Re-instated Sum Insured

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 Years 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:

i. 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 Year with the Company or Rs 50 lacs whichever is lower;

ii. The call option shall cease to apply:

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

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

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

iv. 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 Years without any claim and continue to be insured under the current/subsequent Policy Year. 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, 3.2 & 3.3 of the Policy

v. 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 Years without any claim and continue to be insured in the current/subsequent Policy Year.

vi. Call Option shall not be available if Policy is not renewed on or before Grace Period end date.

vii. In case the Insured Person(s) in the expiring 4 consecutive claim free Policy Years 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 options shall be the least of the Base Sum Insured amongst all the Insured Person(s).

viii. In case where the Insured Person(s) in the expiring 4 consecutive claim free Policy Years 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

ix. 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.

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

xi. 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.

xii. 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

xiii. 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 5.1, 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 :

a. 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 5 (" 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:

a. 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 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 that payable under General Terms and Conditions: 6.7 Claim Settlement (provision for Penal Interest)

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 the first Policy Year and shall not be applicable for subsequent Policy Years, renewals/auto-renewals. This Sum Insured shall not be taken into consideration for calculating the Cumulative Bonus &/or the Re-instatement Sum Insured.

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 the first Policy Year and shall not be applicable for subsequent Policy Years, 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 Year 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 Period 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 Year, 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:

i. Any pre-existing injury or physical condition
ii. 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 .
iii. An Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline.
iv. Any intentional self-inflicted Injury, suicide or attempted suicide, sexually transmitted conditions, mental and nervous, insanity, disorder, anxiety, stress or depression.
v. Influence of drugs alcohols or other intoxications or hallucinogens
vi. 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.
vii. Insured Person serving in any branch of the Military, Navy or Air-force or any branch of Armed Forces or any paramilitary forces except during peace time
viii. 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
ix. Results from pregnancy or child-birth
x. 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 the Company without any Break in Policy 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

i. 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 —

a. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
c. Malignant melanoma that has not caused invasion beyond the epidermis;
d. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
f. Chronic lymphocytic leukaemia less than RAI stage 3
g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

All tumors in the presence of HIV infection.

ii. Open chest Coronary Artery Bypass Graft (CABG)

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

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

iii. 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:

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

iv. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

Benefit 14: Modern Treatment

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

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy-Monoclonal Antibody to be given as injection
vi. Intra Vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neutro Monitoring)
xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Benefits 1 to 5.

3. Waiting Period

The Waiting Periods as defined in Clause 3.1, 3.2 &3.3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

If there is any Break in Policy 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.

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

3.1 Pre-Existing Diseases (Code- Excl 01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of Base Sum Insured the exclusion shall apply afresh to the extent of Base Sum Insured increase.
iii. If the Insured Person is continuously covered without any Break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by the Company.

3.2 Specific Waiting Period (Code- Excl 02)

i. Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of Base Sum Insured the exclusion shall apply afresh to the extent of Base Sum Insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any Break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

24 months waiting period:

- 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 SurgeryBenign 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

3.3 First Thirty Days Waiting Period (Code- Excl 03)

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

are covered.

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

iii. The within referred waiting period is made applicable to the enhanced Base Sum Insured in the event of granting higher Base Sum Insured subsequently

3.3 First Thirty Days Waiting Period (Code- Excl 03)

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

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

iii. The within referred waiting period is made applicable to the enhanced Base Sum Insured in the event of granting higher Base Sum Insured subsequently

4. Exclusions

4.1 General Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

i. Investigation & Evaluation (Code: Excl04)

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

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

ii. Rest Cure, rehabilitation and respite care (Code:Excl05)

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

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

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

iii. Obesity/ Weight Control (Code:Excl06):

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

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

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

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

d. Body Mass Index (BMI);

- greater than or equal to 40 or
- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
  - Obesity-related cardiomyopathy
  - Coronary heart disease
  - Severe Sleep Apnea
  - Uncontrolled Type2 Diabetes

iv. Change-of-Gender treatments (Code: Excl 07):

