RELIANCE GENERAL INSURANCE

RELIANCE HEALTH SUPER TOP UP

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 Identity Number: U66603MH2000PLC128300.

Reliance Health Super Top Up - UIN-RELHLIP21617V012021

RGI/MCOM/CO/RELIANCE-HSTU-PW/Ver. 1.0/11052021

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Section 1: Preamble

This **Policy** is a contract of insurance issued by Reliance General Insurance Company Limited (hereinafter called the 'Company') to the Proposer mentioned in the Policy Schedule to cover the person(s) named in the Policy Schedule (hereinafter called the 'Insured Person(s)'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the requisite premium.

Section 2: Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1) **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2) **Act** means the Insurance Act 1938
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
4) **AIDS** means Acquired Immuno Deficiency Syndrome, a condition characterized by a combination of signs and symptoms, caused by Human Immuno Deficiency 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
5) **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
6) **Annexure** means a document attached and marked as Annexure to this Policy
7) **Any One Illness** means continuous period of illness and it includes relapse within forty-five days from the date of last consultation with the hospital where treatment has been taken.
8) **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of IRDA Act 1999
9) **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered

   AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   Iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
10) **AYUSH Hospital** is a healthcare facility wherein medical/surgical/Para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital or
   ii. Teaching hospital attached to AYUSH College 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 criterion:
      a. Having at least 5 in-patients beds;
      b. Having qualified AYUSH Medical Practitioner in charge round the clock;
      c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      d. Maintaining daily records of the patient and making the accessible to the insurance company's authorized representative.
11) **AYUSH Treatment** refers to the medical and /or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems
12) **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.
13) **Base Sum Insured** means the amount specified as **Base Sum Insured** in the **Policy Schedule**. Calculation of bonus and sub-limits, if any mentioned under the **Policy** shall be on the basis of **Base Sum Insured**.
14) **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
15) **Cashless Facility** means a facility extended by the insurer or TPA on behalf of the insurer to the insured, where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
16) **Claim** means a demand made by the **Policyholder / Insured Person** or on his/her behalf, for payment under any Benefit, as covered under the **Policy**

17) **Company** means Reliance General Insurance Company Limited.

18) **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**.

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

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

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

21) **Congenital Anomaly** refers to a condition(s) 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

22) **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.

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

24) **Day Care Centre** means any institution established for day care treatment of disease / injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified **Medical Practitioner** and must comply with all minimum criteria as under:

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

25) **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 twenty four hours because of technological advancement, and

ii. which would have otherwise required a Hospitalisation of more than twenty four hours.

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

26) **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**.

i. **Deductible** applicable under this Policy for Plan A is **Annual Aggregate Deductible**. For a claim to become payable, the sum of all admissible claims under the Policy, subject to **Policy** terms and conditions, in a given **Policy Year** has to exceed the **Aggregate Deductible** as mentioned in the **Policy Schedule**.

ii. **Deductible** applicable under this **Policy** for Plan B is **Long Term Aggregate Deductible**. For a claim to become payable, the sum of all admissible claims under the **Policy**, subject to **Policy** terms and conditions, in a given **Policy Period** has to exceed the **Aggregate Deductible** as mentioned in the **Policy Schedule**.

Deductible shall apply on individual basis in case of an Individual Policy and on floater basis in case of a Floater Policy.

27) **Dependent Child** means Insured Person's biological or legally adopted son or daughter, whose completed age is between 3 months to 25 years as on **Policy Period Start Date**, and who is unmarried and financially dependent on the Insured Person and does not have an independent source of income

28) **Dependent** means **Insured Person**, within the scope of **Family** definition, who is financially dependent on the Policyholder and does not have independent source of income.

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

30) **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.

31) **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**

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

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**.

33) **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a **Medical Practitioner** to prevent death or serious long term impairment of the insured person's health.

34) **Emergency Assistance Service Provider** means any organization or institution appointed by the **Company** for providing services to the **Insured Person** for an insurable event under this **Policy** and as mentioned in the **Policy Schedule**

35) **Family** means as defined in the **Policy Schedule**. For the purposes of this **Policy**, it shall include the **Policyholder** and anyone or more of the family members as mentioned below:

i. legally wedded spouse

ii. Parents and Parents- in law

iii. maximum six dependent children (i.e. biological or adopted) between the age of 3 months to 25 years. If the child is above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

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

37) **Hospital** means any institution established for In-patient care and Day care treatment of disease / injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, or under such relevant Regulation in the state or country in which it operates; 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 those towns having a population of less than 1000000 and 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 shall make these accessible to the Company's authorized personnel.

Hospital does not mean:

- A Convalescent, nursing, or rest home or facility, or a home for the aged; rejuvenation or health resort
- A place mainly providing Custodial, Educational, or Rehabilitative Care; or

A facility mainly used for the treatment(s) of drug addicts or alcoholics

38) **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient care' hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

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

i. **Acute Condition** means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / illness / injury which leads to full recovery.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

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

c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

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

41) **In-Patient Care/Treatment** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

43) **Intensive Care Unit** 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.

44) **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

45) **Life Threatening Medical Condition"/"Life Threatening condition is** a medical condition suffered by the Insured Person which has any of the following characteristics:

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

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

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

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

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

46) **Maternity Expenses** means;

i. **Medical 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

47) **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

48) **Medical Emergency:** Occurrence of a Sickness, Illness or Injury, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that an individual could reasonably expect the absence of immediate medical attention to result in any or all of the below:

i. placing the health of the person afflicted with such condition in serious jeopardy;

ii. serious impairment to such person's bodily functions;

iii. serious dysfunction of any bodily organ or part of such person; or

iv. serious disfigurement of such person.

v. Additionally, a Medical Emergency will include visits where the only option for Medically Necessary Treatment is an emergency room.

49) **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.

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

iii care in scope, duration, or intensity;

iv. must have been prescribed by a **Medical Practitioner**;

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

51) **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 the scope and jurisdiction of the licence.

The **Medical Practitioner** should not be the **Policyholder/Insured** or their close **Family** member.

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

Physician, wherever mentioned under this Policy shall also satisfy the definition of a **Medical Practitioner**.

For the purposes of Worldwide Emergency Cover, the **Physician** must hold a valid license issued by the appropriate authority in the current Country of treatment.

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

53) **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.

54) **Network Provider** means network provider as defined in IRDAI(Third Party Administrators-Health Services) Regulations,2016

55) **New Born Baby** means baby born during the Policy Period and is aged up to 90 days

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

57) **Non- Network Provider** means any hospital, daycare centre or other provider that is not part of the network.

58) **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

59) **Out-Patient (OPD) Treatment** means treatment 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**.

60) **Plan** means a predefined set of Cover, limits, Deductibles, Co-pays, terms and conditions as mentioned in the **Policy Schedule**

61) **Pre-Existing Disease (PED):** 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

62) **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.

