RELIANCE GENERAL INSURANCE

RELIANCE HEALTH INFINITY INSURANCE

POLICY WORDINGS

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IRDAI Registration No. 103.

Reliance General Insurance Company Limited.

Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai - 400063.

Corporate Indentity No. U66603MH2000PLC128300.

Reliance Health Infinity Insurance
UIN - RELHLIP21521V032021

RGI/MCOM/CO/RELIANCE-HII-PW/Ver. 1.0/16122020

An ISO 9001:2015 Certified Company

Tech + ♥ = *live* Smart

We will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the receipt of premium in full, any applicable sub-limits and the terms, conditions and exclusions of this Policy.

Section 1. Basic Benefits:

The following Basic Benefits are available to all Insured Persons. Claims made in respect of any of these Basic Benefits will be subject to the availability of the Sum Insured, any applicable sub-limits for the Benefit claimed and will affect the eligibility for the More Options Benefits set out in Section 2.

Cashless Facility at a Network Provider can be availed for the Basic Benefits unless the Basic Benefit expressly specifies that the benefit can be availed only on a reimbursement basis. If Cashless Facility is not available or is not availed by the Insured Person, then the claim will be considered on a reimbursement basis.

If any Insured Person suffers an Illness or Injury during the Policy Period that requires that Insured Person's Hospitalisation for Inpatient Care, then We will pay:

a) Inpatient Care

Medical Expenses incurred for:

i) Room Rent,
ii) Nursing
iii) Intensive Care Unit (ICU) Charges,
iv) Medical Practitioner(s) fees,
v) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
vi) Prosthetic devices if implanted internally during a surgical procedure, unless specifically excluded
vii) Medicines, drugs and allowable consumables,
viii) Investigative tests and diagnostic procedures directly related to the Injury or Illness for which the Insured Person is Hospitalised.

b) Special Treatment:

Medical Expenses incurred for the following

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
xiii) Treatment for correction of eye sight due to refractive error above dioptre 14.0

These Medical Expenses will be covered upto the amount specified in the Schedule of Benefits, provided that:

i) A Co-payment of 50% will be applicable on the admissible amount under this Benefit for each and every claim. This Co-payment will apply in addition to any other Co-payment already applicable under the Policy.
ii) The MoreCover Benefit and MoreGlobal Benefit under More Options Benefits 2.b) and 2.c) shall not apply to any claim under this Benefit, even if same are specified to be in in force for the Insured Person under this Policy.
iii) Our maximum liability will be restricted to the amount specified in the Schedule of benefits.

c) Day Care Procedures:

Medical Expenses incurred for Day Care Treatment which is a Surgical Procedure, chemotherapy or radiotherapy or haemodialysis taken by an Insured Person during the Policy Period at a Hospital or Day Care Centre provided that:

i) Any Day Care Treatment carried out for diagnostic purposes shall not be covered under this Benefit,
ii) Any Day Care Treatment which also falls within the scope of cover under Basic Benefit 1. b) will be considered under Basic Benefit 1.b) and not this Benefit.
iii) No list of Day Care Treatments will be provided for this benefit.

d) Domiciliary Hospitalisation:

Medical Expenses for Domiciliary Hospitalisation of the Insured Person provided that:

i) The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case We will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and
ii) If We accept a claim under this Benefit We will pay Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses in accordance with Basic Benefit 1.g) and Basic Benefit 1.h), respectively

e) Organ Donor:

Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

i) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994. and the organ donated is for the use of the Insured Person, and
ii) We will not pay any Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses or expenses incurred towards any other medical treatment for or attributable to the organ donor consequent to the harvesting, and
iii) We have accepted a claim under Basic Benefit 1.a). Inpatient Care
iv) We will not pay for the Medical Expenses incurred by an Insured Person while donating an organ.

f) Ayush Benefit:

Expenses incurred on treatment taken in a Hospital under Ayurveda, Unani, Sidha and Homeopathy, provided that:

i) The treatment is taken in an AYUSH Hospital as defined under this Policy
ii) We have accepted a claim under Basic Benefit 1.a) Inpatient Care,

iii) Cashless Facility will be provided under this Basic Benefit on a best efforts basis. Where Cashless Facility is not available, due to any reason, We shall consider the claim on a reimbursement basis.

If any Insured Person suffers an Illness or Injury during the Policy Period that requires that Insured Person to undergo medical treatment in respect of that Illness or Injury, then We will pay:

g) Pre-Hospitalisation Medical Expenses:

Pre-Hospitalisation Medical Expenses incurred in the 90 days immediately before the Insured Person's Hospitalisation, provided that:

i) Such expenses are incurred for the same Illness or condition for which the Insured Person was subsequently Hospitalised, and

ii) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

iii) No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimburse ment basis only.

h) Post-Hospitalisation Medical Expenses:

Post-Hospitalisation Medical Expenses incurred in the 180 days immediately after the Insured Person's discharge post Hospitalisation provided that:

i) Such expenses are incurred for the same Illness or condition for which the Insured Person was Hospitalised, and

ii) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

iii) No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

i) Emergency Ambulance:

Expenses incurred on an Ambulance used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency, provided that:

i) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

ii) The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services, provided that that transportation has been prescribed by a Medical Practitioner and is medically necessary, and

iii) Cashless Facility will be provided under this Basic Benefit on a best effort basis. Where Cashless Facility is not available, due to any reason, We shall consider the claims on a reimbursement basis.

j) Transportation Benefit:

Reasonable expenses incurred upto the amount specified in the Schedule of Benefits for utilizing a registered radio cab operator's services for transporting the Insured Person to and/or from the Hospital, provided that:

i) We have approved a pre-authorization request for the Insured Person in respect of the same period of Hospitalisation under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

ii) No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

k) Restore Benefit:

If the Sum Insured is exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a Restore Benefit Sum Insured (equal to 100% of the Sum Insured) will apply to future claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits, provided that:

i) The Restore Benefit Sum Insured will be applied and can be utilised only after the Sum Insured has been completely exhausted;

ii) The Restore Benefit Sum Insured cannot be used for any claim in respect of an Illness (including its complications) for which a claim has been paid in the current Policy Year/Extended Policy Year (if applicable) under Section 1 for the same Insured Person;

iii) For Individual Policies as specified in the Schedule, the Restore Benefit Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);

iv) For Family Floater Policies as specified in the Schedule, the Restore Benefit Sum Insured will be applied only once under the Policy during the Policy Year/Extended Policy Year (if applicable);

v) If the Restore Benefit Sum Insured is not utilised in a Policy Year/Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year.

vi) If the Restore Benefit and MoreCover under More Options Benefits 2.b) (if opted) are both applicable under the Policy, then the Restore Benefit will be applied and can be utilised only if the Sum Insured and the MoreCover Sum Insured have both been exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable.

vii) The Restore Benefit shall not be applicable to any claims made under Basic Benefit 1.b) Special Treatment;

viii) Our maximum, total and cumulative liability for any and all claims made during a Policy Year/Extended Policy Year (if applicable) in respect of the Insured Person for Individual Policies as specified in the Schedule and all Insured Persons for Family Floater Policies as specified in the Schedule shall be the total of:

1) Sum Insured

2) MoreCover Sum Insured (if applicable, and if Sum Insured is exhausted)

3) Restore Benefit Sum Insured (if applicable, and if Sum Insured + MoreCover Sum Insured is exhausted)

Section 2. More Options Benefits

The following More Options Benefits will be applicable to the Insured Person only if the Schedule specifies that the More Options Benefit is in force, provided that

1. You may choose any one of the following More Options Benefits and that Benefit will be applied to the Policy with no additional premium. Where more than one Insured Person is covered under the same Policy, the same More Options Benefit shall be applicable for all Insured Persons.

2. On Renewal with Us, if no claim has been made in respect of the Insured Person under this Policy and the Policy is renewed without any Break, We will continue offering that More Options Benefit for the next Policy Year.

   a. For Individual Policies where claim has been made in respect of an Insured Person, We will continue offering this More Options Benefit without additional premium to the other Insured Persons in respect of whom no claim has been made in the previous Policy Year. However, the insured person who has made claim shall continue to avail this benefit or any other More Options Benefit on paying additional premium at the time of renewal.

   b. For Family Floater Policies, We will continue offering this More Options Benefit for the next Policy Year, only if no claim has been made in respect of any of the Insured Persons under the Policy.

3. In the event of claim in the immediately preceding policy, we will not offer that More Options Benefit for the next Policy Year.

4. You may also, additionally, opt for any of the other More Options Benefits which will be applied under the Policy only on receipt of the additional premium payable for that Benefit in full.

5. Any changes to the More Options Benefits opted for can be made only on Renewal.

a) MoreTime:

If opted, We will provide an Extended Policy Year based on the Policy Period in force, provided that:

i) The Extended Policy Year will be 13 months if Policy Period opted is 1 year and 26 months if the Policy Period opted is 2 years. Each Policy Year will be extended by one month's time with no change in the Sum Insured. The MoreTime shall not be available for a 3 year Policy Period.

Policy Period	1 Year	2 Year		3 Year
Policy Year	1st Year	1st Year	2nd Year	Not Applicable
Months	12 Months	12 Months	12 Months	
Additional Month	1 Month	1 Month	1 Month	
Extended Policy Period	13 Months	26 Months		

ii) The Policy will be Renewed after the completion of the Extended Policy Year and premium as per completed Age at Renewal shall be applicable.

iii) If the MoreTime option is continued at the time of the Renewal, the Policy will be extended for 13 months if the Policy Period opted is 1 year and 26 months if the Policy Period opted is 2 years.

iv) The Policy will be Renewed for opted Policy Period only if the MoreTime option is not opted after the completion of the Extended Policy Year.

v) The MoreTime shall also be applicable to any claims made under Basic Benefits 1.b).

b) MoreCover:

If the Sum Insured is exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a MoreCover Sum Insured of the amount specified in the Schedule of Benefits will apply to claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits in Section 1, provided that:

i) The MoreCover Sum Insured will be applied and can be utilised in respect of the same claim or any future claim only after the Sum Insured has been completely exhausted;