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

v. Cosmetic or Plastic Surgery (Code: Excl 08):

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

vi. Hazardous or Adventure sports (Code: Excl 09):

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

vii. Breach of law (Code: Excl 10):

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

viii. Excluded Providers (Code: Excl 11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. (For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

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

x. Wellness and Rejuvenation (Code:Excl13): Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

xi. Dietary Supplements & Substances (Code: Excl14): Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure

xii. Refractive Error (Code: Excl 15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

xiii. Unproven Treatments-Code (Code: Excl 16)

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

xiv. Sterility and Infertility (Code: Exc l7):

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

xv. Maternity Expenses (Code - Excl 18)

a. Medical treatment expenses traceable to childbirth (including

complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

2 **STDs:** 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, 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.

xvii. **Dental Treatment:** Any dental treatment or surgery unless necessitated due to an Injury and requiring Hospitalization.

xviii. **Treatment outside Discipline:** 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

xix. **Hearing Aids and spectacles:** Any charges incurred on hearing aids, cost of spectacles, contact lenses, routine eye and ear examinations

xx. **External durable medical equipment:** Any expenses incurred on , 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.

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

xxiv. **Vaccination and Immunization:** All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

xxv. **Aritifical Life support equipments:** Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

xxvi. **Travel Charges:** Any travel or transportation expenses including Ambulance charges, other than allowable under Benefit 3.

xxvii. **Donor Transplant Expenses:** All expenses related to donor screening, treatment, including surgery to remove organ(s) from the donor, in case of transplant surgery

xxviii. **Non-Allopathy:** Any expenses related to Non-allopathic treatment, except for AYUSH treatment.

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

xxx. **Out Patient Treatment:** Any expenses related to Out-patient treatment.

xxxi. **Overseas Treatment:** Treatment received outside India.

xxxii. **Domiciliary Treatment:** Domiciliary hospitalization/ treatment.

xxxiii. **Self-injury:** Any intentional self-inflicted Injury.

xxxiv. **Documentation charges:** Any charges incurred to procure any medical certificate, treatment/Illness related documents pertaining to any period of Hospitalization/Illness.

xxxv. **Charges other than Reasonable & Customary Charges**

xxxvi. **Transplant other than from human body:** Expenses incurred on organ transplant surgery involving organs not harvested from a human body

xxxvii. **RMO charges, Service charge and alike:** Expenses related to any kind of RMO charges, service charge where nursing charges are also charged, night charges levied by the Hospital under whatever head.

xxxviii. **Nuclear Attack:** 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.

xxxix. 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

4.2 Permanent Exclusions

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

5.1 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

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

ii. 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:

i. Policy Number
ii. Name of the Policyholder
iii. Name of the Insured Person in whose relation the Claim is being lodged
iv. Nature of Illness / Injury
v. Name and address of the attending Medical Practitioner and Hospital
vi. Date of Admission
vii. Any other information as requested by the Company

5.2 Claims Procedure

i. 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 5.4 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.

ii. **Re-imbursement :**

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in Clause 5.4 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.

5.3 Policyholder's / Insured Person's duty at the time of Claim

i. 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.

ii. Forthwith intimate / file / submit a Claim in accordance with Clause 5 of this Policy.

iii. 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.

iv. 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

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

a. 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.

b. 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.

5.4 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:

i. Duly completed and signed Claim Form, in original
ii. Medical Practitioner's referral letter advising Hospitalization
iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner

v. Original bills from pharmacy / chemists
vi. Original pathological/diagnostic test reports and payment receipts
vii. Indoor case papers
viii. Ambulance receipt and bill
ix. First Information Report / Final Police Report, if applicable
x. Post mortem report, if available
xi. 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 :

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

5.5 Proportionate Deductions

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

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

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

i. Cost of Pharmacy and Consumables
ii. Cost of Implants and Medical Devices
iii. Cost of Diagnostics

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

a. Base Sum Insured
b. Cumulative Bonus
c. Policy Service Guarantee Sum Insured
d. Reinstated Sum Insured