63) **Post-hospitalisation Medical Expenses** means medical expenses incurred during the pre defined 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 inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

64) **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person

65) **Policyholder** means the person who is the Proposer and whose name specifically appears in the Policy Schedule

66) **Policy Period** means a period beginning from **Policy Period Start Date**, as specified in **Policy Schedule**; and ending on the **Policy Period End Date** as specified in the **Policy Schedule** or on the date of cancellation of the **Policy**, whichever is earlier

67) **Policy Period End Date** means the date and time at which the **Policy Period** ends as specified in the **Policy Schedule**

68) **Policy Period Start Date** means the date and time at which the **Policy Period** commences as specified in the **Policy Schedule**

69) **Policy Schedule** means **Policy Schedule** issued to the **Policyholder** in line with the terms and conditions as agreed upon, attached to and forming part of this insurance contract mentioning details including but not limited to, details of the **Insured Persons**, coverage, sections and benefits applicable, the **Base Sum Insured**, the **Policy Period**, premium paid (including duties, taxes and levies thereon).

70) **Policy Year** means a period of 12 consecutive months starting from the **Policy Period Start Date** and ending on the last day of such 12 month period. For the purpose of subsequent years, **Policy Year** shall mean a period of 12 months commencing from the end of previous **Policy Year** and lapsing on the last day of such 12 month period, till the **Policy Period End Date**, as mentioned in the **Policy Schedule**.

71) **Portability** means the right accorded to an individual health insurance policyholder (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.

72) **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

73) **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**.

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

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

For the purposes of Worldwide Emergency Cover, the **Qualified Nurse** must hold a valid registration from the appropriate authority in the current Country of treatment

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

77) **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.

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

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

80) **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.

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

The Sum Insured specified in the **Policy Schedule** is available to the **Insured Person** on annual/per **Policy Year** basis

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

83) **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

84) **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

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

86) **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

Section 3: Scope of Cover

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

3A Base Covers

Benefit - 3.1: Hospitalization Expenses

If any of the **Insured Person**, during the **Policy Year**, is diagnosed with any Illness or suffers any Injury that requires **Inpatient Treatment** or **Day Care Treatment**, then the **Company** will pay Medical Expenses incurred by the **Policyholder/Insured Person** in excess of **Deductible** amount and up to the **Sum Insured**, subject to the below mentioned terms, conditions and exclusions mentioned under this **Policy**, for:

3.1.1 In Patient Treatment

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

i. **Room Rent**
ii. Nursing expense
iii. Intensive care Unit (ICU) charges,
iv. Medical Practitioner(s) fees,
v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses,
vi. Medicines, drugs and Consumables expenses
vii. Diagnostic procedures expenses
viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

3.1.2. Pre- Hospitalization

The **Company** will indemnify the **Policyholder/Insured** Peron for the **Medical Expenses** incurred in the 90 days immediately before the **Policyholder/Insured Person** was Hospitalized, provided that:

i. such **Medical Expenses** are incurred in respect of the same condition for which **Insured Person** has taken **Inpatient Treatment**, and
ii. **Company** has accepted the **Claim** for these **Inpatient Treatment** expenses under Scope of Cover- Section 3.1.1,3.1.4,3.2,3.3,3.5,3.8,3.10,3.15

3.1.3. Post Hospitalization

The **Company** will indemnify the **Policyholder/Insured** Person for the **Medical Expenses** incurred in the 180 days immediately after the Insured Person was discharged post **Hospitalization** provided that:

i. Such costs are incurred in respect of the same condition for which the **Insured Person** has taken **Inpatient Treatment**, and
ii **Company** has accepted the **Claim** for these **Inpatient Treatment** expenses under Scope of Cover Section 3.1.1,3.1.4,3.2,3.3,3.5,3.8,3.10,3.15

3.1.4. Day Care Treatment

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

3.2 Benefit - 2: Domiciliary Hospitalization

The **Company** will indemnify the **Insured Person(s)** for the **Medical Expenses** incurred during **Domiciliary Hospitalization** as defined under this **Policy**, provided that the condition for which the medical treatment is required

continues for at least three continuous and completed days, during the **Policy Year**, in which case the **Company** will pay the **Reasonable and Customary Charges** of any necessary medical treatment for the entire period, subject to **Deductible**.

The **Company** shall not be liable for payment of any Claim under this Benefit in relation to treatment of any of the following diseases:

i. Asthma
ii. Bronchitis
iii. Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome
iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis
v. Epilepsy
vi. Influenza, Cough and Cold
vii. Pyrexia of unknown origin for less than 10 days
viii. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
ix. Arthritis, Gout and Rheumatism

3.3 Benefit - 3: Maternity Cover

The **Company** will indemnify the **Policyholder/Insured Person** up to Rs. 2 lakhs for **Maternity Expenses** incurred on **Inpatient Treatment** during the **Policy Year** subject to the following:

i. The **Company** will cover the **Maternity Expenses** in excess of **Deductible** as specified under the **Policy Schedule**.
ii. This benefit shall become available only after the expiry of 12 months from the date of inception of the first **Policy** with the **Company**.
iii. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the **Insured Person**.
iv. For a covered delivery or termination, Pre-natal **Medical Expenses** from the date of conception and upto the child birth and Post-natal **Medical Expenses** for a period of one month from the date of childbirth shall be covered within the Maternity limit of Rs. 2 lakhs.
v. For a covered delivery, **Medical Expenses** incurred by the **Insured Person's New Born Baby** from date of birth till 90 days of age towards **In Patient Treatment** shall be covered within the Maternity limit of Rs. 2 lakhs.

Subject to the terms & conditions, the **Policy** will cover New Born Baby beyond 90 days only after the receipt of requisite premium for the addition.

3.4 Benefit 4: Organ Donor

The **Company** will indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred during **In Patient Treatment**, in respect of donor for any organ transplant **Surgery** conducted on the **Insured Person** during the **Policy Year**, provided that:

i. The organ donated is for the use of the **Insured Person**, and
ii. **Company** shall not pay the donor's Pre and Post **Hospitalization Expenses**
iii. **Company** has accepted **In patient Hospitalization Claim** under Scope of Cover - Benefit **3.1.1 In Patient Treatment**

An organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended).

3.5 Benefit - 5: AYUSH treatment

The **Company** will indemnify the **Policyholder/Insured Person** for the **Medical Expenses** which are incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to the **Sum Insured** in excess of **Deductible** under the **Policy**. The **AYUSH Treatment** should be carried out in an **AYUSH Hospital** or **AYUSH Day Care Centre** as defined under the **Policy**.