Ii) For Individual Policies as specified in the Schedule of Benefits, the MoreCover Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);

iii) For Family Floater Policies as specified in the Schedule of Benefits, the MoreCover Sum Insured will be applied only once under the Policy during the Policy Year/Extended Policy Year (if applicable);

iv) If the MoreCover Sum Insured is not utilised in a Policy Year/Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year;

v) If the Restore Benefit under Basic Benefit 1.k) and MoreCover (if opted) are both applicable under the Policy, then the Restore Benefit will be applied and can be utilised only if the Sum Insured and the MoreCover Sum Insured have both been exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable;

vi) The MoreCover shall not be applicable to any claims made under Section 1.b) Special Treatment;

vii) Our maximum, total and cumulative liability for any and all claims made during a Policy Year/Extended Policy Year (if applicable) in respect of the Insured Person for Individual Policies as specified in the Schedule and all Insured Persons for Family Floater Policies as specified in the Schedule shall be the total of:

1) Sum Insured

2) MoreCover Sum Insured (if applicable, and if Sum Insured is exhausted)

3) Restore Benefit Sum Insured (if applicable, and if Sum Insured + MoreCover Sum Insured is exhausted)

c) MoreGlobal:

If opted, this benefit covers Emergency Care on treatment of illness or conditions first manifested during the Policy Period while travelling overseas, provided that:

I) The Insured Person's Hospitalisation or Day Care Treatment was Medically Necessary Treatment and was carried out up to limits specified in the Schedule of Benefits.

ii) The Insured Person's condition was certified in writing by the treating Medical Practitioner to be such that Emergency Care is required and treatment cannot be postponed until the Insured Person has returned to India.

ii) No claim under this More Options Benefits will be considered if the Insured Person was not an Indian resident per applicable Indian law on the date of the event giving rise to the claim.

iv) No Cashless Facility is available under this More Options Benefit and all claims will be considered on a reimbursement basis only.

v) The payment of any claim under this More Options Benefit will be based on the rate of exchange as on the date of invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

vi) The MoreGlobal Benefit shall not be applicable to any claims made under Section1.b).

For the purpose of this More Options Benefit alone, Hospital means "Any institution established for In-patient treatment and Day Care Treatment of injury or illness and which has been registered as a Hospital or a clinic as per law rules and/or regulation applicable for the country where the treatment is taken."

Section 3. Voluntary Co-payment

We offer a discount on the premium if You opt for a voluntary Co-payment. If the Schedule specifies that a Co-payment has been opted for, We shall not be liable for the Co-payment share of the Medical Expenses incurred, and

a) The Co-payment shall be applicable to each and every claim, and

b) The Co-payment as specified in the Schedule of Benefits shall be applicable, and

c) The Co-payment is applicable on the admissible amount under any Benefits under Section 1 and Section 2.

Section 4. Renewal Benefit: MoreResults Discount:

The Insured Person will be entitled to a discount on the premium at the time of Renewal of the Policy irrespective of claims made during the Policy Period, if an annual health check-up is carried out during the Policy Year/(s) and the results of the same are shared with Us then,

a) The Insured Person will be entitled to the discount irrespective of the results of the tests,

b) The annual health check-up tests must include these tests: blood glucose, blood pressure, cholesterol and weight assessment,

c) The results of respective Policy Year/(s) must be submitted to Us at least 30 days prior to the expiry of the Policy Year/Extended Policy Year (if applicable),

d) For Individual Policies, this Benefit would be applicable to Insured Persons who are Aged 18 and above on the Policy Commencement Date,

e) For Family Floater Policies, this Benefit would not be applicable to Dependent Children covered under the Policy,

f) The cost of the health check-up will be borne by the Insured Person, and

g) The discount available will be as follows:

Policy Period	Discount applicable per adult for the Policy Period for an Individual Sum Insured Policy	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 2 adults	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 1 adult
1 Year	10.00%	5.00%	10.00%
2 Year	5.00%	2.50%	5.00%
3 Year	3.33%	1.66%	3.33%

h) We will not reassess or alter Your existing coverage based on annual health check-up report submitted to Us for availing MoreResults discount.

i) However, in the event of any fraud, misrepresentation or non-disclosure of material facts, We will re-evaluate Your coverage in accordance with the Policy terms and conditions.

Section 5. Exclusions

Waiting Periods

We shall not be liable to make any payment for any treatment which begins during waiting periods unless the Insured Person suffers an Accident. All waiting periods shall apply individually for each Insured Person and claims shall be assessed accordingly.