Proportionate Deduction is subject to the following:

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

5.6 Payment Terms

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

ii. 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.
iii. The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure D (List of Day Care Treatments).
iv. The claims payable under all benefits are in totality subject to Sum Insured, unless specifically provided in the Policy Schedule.
v. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.
vi. The claim under Benefit 2 to 5 shall be admissible provided a Claim under the Benefit 1 is admissible, unless specifically provided for.
vii. The Company shall have no liability under the Benefits 1 to 6 in respect of an Insured Person, once the Sum Insured or the limit mentioned against the Benefit as stated against such Insured Person is exhausted.
viii. 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.
ix. 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.
x. For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.
xi. 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.
xii. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form.

6. General Terms and Conditions

6.1 Disclosure of Information

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

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

6.2 Condition Precedent to Admission of Liability

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

6.3 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

6.4 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.

6.5 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.

6.6 Claim Settlement (provision for Penal Interest)

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

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

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

6.7 Complete Discharge

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

6.8 Cause of Action

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

6.9 Multiple Policies

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

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

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

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

6.10 Fraud

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

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

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

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

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

iii. any other act fitted to deceive; and

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

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

6.11 Cancellation

i. The Policyholder may cancel this policy by giving 15days’ written notice and in such an event, the Company shall refund premium for the unexpired Policy Period of this Policy at the short period scales as detailed below:

Policy Tenure - >	1 year	2 year
Cancellation date up to (x months) from Policy Period Start Date	Refund (note: will be used as per policy tenure)	
Up to 1 month	75.0%	87.5%
Up to 3 months	50.0%	75%
Up to 6 months	25.0%	62.5%
Up to 9 months	0.0%	50%
Up to 12 months	0.0%	25%
Up to 18 months	NA	12.5%
Up to 24 months	NA	0%

Refund % to be applied on Policy Premium

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has

been availed by the insured person under the Policy. Also 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.

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

6.12 Migration

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

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

6.13 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the Policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in Waiting Periods as per IRDAI guidelines on portability.

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

6.14 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period
iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

6.15 Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

6.16 Moratorium Period

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

6.17 Premium Payment in Instalments (wherever applicable)

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

i. Grace Period of 30 days days would be given to pay the instalment premium due for the Policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods' ' Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

6.18 Possibility of Revision of Terms of the Policy Including the Premium Rates

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

6.19 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.

6.20 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.

6.21 Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 5 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.

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.

6.22 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. However, change or alteration with respect to increase/ decrease of the Base Sum Insured shall be permissible only at the time of renewal of the Policy subject to underwriting decision of the Company

6.23 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

6.24 Free Look Period

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

6.25 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.

6.26 Nomination

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

6.27 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

6.28 Redressal of Grievance

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

Website: www. Relianceada.com

Toll free: 1800-3009

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: rgicl.services@relianceada.com

Fax:+91 22 3303 4662Courier: Any branch office, the correspondence address, during normal business hours.

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, Winway Building 2nd &3rd Floor,11/12 Block No-4,Old no-67,South Takoganj,Indore(M.P)-452001.Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

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

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor,

Krishe Block, Krishe Sapphire, Madhapur

Hyderabad – 500 081

Grievance Redressal officer email ID:

rgicl.headgrievances@relianceada.com

(For updated details of grievance officer, kindly refer the link.

https: / / reliance general.co.in/ Insurance/About -Us/Grievance-Redressal.aspx

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

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System https://igms. irda.qov. in/