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

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

3.6 Benefit - 6: Ambulance Cover

The **Company** will indemnify the **Policyholder/Insured Person** upto an amount of Rs. 3500 per Hospitalization for expenses incurred on availing **Ambulance** services offered by a **Hospital** or by an **Ambulanc**e service provider that

i Such life-threatening emergency condition is certified by the **Medical Practitioner**.
ii. **Company** has accepted Inpatient **Hospitalization Claim** under Scope of Cover- Section **3.1.1 In Patient Treatment**
iii. The coverage includes the cost of the transportation of the **Insured Person** to the nearest **Hospital** or from one **Hospital** to another **Hospital**, which is prepared to admit the **Insured Person** and provide the necessary medical services, provided that transportation has been prescribed by a **Medical Practitioner** and is **Medically Necessary**.

3.7 Benefit - 7: Emergency Air Ambulance Cover

The Company will indemnify the Policyholder/Insured Person upto the limits specified below, for the expenses incurred on availing Air Ambulance services during the Policy Year, provided:

i. The amount payable under this benefit shall be upto Rs. 2 lakhs for policies having **Sum Insured** less than Rs. 10 lakhs and upto Rs. 5 lakhs for policies having **Sum Insured** greater than and equal to Rs. 10 lakhs.

ii. The air Ambulance service benefit is available to **Insured Person** only in case of an **Emergency Care** which requires immediate and rapid ambulance transportation as prescribed by the **Medical Practitioner** and is **Medically Necessary**, which in actual cannot be provided by a ground **Ambulance**.

iii. The expenses are payable only from the place of first occurrence of the **Illness/Accident** to the nearest **Hospital**

iv. The Origin and Destination of Emergency Air Ambulance Service are within the geographical boundaries of Republic of India

v. **Company** has accepted **Inpatient Hospitalization Claim** under Scope of Cover - Section **3.1.1 In Patient Treatment**

vi. This benefit can be availed once in a **Policy Year**.

vii. Such Air Ambulance should have been duly licensed to operate as such by the Competent Authorities of the Government.

3.8 Benefit - 8: Modern Treatments

The Company will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Medical Expenses incurred during the Policy Year on Inpatient Treatment or Day Care Treatment or Domiciliary Treatment of below mentioned Modern Treatments:

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. Robot surgeries

viii. Stereotactic radio surgeries

ix. Bronchial Thermoplasty

x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)

xi. IONM - (Intra Operative Neutro Monitoring)

xii. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

The claim under this benefit shall be subject to all other terms under Benefit 3.1 and 3.15.

3.9 Benefit - 9: Additional Item Cover

The **Company** shall pay the **Reasonable and Customary** expenses incurred by the **Policyholder/Insured Person**, during the **Policy Year**, which are listed in 'Annexure A - List I as Optional Items' of this Policy, provided:

i. such consumables or items are prescribed by the treating **Medical Practitioner** and are medically necessary for the treatment of the same condition for which **Insured Person** has taken **In-Patient** or **Daycare Treatment**, and

ii. The **Company** has accepted **Claim** for Hospitalization expenses under the **Policy**

iii. The amount payable towards this Benefit, in conjunction with the payment for all the other benefits under the Policy, shall be within the **Sum Insured** limit, and subject to Aggregate **Deductible** as specified under the **Policy Schedule**. No separate Deductible shall be applicable for this benefit.

3B. Personal Accident Cover

3.10 Benefit-10: Waiver of Deductible for Accidental Claims

In case any of the **Insured Person** covered under the **Policy**, sustains an injury, from an **Accident**, resulting in **Hospitalization** of the **Insured Person** ,during the **Policy Year**, then the General Exclusion - 5 (15) **Deductible** under the **Policy** will be waived off by the **Company** for that Accidental Hospitalization claim, provided:

i. The **Insured Person** has taken an **In-Patient** or **Daycare Treatment** for such Accidental Claim.

ii. **Pre** and **Post Hospitalization Medical Expenses** are payable.

iii. The benefit Waiver of Deductible for Accidental Claims shall be available to **Insured Person(s)** at each **Policy Year**, starting from day 1 of the **Policy Start Date**.

iv. The amount claimed under this benefit shall be considered towards the Deductible for any illness related claims.

Note

- The benefit, Waiver of Deductible for Accidental claims shall not be applicable on availing Benefit-14 (Deductible-Buy Back) under the **Policy**.

3C. Renewal Benefits

3.11 Benefit - 11: Waiver of Premium - On First Diagnosis of Critical Illness

If any of the **Insured Person** other than **Dependent children** as covered under the **Policy** is diagnosed for the first time, for any of the listed **Critical Illness** which is admissible and payable under this Cover, during the **Policy Year**, then the renewal Policy premium for a period of one year shall be waived off. For long term policies, the Company shall waive one-year proportionate renewal Policy premium. This is subject to the following:

i. This benefit is provided once in the lifetime of the **Insured Person**

ii. The **Critical Illness** has been diagnosed during the **Policy Year**.

iii. Such **Renewal** shall be done on the same basis as the expiring **Policy**.

iv. The **Cumulative Bonus** will not be accrued in the year claim has been made under the **Policy**

v. **Aggregate Deductible** shall not be applicable to this Benefit

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

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

i. **Cancer of specified severity**

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

b. The following are excluded -

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

ii. **Open Heart Replacement or Repair of Heart Valves**

a. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

iii. **Major Organ /Bone Marrow Transplant**

a. The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner

b. The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

iv. **Coma of specified severity**

a. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

b. The condition has to be confirmed by a Specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

v. **Surgery of Aorta**

a. The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneurysms)
- Angiography (an x-ray of the blood vessels)

vi. **Benign Brain Tumor**

a. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

b. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

c. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, and tumors of skull bones, and tumors of the spinal cord.

vii. **Kidney Failure Requiring Regular Dialysis**

a. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner

viii. **End Stage Lung Failure**

a. End stage lung disease, causing chronic respiratory failure, as confirmed by a physician and evidenced by all of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
- Dyspnea at rest.

ix. **End Stage Liver Failure**

a. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

x. **Stroke resulting in permanent symptoms**

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

b. The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain

Vascular disease affecting only the eye or optic nerve or vestibular

xi. **Permanent Paralysis of Limbs**

a. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

xii. **Multiple Sclerosis with persisting symptoms**

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

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

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

xiii. **Blindness**

a. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

b. The Blindness is evidenced by:

- corrected visual acuity being 3/60 or less in both eyes or ;
- the field of vision being less than 10 degrees in both eyes.

c. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

xiv. **Third Degree Burns**

a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

xv **Bacterial Meningitis**

a. Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

3.12 Benefit - 12: Cumulative Bonus

The **Company** shall provide 10% of the **Base Sum Insured** as **Cumulative Bonus** at the end of each completed and continuous **Policy Year**, provided that no claim has been made in the expiring **Policy Year**. This benefit is subject to the following:

i. In any **Policy Year**, the accrued **Cumulative Bonus**, including the one credited under **Portability** if any, shall not exceed 50% of the **Base Sum Insured** available in this renewed **Policy**.