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 Commencement Date

a) Pre-Existing Disease waiting period(Code:Excl01)

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 Reliance Health Infinity Insurance Policy with Us

ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase

iii) If You are 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 Us.

b) Specific waiting period (Code:Excl02)

i) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an accident

ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of 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 You are 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

vi) List of specific diseases/procedures in respect of which waiting period is imposed is mentioned below:

Organ / Organ System	Illness /Diagnosis ((irrespective of treatment being medical or surgical)	Surgeries / Surgical Procedure (irrespective of any Illness / diagnosis)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynae-cological	• Cysts, polyps, including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed uterus	• Hysterectomy unless necessitated by malignancy
Orthopaedic	• Non-infective arthritis • Gout and rheumatism • Osteoporosis • Ligament, tendon and meniscal tear • Prolapsed intervertebral disk	• Joint replacement surgery
Gastro-intestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, haemorrhoids, pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), ulcer and erosion of stomach and duodenum • Cirrhosis (however alcoholic cirrhosis is permanently excluded)	• Joint replacement surgery • Cholecystectomy • Surgery of hernia
	• Perineal and perianal abscess • Rectal prolapsed	
Urogenital	• Calculus diseases of urogenital system including kidney, ureter, bladder stones • Benign hyperplasia of prostate • Varicocele	• Surgery on prostate unless necessitated by malignancy • Surgery for hydrocele/ rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Surgery for correction of eye sight due to refractive error above dioptre 14.0
Others	• Congenital internal disease	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/ organs whether or not described above)	• Benign tumors of non-infectious etiology Such as cysts, nodules, polyps, lumps or growth.	• Nil

c) 30-Day Waiting Period (Code:Excl03)

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 Sum Insured in the event of granting higher Sum Insured subsequently

d) Reduction in Waiting Periods

If the proposed Insured Person is presently covered and has been continuously covered without any Break under:

i) any health insurance plan with an Indian non-life insurer as per guidelines on Portability, or

ii) any other similar health insurance plan from Us,

Then:

i) The waiting periods specified in Section 5 a), Section 5 b) and Section 5 c) of the Policy shall stand waived if these waiting periods have been completed under the previous health insurance policy; OR

ii) The waiting periods specified in the Section 5 a), Section 5 b) and Section 5 c) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; and

iii) If the proposed Sum Insured for a proposed Insured Person is more than the sum insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the sum insured and any other accrued benefits under the previous health insurance policy.

e) The reduction in the waiting period specified above shall be applied subject to the following:

i) We will apply the reduction of the waiting period only if We have received the database and past claim history related information as mandated under Portability guidelines from the previous Indian insurance company (if applicable);

ii) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.

iii) We will retain the right to underwrite the proposal.

iv) We shall consider only completed years of coverage for waiver of waiting periods. Policy extensions, if any, sought during or for the purpose of porting the insurance policy shall not be considered for waiting period waiver.

II. General Exclusions

f) We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy:

i) Investigation & Evaluation (Code:Excl04)

1. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
2. 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:

- Custodial care either at home or in a nursing facility for personal care such as help with activities of dailyliving such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual

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

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);

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

iv) Change-of-Gender treatments (Code:Excl07):

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

v) Cosmetic or Plastic Surgery (Code:Excl08):

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

vi) Hazardous or Adventure sports (Code:Excl09):

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

vii) Breach of law (Code:Excl10):

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

viii) Excluded Providers (Code:Excl11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in the website / notified to You are not admissible. However, in case of life threatening situations 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:Excl15):

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

xiii) Unproven Treatments-Code (Code:Excl16):

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

xiv) Sterility and Infertility (Code:Excl17):

Expenses related to Birth Control, sterility and infertility. This includes:

1. Any type of contraception, sterilization
2. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
3. Gestational Surrogacy
4. Reversal of sterilization

xv) Maternity (Code:Excl18)

1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sec tions incurred during hospitalization) except ectopic pregnancy;

2. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

xvi) Alternative Treatments

Alternative Treatment or any other non-allopathic treatment, except to the extent covered under Basic Benefit 1.f).

xvii) Circumcision

Circumcision (unless necessitated by Illness or Injury and forming part of medical treatment);

xviii) Convalescence or Rehabilitation

Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").

xix) Dental Treatments

Dental Treatments of any kind, unless requiring Hospitalisation due to accident.

xx) Unprescribed Drugs or treatments

Any drugs or treatments which are not supported by a prescription.

xxi) Enteral feedings

Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements.

xxii) External Congenital Anomaly

External Congenital Anomaly and genetic disorders.

xxiii) Hearing aids

Provision or fitting of hearing aids

xxiv) Hormonal therapies

1. Growth hormone therapy.

2. Any form of hormone replacement therapy (HRT) and or administration of other hormonal medication.

xxv) Non-Medically Necessary Treatment

Any treatment or part of a treatment that is not Medically Necessary Treatment

xxvi) Medical supplies

Medical supplies including elastic stockings, diabetic test strips, and similar products.

xxvii) Non-medical expenses

Any non-medical expenses mentioned in Annexure A.

xxviii) Outpatient treatment (OPD)

Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.

xxix) Overseas treatment

Treatment availed outside India except in case where the MoreGlobal Benefit (Benefit 2.c under More Options Benefits) is in force for the Insured Person, subject to the conditions contained therein.

xxx) Peritoneal dialysis

Charges related to peritoneal dialysis, including supplies.

xxxi) Prosthetic and other devices

Prosthetic and other devices which are self-detachable/ removable without surgery involving anaesthesia.

xxxii) Charges other than Reasonable & Customary Charges

Any Medical Expenses which are not Reasonable & Customary Charges.

xxxiii) Self-injury or suicide

Intentional self-injury or attempted suicide.

xxxiv) Sexually transmitted diseases

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.