7. Coverage Summary

	Benefit	Basis of Offering*
i	Hospitalization ExpensesMedical	Expenses incurred as In-patient Hospitalization or Day Care Treatment
ii	Pre-hospitalization & Post-hospitalization Expenses	Pre-hospitalization up to 60 days Post-hospitalization up to 60 days
iii	Domestic Road Ambulance	Upto Rs. 1500 per Hospitalization for Plan A Upto Rs. 3000 per Hospitalization for Plan B
iv	Donor Expenses	Upto 50% of Base Sum Insured subject to maximum of Rs 5 lacs
v	Domiciliary Hospitalization	Upto 10% of the Base Sum Insured subject to a maximum of Rs 50,000
vi	Wellness	Available
vii	Cumulative Bonus	33 1/3 % increase in Base Sum Insured for every claim free year; Max up to 100% of Base Sum Insured 33 1/3 % decrease in Base Sum Insured for every claim year; Max up to earned Cumulative Bonus
viii	Re-instatement of Base Sum Insured	One re-instatement upto 100% of Base Sum Insured, subject to sublimit of 20% for related illness/ injury
ix	Call option	Once at the end of every consecutive 4 claim free years
x	Claim Service Guarantee	Cashless Claims - 1% for every delay of 6 hours beyond 6 hours of receipt of all information /documents Re-imbursement Claims - 1% for every delay of 21 days beyond 21 days of receipt of all information/documents Maximum - 6% for a claim
xi	Policy Service Guarantee	Sum Insured of Rs 10,000 under Plan A Sum Insured of Rs 20,000 under Plan B
xii	Accidental Death Cover for No claim Renewal	Accidental Death cover of Rs.1 lac for Insured who is the Policyholder
xiii	Insurance Renewal	One time Automatic extension for a tenure of 1 year if the Policyholder-Insured suffers from named Critical Illness
xiv	Modern Treatment	Medical Expenses incurred as In-patient Hospitalization or Day Care Treatment using Modern Treatment method, up to 50% of Base Sum Insured.

Annexure - A

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

Sl No	Item
1	Baby Charges (Unless Specified/indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-de-cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges
38	Nebulize R Kit
39	Steam Inhaler
40	Armsling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Foot Wear
45	Knee Braces (Long/ Short/ Hinged)
46	Knee Immobilizer/shoulder Immobilizer
47	Lumbo Sacral Belt

48	Nimbus Bed Or Water Or Air Bed Charges
49	Ambulance Collar
50	Ambulance Equipment
51	Abdominal Binder
52	Private Nurses Charges- Spe Cial Nursing Charges
53	Sugar Free Tablets
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
55	Ecg Electrodes
56	Gloves
57	Nebulisation Kit
58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit,recovery Kit, Etc]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

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

Si No	Item
1	Baby Charges (Unless Specified/indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-de-cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet

26	Blanket/warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges

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

Si No	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Camera Cover
6	Dvd, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonicscalpel,shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Orthobundle, Gynaec Bundle

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

Si No	Item
1	Admission/registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipments
7	Infusion Pump - Cost
8	Hydrogen Peroxide\spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges - Diet Charges
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/sterillium
17	Glucometer & Strips
18	Urine Bag