ii. The **Cumulative Bonus** shall not enhance the available Room Category limit and other such limits which are a function of **Sum Insured** which shall always be applicable on the **Base Sum Insured**.

iii. In relation to a Floater, the **Cumulative Bonus**, shall be available on Floater basis. The **Cumulative Bonus** which accrued during a claim-free **Policy Year** will only be available to those **Insured Persons** who were insured in such claim-free **Policy Year** and continue to be insured in the subsequent **Policy Year**.

iv. If the **Insured Persons** in the expiring **Policy** are covered on an Individual basis and the expiring **Policy** has been Renewed on a Floater basis, then the **Cumulative Bonus** to be carried forward for such Renewed **Policy** shall be the one that is applicable to the lowest among all the **Insured Persons**

v. In case of Floater Policy where **Insured Persons** renew their expiring **Policy** by splitting the **Policy** in to two or more Floater Policies/Individual Policies ,the **Cumulative Bonus** shall be split equally amongst **Insured Persons**; except where the **Policy** is split due to the child attaining the age of 25 years, in which case both the Renewed Policies shall carry the full accrued **Cumulative Bonus**.

vi. If a claim is made in the expiring **Policy Year**, and is notified to the **Company** after the acceptance of **Renewal** premium any incremental **Cumulative Bonus** awarded basis the expiring **Policy Year** shall be withdrawn.

vii. Entire **Cumulative Bonus** will be lost if **Policy** is not continued / renewed within the **Grace Period**.

viii. **Cumulative Bonus** shall be applicable on an annual basis subject to continuation of the **Policy** with the **Company**.

ix. In case of a claim in any given **Policy Year** the accrued **Cumulative Bonus** amount shall not be reduced in the subsequent year, unless the **Cumulative Bonus** amount has been utilized partially or fully for settlement of claim.

x. The **Cumulative Bonus** will be carried forward to next Renewal Year, even if the **Policyholder** avails the Benefit -14 (Deductible-Buy Back)

xi. This clause does not alter the **Company's** right to decline renewal or to cancel the **Policy**.

xii. For a claim to be admissible under **Cumulative Bonus** it should be admissible under the Benefit 3.1 to 3.10 and 3.15

3.13 Benefit - 13: Health Check Up

Irrespective of Claim, at the end of every three consecutive and continuous Policy Years, the Company shall provide the listed diagnostic or preventive medical check-up expenses with respect to the Insured Person's, on Individual or Floater basis. This benefit is subject to

i. The **Policy** has been continuously renewed with the **Company** without any break

ii. The cost of medical check-up is limited to Rs. 3000 for policies with **Deductible** less than Rs. 10 lakhs and upto Rs. 5000 for policies with Deductible equal to and greater than Rs. 10 lakhs

iii. In case of a Floater Policy, the medical check-up limit mentioned above in point (ii) is available on Floater basis. following:

iv. This benefit has a separate limit and does not affect the **Cumulative Bonus** under the **Policy**.

v. The **Deductible** shall not be applicable for this Benefit.

vi. The **Insured Person** can execute the listed medical tests anytime within a period of four months of eligibility.

vii. The benefit will be available only on Cashless basis and arranged with Company's Empanelled Service Providers.

viii. The benefit shall only be applicable to those **Insured Person's** who were insured under the **Policy** during the last three consecutive and continuous **Policy Years**

ix. After availing Benefit-14 Deductible-Buy Back, the cost of medical check-up payable under this benefit is limited to Rs. 5000.

Following are the list of medical tests:

Organ/Disease Specific	Tests
Heart	ECG, 2D Echo, TMT, Lipid Profile
Liver	Liver Profile, Sonography Abdomen
Kidney	Kidney Profile, Sonography Abdomen
Lungs	Chest X-Ray, PFT
Eyes	Vision Test, Colour Vision Test, Eye Dilation Test, Intraocular Pressure Measurement
Female Specific	PAP Smear, Sonography Abdomen and Pelvis, Mammography
Thyroid Gland	Thyroid Function Test
ENT	ENT check Up, Audiometry Test
Dental	OPG Dental (X Ray)
Diabetes	Blood Sugar (PP/Fasting), HbA1c
General	CBC, C-Reactive Protein, Urine Routine, Serum Electrolytes (Calcium, Potassium, Sodium, Phosphorus, Chloride), Vitamin D, Vitamin B-12

3.14 Benefit - 14: Deductible- Buy Back (Optional Benefit)

At the end of four consecutive and continuous **Policy Years** if there has been no **In-patient** or **Day Care Hospitalization** in respect of any of the **Insured Persons** in the **Policy**, the **Company** shall provide the **Policyholder**, with the option to buy back the **Deductible** amount. If the **Policyholder** chooses to exercise this option, and make appropriate payment for such option, the **Base Sum Insured** shall be the sum of:

- The expiring Policy's **Base Sum Insured and**
- the expiring Policy's **Deductible**

No Deductible shall apply on such renewal where buy back option has been exercised and paid for

This benefit is subject to the following:

i. The buy back option shall be subject to underwriting approval.

ii. The Policyholder can exercise this option at the time of renewal, provided that the Policy was in force for four consecutive and continuous years immediately preceding such renewal, and all renewing members (except new born baby) had been continuously covered under the Policy for such four Policy Years, and had no In-Patient or Day Care Hospitalization during this period.

iii. On exercising of the buy back option, Insured Person will be offered continuity of coverage to the extent of the full amount of the enhanced Sum Insured, in terms of Waiting Period with respect to Pre-Existing Diseases and time bound exclusions as specified in Section-4 of this Policy.

iv. The buyback option will not alter the Cumulative Bonus. The accrued Cumulative Bonus under the expiring Policy will be carried forward to subsequent renewal.

v. Even on availing buy back option, the sub-limits applicable to the other benefits/section of this Policy will remain unchanged.

vi. If Policy holder opts buy back option under the Policy then

   a. Benefit-10: Waiver of Deductible for Accidental Claims shall not be applicable under the Policy.

   b. Benefit-13-Health Check up under the Policy shall be limited to Rs 5000.

vii. Buy back option shall not be available if Policy is not renewed on or before expiry of Grace Period.

viii. Except for enhancement in Base Sum Insured due to Deductible buyback, the Policy shall be renewed on the same basis as the expiring Policy. Any change in terms and conditions shall be subject to underwriting approval.

ix. Waiting Periods may be applied afresh for any change in Policy terms and conditions, addition or deletion of member at the time of renewal, subject to underwriting.