xxxv) Sleep-apnea

Treatment of sleep-apnoea

xxxvi) Spinal subluxation, manipulation and muscle stimulation

Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

xxxvii) Treatment by a family member

Treatment rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

xxxviii) Treatment outside discipline

Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

xxxix) Vaccination and immunisation

Vaccination including inoculation and immunisation (except in case of post-bite treatment).

xl) 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.

xli) War (whether declared or not)

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.

g) 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) listed under Annexure E that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

Section 6. General Conditions

a) Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to Us 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 Us in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

b) Condition Precedent

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

c) Premium Payments

The premium shall be paid in full at the inception of the Policy as single premium for opted Policy Period. The premium for the Policy will remain the same for the Policy Period. The Policy will be issued for a period of 1 or 2 or 3 year(s) based on the Policy Period selected and specified in the Schedule. The Sum Insured and the benefits under the Policy will be applicable on Policy Year/Extended Policy Year (if applicable) basis.

d) Geography & Currency

This Policy is applicable solely to an Insured Person who is an Indian resident per applicable Indian law. In the event of a change in status other than Indian resident of such Insured Person, the same should be informed to Us and We shall cancel the Policy with refund of premium paid for the remaining Policy Period provided that no claims have been made.

This Policy only covers medical treatment taken within India, unless section 2.c) MoreGlobal Benefit is opted and in force for the Insured Person under the Policy. All payments under this Policy will only be made in Indian Rupees within India.

e) Insured Person

Only those persons named as Insured Persons in the Schedule will be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

f) Loadings & Discounts

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

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

Please note that We will issue Policy only after receiving Your consent and additional premium (if any).

The application of loading does not mean that the Illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section 5 a), Section 5 b) and Section 5 c) above or specifically mentioned on the Schedule shall be applied on the Illness/condition, as applicable.

We will provide the following discounts at inception and Renewal of the Policy:

i) Prime Discount:

A one-time discount of 10% on the Premium is applicable if the Insured Person is a

1. Reliance Group employee (full time employee) / Reliance Group shareholder at the time of enrolment, or
2. Repeat customer (customers who hold an active health insurance policy with Us at the time of enrolment).

Provided that the such Policy is purchased through Our website or Our mobile app and without the involvement of any insurance agent or insurance intermediary.

This discount is not available at subsequent renewals and if two or more family members are covered under the same Policy under the individual Sum Insured policy option.

ii) Buy Online Discount:

The Insured Person is eligible for 10% discount on premium in case of buying or Renewing the Policy online from Our website, Our mobile app, or any duly licensed web aggregator provided that the first Policy with Us was also purchased through Our website, Our mobile app, or such web aggregator, and without the involvement of any other insurance agent or insurance intermediary.

iii) Family Discount:

The Insured Person will be entitled to receive 10% discount on the premium if two or more family members are covered under the same Policy under the individual policy option.

iv) Policy Tenure Discount:

If the Policy Period is more than one year, the Insured Person will be entitled to receive a discount of 10%, if You pay 2 years or 3 years premium in advance as a single premium.

v) Voluntary Co-payment Discount:

The Insured Person is eligible for 10% discount on the premium if You opt for a Voluntary Co-payment of 10%.

vi) MoreResults Discount:

The Insured Person will be entitled upto 10% discount (refer table under section 4.g) on the premium at the time of Renewal of the Policy for getting an annual health check-up carried out and sharing results of the same with Us. Please note that the above-mentioned discounts are additive in nature. The maximum discount available is 30% (excluding Voluntary Co-payment Discount and MoreResults Discount)

g) Pre-Policy Check-up (PPC)

In case of a prospect whose medical check-up is conducted for the purpose of underwriting and for whom We grant an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, We shall re-imburse 100% of the cost of such medical check-up.

h) Notification of Claim:

It is a Condition Precedent to Our liability under this Policy that the following procedures must be followed strictly in respect of all claims:

	Treatment, Consultation or Procedure:	We must be notified:
1	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission to Hospital.
2	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an emergency:	Within 24 hours of the Insured Person's admission to Hospital.
3	For all benefits which are contingent on Our prior acceptance of a claim under Section 1a):	Within 7 days of the Insured Person's discharge from the Hospital.

j) Supporting Documentation & Examination

For all requests for pre-authorisation of Cashless Facility, We shall be provided with the following necessary information and documentation:

I Our pre-authorization form, duly completed and signed for or on behalf of the Insured Person and the treating Medical Practitioner, as applicable, provided that no signatures are required if the same is being completed or populated digitally in Our website.

ii) Copy of the identification document of the Insured Person such as voter ID card, driving license, passport, PAN card or Aadhar card.