Annexure D - List of Day Care Procedures

1.	**Microsurgical operations on the middle ear**
1.	Stapedotomy to treat various lesions in middle ear
2.	Revision of a stapedectomy
3.	Other operations on the auditory ossicles
4.	Myringoplasty (post-aura/endaural approach as well as simple Type -I Tympanoplasty)
5.	Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
6.	Revision of a tympanoplasty
7.	Other microsurgical operations on the middle ear
2.	**Other operations on the middle & internal ear**
9.	Myringotomy
10.	Removal of a tympanic drain
11.	Incision of the mastoid process and middle ear
12.	Mastoidectomy
13.	Reconstruction of the middle ear
14.	Other excisions of the middle and inner ear
15.	Fenestration of the inner ear
16.	Revision of a fenestration of the inner ear
17.	Incision (opening) and destruction (elimination) of the inner ear
18.	Other operations on the middle and inner ear
19.	Removal of Keratosis Obturans
3.	**Operations on the nose & the nasal sinuses**
20.	Excision and destruction of diseased tissue of the nose
21.	Operations on the turbinates (nasal concha)
22.	Other operations on the nose
23.	Nasal sinus aspiration Foreign body removal from nose
4.	**Operations on the eyes**
24.	Incision of tear glands25. Other operations on the tear ducts
26.	Incision of diseased eyelids
27.	Correction of Eyelid Ptosis by Levator Palpebrae Superioris Resection (bilateral)
28.	Correction of Eyelid Ptosis by Fascia Lata Graft (bilateral)
29.	Excision and destruction of diseased tissue of the eyelid
30.	Operations on the canthus and epicanthus
31.	Corrective surgery for entropion and ectropion
32.	Corrective surgery for blepharoptosis
33.	Removal of a foreign body from the conjunctiva
34.	Removal of a foreign body from the cornea
35.	Incision of the cornea
36.	Operations for pterygium
37.	Other operations on the cornea
38.	Removal of a foreign body from the lens of the eye
39.	Removal of a foreign body from the posterior chamber of the eye
40.	Removal of a foreign body from the orbit and eyeball
41.	Operation of cataract
42.	Diathermy/Cryotherapy to treat retinal tear
43.	Anterior chamber Paracentesis/Cyclodiathermy/ Cyclocryotherapy/Goniotomy/Trabeculotomy and Filtering and Allied Operations to treat glaucoma
44.	Enucleation of Eye without Implant
45.	Dacryocystorhinostomy for various lesions of Lacrimal Gland
46.	Laser Photocoagulation to treat Ratinal Tear
5.	**Operations on the skin & subcutaneous tissues**
47.	Incision of a pilonidal sinus
48.	Other incisions of the skin and subcutaneous tissues
49.	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50.	Local excision of diseased tissue of the skin and subcutaneous tissues
51.	Other excisions of the skin and subcutaneous tissues
52.	Simple restoration of surface continuity of the skin and subcutaneous tissues
53.	Free skin transplantation, donor site
54.	Free skin transplantation, recipient site
55.	Revision of skin plasty
56.	Other restoration and reconstruction of the skin and subcutaneous tissues.
57.	Chemosurgery to the skin.
58.	Destruction of diseased tissue in the skin and subcutaneous tissues
59.	Reconstruction of Deformity/Defect in Nail Bed
6.	**Operations on the tongue**
60.	Incision, excision and destruction of diseased tissue of the tongue
61.	Partial glossectomy
62.	Glossectomy
63.	Reconstruction of the tongue
64.	Other operations on the tongue
7.	**Operations on the salivary glands & salivary ducts**
65.	Incision and lancing of a salivary gland and a salivary duct

66. Excision of diseased tissue of a salivary gland and a salivary duct
67. Resection of a salivary gland
68. Reconstruction of a salivary gland and a salivary duct
69. Other operations on the salivary glands and salivary ducts

8. Other operations on the mouth & face

70. External incision and drainage in the region of the mouth, jaw and face
71. Incision of the hard and soft palate
72. Excision and destruction of diseased hard and soft palate
73. Incision, excision and destruction in the mouth
74. Palatoplasty
75. Other operations in the mouth

9. Operations on the tonsils & adenoids

76. Transoral incision and drainage of a pharyngeal abscess
77. Tonsillectomy without adenoidectomy
78. Tonsillectomy with adenoidectomy
79. Excision and destruction of a lingual tonsil
80. Other operations on the tonsils and adenoids
81. Trauma surgery and orthopaedics
82. Incision on bone, septic and aseptic
83. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84. Suture and other operations on tendons and tendon sheath
85. Reduction of dislocation under GA
86. Arthroscopic knee aspiration
87. Adenoidectomy