Underwriting Norms applicable to Deductible- Buy Back (Optional Benefit)

The Company shall accept the request for Deductible -Buy Back on satisfaction of all the three criteria mentioned below:

i. No claim has been made under this Policy in the four (consecutive and continuous) years immediately preceding the date of application for Deductible -Buy Back.

ii. The Proposer has declared in writing that none of the Insured Persons has undergone Hospitalization (whether In-patient or Day Care treatment) in the four (consecutive and continuous) years immediately preceding the date of application for Deductible -Buy Back

iii. All the Insured Persons aged 18 and above have undergone the below listed Medical Tests and the results of the medical tests are within the normal ranges.

List of medical tests:

Age in Years	**In all cases**
18-55	Category 1
55 - 60	Category 1
61 - 65	Category 2
#	**Description**
Category 1	MER, CBC, FBS, RUA, S. Creatinine
Category 2	MER, CBC, FBS, HbA1c, Lipid profile, SGOT, SGPT, GGT, RUA, ECG, HBsAg, S. Creatinine
Test Abbreviation	**Description**
MER	Medical Examination Report
CBC	Complete Blood Count
HbA1c	Glycosylated Haemoglobin
Lipid Profile	HDL, LDL, Serum Total Cholesterol, Serum Triglycerides, Sr. Total Cholesterol/HDL ratio
SGOT	Serum Glutamic Oxaloacetic Transaminase (also called AST - Aspartate Aminotransferase)
SGPT	Serum Glutamic Pyruvic Transaminase (also called ALT - Alanine Aminotransferase)
GGT	Gamma Glutamyle Transferase
RUA	Routine Urine Analysis
TMT	Exercise Electro cardiogram (Tread Mill Test)
ECG	Resting Electro Cardiogram
2D Echo	2D Echocardiogram with Color Doppler
HbsAg	Australia Antigen
HIV	HIV (I&II)
S Creatinine	Serum Creatinine
USG (Abdo & Pelvis)	Ultrasound Sonography of Abdomen and Pelvis
PSA	Prostate Specific Antigen (for Males only)
PAP	Papanicolaou test (PAP Smear Test) - For females only

Note :

The Company may ask additional tests for Insured Persons whose test results vary from the normal ranges.

Where request for Deductible - Buy Back is accepted by the Company, the Company shall bear 100% of the cost of the medical tests requested for underwriting.

In case where the request for Deductible- Buy Back is rejected by the Company, the Policyholder shall have the right to renew the Policy on the same terms as the expiring policy (with Deductible).

3D. Global Cover

3.15 Benefit - 15: Worldwide Emergency Cover

In the event, the **Insured Person** has a **Medical Emergency** whilst being overseas, during the Policy Year, and if such **Medical Emergency** shall, upon the written Medical Advice of a **Medical Practitioner/Physician**, require any such Insured Person, to incur **Hospitalisation** within the **Policy Year** at any **Hospital**, for the **Medically Necessary Treatment** of the **Insured Person**, then the **Company** will indemnify the **Insured Person** for the amount of such **Medical Expenses**, which should be **Reasonable** and **Customary Charges** and are incurred by the **Policyholder/Insured Person** up to the extent of **Sum Insured** specified in the **Policy Schedule**.

The Aggregate Deductible shall not be applied for claims under this benefit. However, an amount (in INR) equivalent to USD 100 shall be deducted from each and every claim made under this benefit.

For a given Medically Necessary Treatment that is admissible as a Claim under the Benefit, the following are covered:

i. In-Patient Treatment in a local Hospital at the place the Insured Person is staying at the time of occurrence of an insurable event or at the nearest Hospital. The below mentioned Medical Expenses are covered under In-Patient Treatment
   a. Room Rent Charges
   b. Nursing Expense
   c. Intensive care Unit (ICU) charges
   d. Medical Practitioner(s) fees
   e. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses, Medicines, drugs and Consumables expenses
   f. Diagnostic procedures expenses
   g. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

ii. **Day Care Treatment** as defined under the **Policy**

iii. **Out-Patient treatment**, provided, the same is critical and cannot be deferred till the **Insured Person's** return to the Republic of India.

iv. **Medical aid** that is prescribed by a **Physician** as necessary part of the treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).

v. **Cost of Road Transportation**, including necessary medical care en-route, by an Ambulance to the nearest **Hospital** or to the nearest **Physician**

vi. **Cost of being transferred by Road to a special clinic** if this is **Medically Necessary Treatment** and is prescribed by the **Physician**.

Special Clinic shall mean a Clinic (or Hospital or equivalent medical facility) where the Insured is required to be transferred for a specialised treatment or specialised testing or consultation from an expert **Medical Practitioner**, which is not available at the current place of treatment.

vii. **Emergency Air Ambulance Service:** The transportation cost for availing Air Ambulance Service during the **Policy Year** from the place of first occurrence of the **Illness/Accident** to the nearest **Hospital** will be payable only in case of an **Medical Emergency** which requires immediate and rapid ambulance transportation as prescribed by the **Medical Practitioner/Physician** and is **Medically Necessary**, which in actual cannot be provided by a ground **Ambulance**. The total liability of the **Company** with respect to Emergency Air Ambulance service shall be upto Rs. 2lakhs for policies having Sum Insured less than Rs 10 lakhs and upto Rs. 5 lakhs for policies having Sum Insured greater than and equal to Rs. 10 lakhs, provided that a corresponding claim for **Hospitalization** has been made and accepted under this benefit.

viii. Lifesaving unforeseen emergency measures provided to the **Insured Person** by the Physician for **Hospitalization** arising out of a **Pre-Existing Disease** in case of **Life Threatening Medical Conditions**. The treatment for these emergency measures would be paid till the **Insured Person** becomes medically stable. All further medical cost to maintain medically stable condition or to prevent the onset of acute pain would have borne by the Insured Person.

Specific Conditions applicable to Section 3D. Global Cover

i. **Total Liability:** The **Company's** total liability to pay the claim under this benefit during each **Policy Year** shall be the **Sum Insured** as specified in the **Policy**.

ii. **Duration:** This benefit is available up to 45 days of international travel on cumulative basis during the **Policy Year**

iii. **Basis of Settlement: The Medical expenses** under this benefit are payable on Reimbursement basis. The Company shall endeavour to provide the Cashless facility, wherever available. The contact details of the Emergency Assistance Service Provider and the updated list of Network Hospitals shall be available on the Company's website.

iv. **Payment:** The payment of any claim under this benefit/Policy will be in Indian Rupees

Specific Exclusion applicable to 3D.Global Cover:

The **Company** shall not be liable to make any payment under this section in connection with or in respect of any expenses whatsoever incurred by the **Insured Person** for:

i. **Travelling for Medical Treatment only:** Traveling against the Medical advice of the **Medical Practitioner** or for receiving Medical treatment abroad if that is the reason for temporary stay abroad.

ii. **Pre and Post Hospitalization Expenses**

iii. **Pre-Existing Diseases:** Any claim arising that is related to **Pre-Existing Disease** except for Lifesaving unforeseen emergency measures as described under Benefit-15 (Worldwide Emergency Cover)

iv. **Treatment that could be delayed:** Treatment which could reasonably be delayed until the **Insured/Insured Person's** return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical **Practitioner/ Physician** and the **Emergency Assistance Service Provider**.

v. **Degenerative**, **Orthopaedic and Cancer related:** Treatment of orthopaedic, degenerative, diseases and any cancer, malignant / benign tumours and such related conditions to Neoplasm, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life or measures solely designed to relieve acute pain in any case excluding chemotherapy or radiotherapy expenses.

vi. **Maternity Expenses**

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

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

vii. **Pregnancy related check-ups:** Medical check-ups during pregnancy or treatment of the pregnancy.

viii. **General Exclusions:** Any exclusion mentioned in the Section-5 General Exclusions of this **Policy**.