For all claims under the Policy, We must be provided with all documentation, medical records and information that is required to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The necessary information and documentation includes the following:

i) Our claim form, duly completed and signed for on behalf of the Insured Person, provided that no signatures are required if the same is being completed or populated digitally in Our website.

ii) Original bills/certified true copies (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto such as receipts or prescriptions in support of any amount claimed which will then become Our property.

iii) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

iv) A precise diagnosis of the treatment for which a claim is made.

v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).

vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.

vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made.

viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection.

ix) Treating Medical Practitioner's certificate regarding missing information in case histories e.g. circumstance of Injury and alcohol or drug influence at the time of Accident.

x) Copy of settlement letter from other insurance company or TPA.

xi) Stickers and invoice of implants used during surgery.

xii) Copy of MLC (medico legal case) records and FIR (First Information Report), in case of claims arising out of an Accident.

xiii) Regulatory requirements as amended from time to time.

xiv) Original Cancelled cheque in CTS 2010 format (Printed A/C No. IFSC Code, Printed Name), In case the Name is not printed on the cheque Leaf, duly attested scanned copy of the first page of the Pass-book or the authorized bank statement for NEFT (to enable direct credit of claim amount in bank account) and KYC (recent photo ID/address proof and photograph) requirements.

xv) Legal heir certificate, in the event of death.

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.

If any claim is not notified/made within the timelines set out above then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.

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

k) Claims Payment

i) We will be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We had requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii) We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule) in India.

iii) The assignment of benefits of under the Policy shall be allowed subject to applicable law.

iv) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable

care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

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

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

Proportionate Deduction is subject to the following:

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, We 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.

m) Claim Settlement (provision of Penal Interest)

i. We 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, We 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 Our opinion, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We 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, We 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.

n) 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 Us to the extent of that amount for the particular claim.

o) 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 repai 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.

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. We 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.

p) 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.

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

q) Endorsements and Alterations in the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorsement signed and stamped by Us.

However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy subject to Our underwriting decision. If You increase the sum insured, the case may be subject to health check-up. In case of increase in the Sum Insured, the waiting periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at Our discretion and subject to Our underwriting guidelines. Additional premium if any, shall be charged as per terms and conditions of the Policy.

r) 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.

s) Renewal of Policy

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

i. We shall endeavor to give notice for renewal. However, We are 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 Us 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.

We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

t) Possibility of Revision of Terms of the Policy Including the Premium Rates

We, 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.

u) Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, We 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 Us 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

v) Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by Us 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 Us, 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, ted-01012020)

w) 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).

x) Change of Policyholder

The change of Policyholder is permitted only at the time of Renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance post underwriting and payment of premium (if any). The renewed Policy shall be treated as having been renewed without Break. The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

y) Notices

Any notice, direction or instruction under this Policy will be in writing and if it is to:

i) Any Insured Person, then it will be sent to You at Your address specified in the Schedule and You will act for all Insured Persons for these purposes.

ii) Us, it will be delivered to Our address specified in the Schedule.

No insurance agents, insurance intermediaries or other person or entity is authorised to receive any notice, direction or instruction on Our behalf.

z) Governing Law & Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy will be determined by the Indian Courts and subject to Indian law.

If any administrative or judicial body imposes any condition on this Policy for any reason, We are bound to follow the same which may include suspension of all Benefits and obligations under this Policy.

If Our performance or any of Our obligations are in any way prevented or hindered as a consequence of any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances beyond Our anticipation or control, the performance of this Policy shall be wholly or partially suspended during the continuance of such force majeure. We will resume Our obligations under the Policy, to the extent possible, after the force majeure conditions cease to exist even for the period during which the force majeure conditions existed.

aa) 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 (30 days if the policy is sold through distance marketing or if the Policy Period is 3 years) 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 Us 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;

bb) 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 Us 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. We 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

cc) Cancellation (other than Free Look Period)

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

Length of time Policy in force	Refund of premium
Upto 90 days	100%
Above 90 days	Pro-rata

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.

ii) We 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.

iii) If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person if there are no claims made in respect of that Insured Person under the Policy for that Policy Period.

Section 7.Schedule of Benefits

Sum Insured mentioned below for

- Per Insured Person per Policy Year for Individual policies.
- Per Policy per Policy Year for Family Floater policies

Sum Insured (in Rs.)	**300,000**	**500,000**		**10,00,000**	**15,00,000**	**50,00,000**	**100,00,000**
Section 1: Basic Benefits							
1 a) Inpatient Care	Covered						
1 b) Special Treatments (in Rs.) Co-payment of 50% of admissible - Medical Expenses for all Sum Insured options	100,000	100,000		100,000	150,000	500,000	10,00,000
1 c) Day Care Procedures	Covered						
1 d) Domiciliary - Hospitalisation	Covered						
1 e) Organ Donor	Covered						
1 f) Ayush Benefit	Covered						
1 g) Pre-Hospitalisation Medical Expenses	Covered, upto 90 days						
1 h) Post-Hospitalisation Medical Expenses	Covered, upto 90 days						
1 I) Emergency - Ambulance	Covered						
1 j) Transportation Benefit	Maximum upto Rs. 500						
1 k) Restore Benefit	Equal to 100% of Sum Insured						
Section 2: More Options Benefits							
2 a) MoreTime	Extended Policy Year of 13 months if Policy period is 1 year and Extended Policy Year of 26 months if Policy Period is 2 years						
2 b) MoreCover (in Rs)	100,000	200,000		300,000	500,000	15,00,000	30,00,000
2 c) MoreGlobal (in Rs)	Equal to 100% of Sum Insured, maximum upto Rs. 20,00,000						
Section 3: Voluntary Co-payment							
3 Voluntary Co-payment	10%, if opted						
Section 4: Renewal Benefit – MoreResults Discount							
4 Renewal Benefit - MoreResults Discount	Upto 10% discount on renewal premium						

Section 8. Interpretations & Definitions

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:

Def. 1. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. Activities of Daily Living are:

I) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

Iv) Mobility: the ability to move indoors from room to room on level surfaces;

v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi) Feeding: the ability to feed oneself once food has been prepared and made available

Def. 3. Age or Aged means "Age as on last birthday" as determined on the date of first Policy issuance or at renewal. In case of change in Age during the proposal stage, then "Age" shall be determined on the date of proposal form submission would be considered for premium calculation.