10. Operations on the breast

88. Incision of the breast abscess
89. Operations on the nipple
90. Excision of single breast lump

11. Operations on the digestive tract,Kidney and Bladder

91. Incision and excision of tissue in the perianal region
92. Surgical treatment of anal fistulas
93. Surgical treatment of hemorrhoids
94. Division of the anal sphincter (sphincterotomy)
95. Other operations on the anus
96. Ultrasound guided aspirations
97. Sclerotherapy, etc.
98. Laparotomy for grading Lymphoma with Splenectomy/Liver /Lymph Node Biopsy
99. Therapeutic Laparoscopy with Laser
100. Cholecystectomy and Choledocho-Jejunostomy/ Duodenostomy/Gastrostomy/Exploration Common Bile Duct
101. Esophagoscopy, gastroscopy, duodenoscopy with polypectomy / removal of foreign body/diathermy of bleeding lesions
102. Lithotripsy/Nephrolithotomy for renal calculus
103. Excision of renal cyst
104. Drainage of Pyonephrosis/Perinephric Abscess
105. Appendicectomy with/without Drainage

12. Operations on the female sexual organs

106. Incision of the ovary

107. Insufflations of the Fallopian tubes
108. Other operations on the Fallopian tube
109. Dilatation of the cervical canal
110. Conisation of the uterine cervix
112. Therapeutic curettage with Colposcopy/Biopsy/ Diathermy/Cryosurgery/
113. Laser Therapy of Cervix for Various lesions of Uterus
114. Other operations on the uterine cervix
115. Incision of the uterus (hysterectomy)
116. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
117. Incision of vagina
118. Incision of vulva
119. Culdotomy
120. Operations on Bartholin's glands (cyst)
121. Salpingo-Oophorectomy via Laparotomy

13. Operations on the prostate & seminal vesicles

122. Incision of the prostate
123. Transurethral excision and destruction of prostate tissue
124. Transurethral and percutaneous destruction of prostate tissue
125. Open surgical excision and destruction of prostate tissue
126. Radical prostatovesiculectomy
127. Other excision and destruction of prostate tissue
128. Operations on the seminal vesicles
129. Incision and excision of periprostatic tissue
130. Other operations on the prostate

14. Operations on the scrotum & tunica vaginalis testis

131. Incision of the scrotum and tunica vaginalis testis
132. Operation on a testicular hydrocele
133. Excision and destruction of diseased scrotal tissue
134. Other operations on the scrotum and tunica vaginalis testis

15. Operations on the testes

135. Incision of the testes
136. Excision and destruction of diseased tissue of the testes
137. Unilateral orchidectomy
138. Bilateral orchidectomy
139. Orchidopexy
140. Abdominal exploration in cryptorchidism
141. Surgical repositioning of an abdominal testis
142. Reconstruction of the testis
143. Implantation, exchange and removal of a testicular prosthesis
144. Other operations on the testis

16. Operations on the spermatic cord, epididymis 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

Annexure F

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

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignantneoplasms of respiratory and intrathoracic organ • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 -
14.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

ANNEXURE-B

Ombudsman Office	
Office Details	**Jurisdiction**
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**AHMEDABAD - Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road,Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	**BENGALURU - Smt. Neerja Shah** 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 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	**BHOPAL - Shri Guru Saran Shrivastava** 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@ecoi.co.in
Orissa.	**BHUBANESHWAR - Shri Suresh Chandra Panda** Office of the Insurance Ombudsman, 62, Forest park,Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	**CHANDIGARH - Dr. Dinesh Kumar Verma** 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@ecoi.co.in

Ombudsman Office	
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	**CHENNAI - Shri M. Vasantha Krishna** 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@ecoi.co.in
Delhi.	**DELHI - Shri Sudhir Krishna** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI - Shri Kiriti .B. Saha** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**HYDERABAD - Shri I. Suresh Babu** 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	**JAIPUR - Smt. Sandhya Baliga** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**ERNAKULAM - Ms. Poonam Bodra** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in

Ombudsman Office	
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA -** Shri P. K. Rath 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@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	**LUCKNOW -** **Shri Justice Anil Kumar Srivastava** 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@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	**MUMBAI -** **Shri Milind A. Kharat** 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@ecoi.co.in

Ombudsman Office	
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, utambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	**NOIDA -** **Shri Chandra Shekhar Prasad** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	**PATNA -** **Shri N. K. Singh** Office of the Insurance Ombudsman, 1st Floor,, KalpanaArcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	**PUNE -** **Shri Vinay Sah** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in