Section 4: Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below. The waiting periods mentioned below shall not apply to Section 3D. Global Cover.

i. **Pre-Existing Disease (Code: Excl 01)**

a. Expenses related to the treatment of a **Pre-existing Disease** (PED) and its direct complications shall be excluded until the expiry of 24/36 months (as specified in the **Policy Schedule**) of continuous coverage after the date of inception of the first **Policy** with **Insurer**

b. In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of **Sum Insured** increase.

c. If the **Insured Person** is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the **Policy** after the expiry of 24/36 months (as specified in the **Policy Schedule**) for any **Pre-Existing Disease** is subject to the same being declared at the time of application and accepted by **Insurer**

ii. **Specified disease/procedure waiting period (Code: Excl 02)**

a 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**.

b. In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of **Sum Insured** increase.

c. If any of the specified disease/procedure falls under the waiting period specified for **Pre-Existing Diseases**, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the **Policy** or declared and accepted without a specific exclusion.

e. If the **Insured Person** is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage

f. List of specific diseases/procedures in respect of which 24 months 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
Gynaecological	• 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

Gastrointestinal	• 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 permanentl excluded) • Perineal and perianal abscess • Rectal prolapse	• Cholecystectomy • Surgery of hernia
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 7.5
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

iii. **30 Days Waiting Period (Code: Excl 03)**

a. Expenses related to the treatment of any illness within 30 days (and treatment of Covid-19 within 15 days) from the first policy commencement date shall be excluded except claims arising due to an **Accident**, provided the same are covered .

b. This exclusion shall not, however, apply if the **Insured Person** has continuous coverage for more than twelve months.

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

iv. **12 months Maternity Waiting Period**

a. The Benefit-3 Maternity Cover defined under this Policy shall become available only after the expiry of 12 months from the date of inception of the first **Policy** with the **Company**

Section 5: Exclusions (Applicable to all benefits under the Policy)

5.1 General Exclusions

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

1) **Investigation & Evaluation (Code: Excl 04)**

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

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are except under the Benefit-13-Health Check Up.

2) **Rest Cure, rehabilitation and respite care (Code: Excl 05)**

a. 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 daily living 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 needs.

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

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

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

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

d. Body Mass Index (BMI);

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

4) **Change-of-Gender treatments (Code:Excl 07):** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

5) **Cosmetic or Plastic Surgery (Code: Excl 08):** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

6) **Hazardous or Adventure sports (Code:Excl 09):** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7) **Breach of law (Code: Excl 10):** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8) **Excluded Providers (Code:Excl 11):** Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. (For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

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

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

11) **Dietary Supplements & Substances (Code: Excl 14):** Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a **Medical Practitioner** as part of hospitalization claim or day care procedure

12) **Refractive Error (Code: Excl 15):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13) **Unproven Treatments-Code (Code: Excl 16):** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14) **Sterility and Infertility (Code: Excl 17):** Expenses related to sterility and infertility. This includes:

   a. Any type of contraception, sterilization

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

   c. Gestational Surrogacy

   d. Reversal of sterilization

15) **Deductible:** Company is not liable for any payments under this Policy unless the Medical Expenses incurred during the Policy Year exceeds the Aggregate Deductible (as specified in the Policy Schedule) except for Benefit-10 (Waiver of Deductible for Accidental Claims) and on availing Benefit-14 (Deductible-Buy Back (Optional Benefit) under the Policy.

   However, under Benefit-14 (Worldwide Emergency Cover), an amount (in INR) equivalent to USD 100 shall be deducted from each and every claim made under the benefit.

16) **External Congenital Anomaly:** Treatment of External Congenital Anomaly

17) **Treatment other than Medically Necessary Treatment:** Any treatment or part of a treatment that is not Medically Necessary Treatment

18) **Outpatient treatment:** Treatment which has been done on an outpatient basis without any **Hospitalization**, except for Benefit-15 (Worldwide Emergency Cover)

19) **Overseas treatment:** Any treatment taken by **Insured Person** outside India, except for Benefit-15 (Worldwide Emergency Cover)

20) **Charges other than Reasonable & Customary Charges:** Any Medical Expenses which are not reasonable and Customary Charge

21) **Self-injury or suicide:** Any intentional self-inflicted Injury, suicide or attempted suicide.

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

23) **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.

24) **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..

5.2 Permanent Exclusions

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

Section 6: Claims Procedure

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

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

6.1 Claim Intimation

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

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

ii. **Emergency Hospitalization**, the **Insured Person** will intimate such admission within 24 hours of such admission.

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

a. **Policy** Number
b. Name of the **Policyholder**
c. Name of the **Insured Person** in whose relation the **Claim** is being lodged
d. Nature of Illness / Injury
e. Name and address of the attending **Medical Practitioner** and **Hospital**
f. Date of Admission to Hospital or proposed date of admission to hospital for Planned Hospitalization
g. Any other information as requested by the **Company**

Claim Intimation under Section 3D.Global Cover (Benefit - 15 Worldwide Emergency Cover)

a. The **Insured Person** shall immediately contact the Help Line of Emergency Assistance Service Provider stating necessary details. The details of phone numbers and Help Line shall be available on Company's website and specified in the **Policy Schedule** attached to this **Policy**.

b. The **Insured Person** needs to contact the Help Line number while abroad as soon as possible and inform in case the **Insured Person** is/will be filing any Claim, even if assistance is not required. The **Company** will not be liable to pay any Claim that has not been informed by the **Insured Person** while being abroad to the Help Line

c. The Help Line of the **Emergency Assistance Service Provider** will verify the identity of the caller by asking appropriate information.

d. In the event of an **Illness** / Injury where it is not possible to contact the Help Line before consulting a **Physician** or going to the **Hospital**, the **Insured Person** shall contact the Help Line as soon as possible. In either case, when being admitted as a patient, the **Insured Person** shall show the concerned **Physician** or personnel this **Policy**.

6.2 Procedure for Cashless and Reimbursement of Claims

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

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

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

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

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

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

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

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

g. The **Insured Person** shall be required to submit the documents as mentioned in Clause - 6.5 Claim Documents with the **Network Hospital**.