Def. 4. Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Def. 5. AIDS means Acquired immunodeficiency syndrome (AIDS), a condition characterized by a combination of signs and symptoms, caused by Human Immunodeficiency Virus(HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions ,as may be specified from time to time

Def. 6. Alzheimer's Disease means progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Our appointed Medical Practitioner. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the 6 Activities of Daily Living for a continuous period of at least 3 months:

I) The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Non-organic disease such as neurosis and psychiatric Illnesses; and
- Alcohol-related brain damage.

Def. 7. Ambulance means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

Def. 8. Any One Illness means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

Def. 9. Authority means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

Def. 10. AYUSH Treatment refers to the medical and / or Hospitalization treatments given under'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

Def. 11. 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:

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).

Def. 12. 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:

i) Central or State Government AYUSH Hospital; or

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

iii) 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:

(i) Having at-least 05 in-patient beds;

(ii) Having qualified AYUSH Medical Practitioner in charge round the clock;

(iii) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedure are to be carried out;

(iv) 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).

Def. 13. 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.

Def. 14. Break in Insurance/Policy means the period of gap that occurs at the end of the existing Policy Period, 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.

Def. 15. Cashless Facility means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy Terms and Conditions, are directly made to the Network Provider by the Company to the extent pre-authorization is approved.

Def. 16. 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.

Def. 17. 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".

Def. 18. Condition Precedent means a policy term or condition upon which the Company's liability under the Policy is conditional upon.

Def. 19. Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

i) Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body;

ii) External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body.

Def. 20. Co-payment means a cost sharing requirement under a health insurance 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.

Def. 21. Day Care Centre means any institution established for Day Care Treatment of Illness and/or Injuries or a medical setup 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 criterion as under –

i) has qualified nursing staff under its employment;
ii) has qualified Medical Practitioner/s in charge;
iii) has fully equipped operation theatre of its own where Surgical Procedures are carried out;
iv) maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

Def. 22. Day Care Treatment means medical treatment, and/or Surgical Procedure which is:

i) undertaken under general or local anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and

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

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

Def. 23. Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 24. Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 25. Dependents means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) Your children Aged between 91 days and 25 years if they are unmarried, financially depended on You and do not have his/her independent source of income;

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in this Policy and the parent is financially depended on You;

iv) Your parents -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in this Policy and the parent-in law is financially depended on You.

Def. 26. Dependent Children means Your children Aged between 91 days and 25 years if they are unmarried, financially depended on You and do not have his/her independent source of income.

Def. 27. 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.

Def. 28. 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.

Def. 29. Domiciliary Hospitalisation 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:

i) the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

ii) the patient takes treatment at home on account of non-availability of room in a Hospital.

Def. 30. Emergency Care means management for an illness or injury which results in symptom 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.

Def. 31. Extended Policy Year means a period of 13 months from the Policy Commencement Date if the Policy Period specified in the Schedule is one year and a period of 26 months if the Policy Period specified in the Schedule is two years.

Def. 32. 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.

Def. 33. Hazardous Activities means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo-cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

Def. 34. Hospital means any institution established for Inpatient Care and Day Care Treatment of Illness and/or Injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

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

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

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

iv) has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

v) maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

Def. 35. Hospitalisation means admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24consecutive hours (Day Care Treatment).

Def. 36. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly totreatment 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

ii) 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.

Def. 37. 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.

Def. 38. Inpatient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 39. Insured Person means You and those of Your Dependents who are named as insured person(s) in the Schedule.

Def. 40. Intensive / Critical Care Unit (ICU/CCU) means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s),and which is specially equipped for the continuous monitoring and treatment of patients who are in 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.

Def. 41. 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.

Def. 42. Maternity expenses: means

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

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

Def. 43. Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription

Def. 44. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 45. 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.

Def. 46. Medically Necessary Treatment means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which:

i) is required for the medical management of the Illness or Injury suffered by the Insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

iii) must have been prescribed by a Medical Practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 47. Mental illness as per The Mental Health Act, 2017 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 subnormality of intelligence.

Def. 48. 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.

Def. 49. 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.

Def. 50. Newborn baby: means baby born during the Policy Period and is aged upto 90 days.

Def. 51. Non-Network Provider means any Hospital, Day Care Centre or other provider that is not part of the Network.

Def. 52. Notification of Claim means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

Def. 53. 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.