Note:

- Under **Cashless** facility, the **TPA/Company** may authorize upon the **Insured Person's** request for direct settlement of admissible **Claim** as per agreed charges & terms and conditions between **Network Hospital** and the **TPA/Company**. In such cases, the **TPA/Company** will directly settle all eligible amounts as per the **Policy** Terms & Conditions with the **Network Hospital** to the extent the **Claim** is covered under the Policy.
- The **Company**, at its sole discretion, reserves the right to modify, add or restrict any **Network Hospital** for **Cashless** services available under the **Policy**. Before availing the **Cashless** service, the **Insured Person** is required to check the applicable list of **Network Hospital** on the **Company's** website.

i **Re-imbursement:**

In case of any Claim under the Benefits, where Cashless facility is not availed, the list of documents as mentioned in Clause - 6.5 **Claim Documents** shall be provided by the Insured Person, to **TPA/Company** immediately but not later than 30 days of discharge from the **Hospital**, at the **Policyholder's / Insured Person's** expense to avail the **Claim**.

Procedure for Cashless and Reimbursement Claim under Section 3D. Global Cover (Benefit-15-Worldwide Emergency Cover)

a. If the procedure stated above (Clause 6.1 Claim Intimation under Section 3D. Global Cover (Benefit-15 Worldwide Emergency Cover) is complied with, **Emergency Assistance Service Provider** may provide Cashless Facility, under which it will guarantee to the Hospital / other providers the costs of **Hospitalisation**, transportation for emergency services. All costs will be directly settled by **Emergency Assistance Service Provider** on the **Company's** behalf and the same shall constitute due discharge of the Company's obligations hereunder.

b. If the Hospital/other providers do not accept the guarantee of payment from Emergency Assistance Service Provider, the **Company** cannot be held liable for the same. The cost will then have to be borne by the **Insured Person** and the same will then be reimbursed by the **Company** on submission of required documents.

c. Reimbursement of all claims will be made by the **Company** in Indian Rupees on the **Insured Person's** return back to the Republic of India, at the exchange rate specified by the Reserve Bank of India, as applicable on the date the amount is billed.

6.3 Responsibility of Insured Person

i. Forthwith intimate / file / submit a **Claim** in accordance with Clause-6 of this Policy.

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

iii. The **Insured Person** is required to check the applicable list of **Network Hospitalization** the **TPA/Emergency Assistance Service Provider / Company's** website or call centre before availing the **Cashless** services.

iv. In case where initial covered **Medical expenses** were not expected to exceed the Aggregate **Deductible** but subsequently found to be exceeding the opted Aggregate **Deductible**, notification must be done immediately along with the copy of intimation made to other Insurer.

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

a. Allow the **Medical Practitioner** or any of the **Company's** representatives to inspect the medical and **Hospitalization** records, investigate the facts and examine the **Insured Person**.

b. Assist and not hinder or prevent the **Company's** representatives in pursuance of their duties for ascertaining the admissibility of the **Claim** under the Policy.

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

6.4 Claim Documents

The Insured Person shall submit to the **TPA/Emergency Assistance Service Provider/Company/Network Hospital** (as applicable) the following documents for or in support of the **Claim**, substantiating expenses up to and above the Aggregate **Deductible** amount:

i. Duly completed and signed **Claim** Form, in original
ii. **Medical Practitioner's** referral letter advising **Hospitalization**
iii. **Medical Practitioner's** prescription advising drugs /diagnostic tests / consultation
iv. Original bills, receipts and discharge card from the **Hospital / Medical Practitioner**
v. Original bills from pharmacy / chemists
vi. Original pathological / diagnostic test reports and payment receipts
vii. **Ambulance** receipt and bill
viii. First Information Report / Final Police Report, if applicable
ix. Post mortem report, if applicable

The Company may call for any other document required by the **Company** to assess the **Claim**.

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

Apart from above mentioned documents, additional claim documents required for Section 3D. Global Cover (Benefit-15-Worldwide Emergency Cover) are following:

x. Copy of Air tickets and boarding passes for the sector travelled.
xi. Copy of passport, visa with exit and entry stamp

Note:

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

6.5 Proportionate Deductions

Subject to the other Terms and Conditions of this Policy, as per the provisions of the IRDAI's 'Modified Guidelines on Product Filing in Health Insurance Business - Norms on Proportionate Deductions' Dated 11th June 2020, 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 **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 section 3.1.1(i.e. Inpatient Treatment) barring the below mentioned expense break ups:

a. Cost of Pharmacy and Consumables
b. Cost of Implants and Medical Devices
c. Cost of Diagnostics

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

Sr. No.	-	Header	Explanation
I		Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
II -	- -	Eligible Room Rent Limit -	Room Rent allowed as per policy is Single Private A.C Room (upto Deluxe Room) -
A	-	Actual Medical Bills Incurred	As per submitted documents
-	(-)	Any expense not covered-under Policy Benefits	
B	=	Covered Medical Expenses	
-	(-)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
D	=	Covered Medical Expenses which shall be subject to Proportionate Deduction	
-	(*)	(Eligible Room Rent Limit) / (Actual Room Rent)	-
E	=	Claim after Proportionate Deduction	If Actual Room Rent is within eligibility, then no deduction to be applied (E=D)
-	(+)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	-
F	=	Ground up claim amount	-
-	(-)	Deductions for Policy Deductibles and Limits*	-
G	=	Payable claim amount	-

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

- Deductible
- Base Sum Insured
- Cumulative Bonus

Proportionate Deduction is subject to the following:

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

6.6 Payment Terms

i. This Policy covers medical treatment taken within India except for Section 3D. Global Cover (Benefit-15 Worldwide Emergency Cover), and payments under this Policy shall be made in Indian Rupees within India.

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

iii. The Company shall not indemnify the Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment.

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

v. For Cashless Claims, the payment shall be made to the Network Hospital / TPA/ Emergency Assistance Service Provider whose discharge would be complete and final.

vi. For the Reimbursement Claims, the Company will pay to the Policyholder / Insured Person.

vii. The Company will only be liable to pay for such Benefits for which the Insured Person has specifically claimed in the Claim Form. The Company shall settle the Claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a Claim warrant an investigation in Company's opinion it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Company shall settle the Claim within 45 days from the date of receipt of last necessary document.

viii. The Company shall also decide and communicate any rejection of claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Company shall also decide and communicate any rejection of the claim within 45 days from the date of receipt of last necessary document.

Section 7: General Terms and Clauses (applicable To All Benefits under the Policy)

1) Disclosure to information

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

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

The Company may, at its discretion, and in compliance with applicable regulations and guidelines, choose to continue the health insurance coverage to the Insured Person in certain circumstances, depending on the merit of the case, subject to terms and conditions of the Policy.