Def. 54. Parkinson's Disease means

I. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

i) The disease cannot be controlled with medication; and

ii) objective signs of progressive impairment; and

iii) There is an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the Activities of Daily Living for a continuous period of at least 6 months.

Def. 55. 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.

Def. 56. Pre-existing Disease means any condition, ailment , Injury or disease:

i) 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

ii) 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

Def. 57. Pre-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that:

i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

Def. 58. Post-Hospitalisation Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the Hospital provided that:

i) Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

Def. 59. Policy means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendices to the Policy and the Schedule (as the same may be amended from time to time).

Def. 60. Policy Commencement Date means the commencement date of this Policy as specified in the Schedule.

Def. 61. Policy Expiry Date means the end date of this Policy as specified in the Schedule.

Def. 62. Policy Decision is the decision made by Us whether to issue the Policy to You or reject the proposal.

Def. 63. Policy Period means the period between the Policy Commencement Date and the Policy Expiry Date specified in the Schedule. If the Extended Policy Year is applicable under the Policy, the Policy Period will end on the Extended Expiry Date specified in the Schedule.

Def. 64. Policy Year means a period of 12 consecutive months commencing from the Policy Commencement Date or any anniversary thereof.

Def. 65. 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

Def. 66. 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.

Def. 67. Prospectus means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products

Def. 68. Qualified Nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

Def. 69. 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 Illness/Injury involved.

Def. 70. 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.

Def. 71. Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

Def. 72. 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.

Def. 73. Sum Insured means:

(a) For a Policy issued as an Individual Policy as specified in the Schedule: the sum shown in the Schedule which represents Our maximum, total and cumulative liability for each Insured Person for any and all claims made in respect of that Insured Person during the Policy Year or Extended Policy Year (if applicable); and

(b) For a Policy issued as a Family Floater Policy as specified in the Schedule: the sum shown in the Schedule which represents Our maximum, total and cumulative liability for any and all claims made in respect of any and all Insured Persons during the Policy Year or Extended Policy Year (if applicable).

Def. 74. Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

Def. 75. 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.

Def. 76. Unproven/Experimental treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 77. We/Our/Us/Company means Reliance General Insurance Company Limited.

Def. 78. You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

Section 9. Service related Information:

You can reach Us through any of the following methods for any service related issue and assistance.

Claims Servicing	
Name	RCare Health: Claims and Care management
Correspondence Address :	Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081.
Contact No. :	1800 3009(toll free)/ 022-41112600
E-mail :	rgicl.rcarehealth@relianceada.com

Section 10. Claim Related Information & Claim Procedure

Please review your Reliance Health Infinity Insurance Policy and familiarize yourself with the benefits available and the exclusions.

To help us to provide you with fast and efficient service, we kindly ask you to note the following:

1. We recommend that you keep copies of all documents submitted to Reliance General Insurance Company Limited
2. Please quote your member ID/policy number in all your correspondences

Intimation & Assistance	Please contact Reliance General Insurance Company at least 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact Reliance General Insurance Company within 24 hours of the event. Reliance General Insurance Company can be contacted through: Website: www.reliancegeneral.co.in Email: rgicl.rcarehealth@relianceada.com Helpline: 1800 3009(toll free)/022-41112600 Courier: Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081
Procedure for eimbursement of Medical Expenses	Please send the duly signed claim form and all the information/ Documents mentioned therein to us within 15 days of the occurrence of incident. Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 10 days of receipt of the claim documents.

	• On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. Note: Payment will only be made for items covered under your policy and upto the limits therein.
Procedure to avail Cashless facility	For any emergency hospitalisation, Reliance General must be informed no later than 24 hours after hospitalisation. For any planned hospitalisation, kindly seek cashless authorization from Reliance General atleast 48 hours prior to the start of the Insured Person's hospitalisation. We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 4 hours of receipt of documents. Please pay the non-medical and expenses not covered to the hospital prior to the discharge. For details on non-medical expenses, please refer Annexure A of Policy wording. In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 4 hours. Note: • Insured person is entitled for cashless only in our network hospitals. • Please refer to the list of network hospitals on our website. • Please refer to the list of non-medical expenses not covered in the policy in Annexure A of Policy wordings. • Rejection of cashless in no way indicates rejection of the claim.

Section 11. Redressal of Grievance

You can reach Us through any of the following methods for any service related issue and assistance.

If You have a grievance that You wish Us to redress, You may contact Us with the details of Your grievance 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 4662 Courier: Any branch office, the correspondence address, during normal business hours.

Write to us at: Reliance General Insurance.
Winway Building 2nd and 3rd Floor, 11/12 Block No - 4, Old No - 67, South Tukoganj, Indore (M.P) - 452001

Insured Person may also approach the grievance cell at any of the Our branches with the details of grievance.

If You are not satisfied with the redressal of grievance through one of the above methods, You 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 You are not satisfied with the redressal of grievance through above methods, You 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/

ANNEXURE - A

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

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

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

Sr. 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

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

Sr. 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

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

Sr. 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 E

Below mentioned Diseases maybe permanently excluded under the Policyin the case where suchDiseases are Pre-Existing at the time of first proposal of this Product with the Company.

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours
		• D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviourz
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 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 - Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 - Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta- (super) infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta - agent;

11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	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