2) Condition Precedent to Admission of Liability

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

3) 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.

4) Observance of terms and conditions

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

5) Nomination

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

6) Arbitration Clause

If any dispute or difference shall arise as to the quantum to be paid under this **Policy** (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation **Act**,1996.

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

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

7) Premium Payment in Instalments (wherever applicable)

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the **Policy**.

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

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

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

v. In case of instalment premium due not received within the **Grace Period**, the **Policy** will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the **Policy**.

8) Complete discharge

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

9) Multiple Policies

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

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

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

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

10) Fraud

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

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

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

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

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

iii. any other act fitted to deceive; and

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

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

11) Limitation Period

In no case whatsoever the **Company** shall be liable for any **Claim** under this **Policy**, if the requirement of Clause - 6 **Claim** Procedure above are not complied with, unless the **Claim** is the subject of pending action; it being expressly agreed and declared that if the **Company** shall disclaim liability for any **Claim** hereunder and such **Claim** shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the **Claim** shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable.

12) Claim Settlement (provision for Penal Interest)

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

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

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

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

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

13) Renewal of Policy

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

ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

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

v. 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.

vi. No loading shall apply on renewals based on individual claims experience.

14) Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the **Insured Person** about the same 90 days prior to expiry of the **Policy**.

ii. **Insured Person** will have the option to migrate to similar health insurance product available with the **Company** at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

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

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

16) Migration

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

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

17) 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)

18) Material change

The **Policyholder/Insured Person** shall immediately notify the **Company** in writing of any material change in the risk at their own expense and the **Company** may adjust the scope of cover and/or premium

19) Records to be maintained

The **Policyholder/Insured Person** shall keep an accurate record containing all relevant medical records until final adjustment (if any) and resolution of all **Claims** under this **Policy**; and shall allow the **Company** or its representative(s) to inspect such records. The **Policyholder/Insured Person** shall furnish such information as the **Company** may require under this Policy.

20) No constructive Notice

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

21) Alteration in the Policy

This **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the **Company**, which approval shall be evidenced by a written endorsement signed and stamped by the **Company**. However, change or alteration with respect to increase / decrease of the **Sum Insured** or Aggregate **Deductible** shall be permissible only at the time of renewal of the **Policy** subject to underwriting decision of the **Company**.

22) Endorsements (Mid term Addition/Deletion of Insured Persons)

i. **Mid-Term Addition of Family:** Mid-term addition of **Family members** shall be allowed in the event of following:

   a) Newborn baby covered from 90 days

   b) Spouse in the event of marriage.

ii. **Mid Term Deletion of Policyholder/Family:** Midterm deletion of **Policyholder** or his/her **Family** members shall be allowed on pro-rata basis only in the event of Death of the **Insured Person** or his/her **Family** members subject to no claim has been made against the deleted person .

iii. The **Company** may at any time terminate coverage to the **Policyholder** or his/her **Family** members on grounds as specified in Section 7 Clause (i) Disclosure to information norm, by giving 15 days' notice and by sending an endorsement to Policyholder's address shown in the **Policy Schedule** without refund of premium.

23) Cancellation

i. The **Policyholder** may cancel this policy by giving 15days' written notice and in such an event, the **Company** shall refund premium for the unexpired **Policy Period** as detailed below.

Retention % to be applied on Policy Premium

Cancellation date up to (x months) From Policy Period Start Date	Retention %(of Full Policy Period Premium)		
Policy Period	**1year**	**2 years**	**3 years**
Upto 1 Month	25.00%	12.50%	8.30%
Upto 3 Months	50.00%	25.00%	16.70%
Upto 6 Months	75.00%	37.50%	25.00%
Upto9 Months	100.00%	50.00%	33.30%
Upto12 Months	100.00%	75.00%	50.00%
Upto18 Months	NA	100%	75%
Upto24 Months	NA	100.00%	87.5%
Beyond 24 months		NA	100.00%

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

24) Policy Disputes

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

25) Communication

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

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

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

26) Overriding effect of the Policy Schedule

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

27) Free Look Period

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

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

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

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

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

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

28) Redressal of Grievances

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

Website: www. Relianceada.com

Toll free: 1800-3009

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

E-mail: rgicl.services@relianceada.com

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

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India - 452001. Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

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

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

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur Hyderabad - 500 081

Grievance Redressal officer email ID:
rgicl.headgrievances@relianceada.com

(For updated details of grievance officer, kindly refer the link. https: / / reliance general.co.in/ Insurance/About - Us/Grievance - Redressal.aspx If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System

https://igms. irda.qov. in/

Section 8: Coverage Summary

This Policy would trigger when the incurred admissible expenses exceed the Aggregate Deductible under the Policy. This means that all the claims, including those falling within the Aggregate Deductible, will be assessed based on the terms and conditions of this Policy for working out the admissible expenses.

Expenses related to Pre Hospitalization and Post Hospitalization in respect of all previous claims would also be taken into consideration.

The benefits 1 to 13 and 15 are in-built Policy benefits and shall be available to the Insured Person in accordance with the procedures set out in this Policy. The benefit 14 is an optional cover under the Policy which shall be available at the end of four continuous and consecutive Hospitalization-free Policy Years .

Policy Term Available	**Plan A**	**Plan B**
	1 year, 2 years 3 years	2 years, 3 years
Room Category	Single Private A.C Room (upto Deluxe Room)	
Type of Deductible	Annual Aggregate Deductible	Long Term Aggregate Deductible

Base Covers			
Cover	**Brief Description**		**Limits**
Hospitalization Expenses	This cover indemnifies the insured for any medical expenses incurred on In-patient Treatment. Pre-Hospitalization and Post-Hospitalization is also covered for the insured for that instance inpatient treatment. This shall also cover Day Care Treatment- i.e. indemnify the insured for the medical expenses incurred under Day care procedure as advised by Medical Practitioner.	Sum Insured is limited to the selected combination of Annual Aggregate Deductible	Sum Insured is limited to the selected combination of Annual Aggregate Deductible
Domiciliary Hospitalization	This cover indemnifies the Insured Person for the medical expenses incurred for treatment under Domiciliary hospitalization	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible

Maternity Cover	This cover will indemnify the Insured Person for the Medical Expenses related to pregnancy, childbirth, or medically recommended and lawful termination of pregnancy. This cover also includes pre and post natal medical expenses and medical expenses incurred for In-patient treatment of new born baby from day 1 to 90 days	Limited to Rs. 2 lakhs subject to Annual Aggregate Deductible	Limited to Rs. 2 lakhs subject to Long Term Aggregate Deductible
Organ Donor	This cover will indemnify the Insured Person for the Medical Expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery performed on Insured	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
AYUSH Treatment	This cover will indemnify the Insured Person for the Medical Expenses incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Ambulance Cover	The cover indemnifies the Insured Person for expenses on availing Ambulance services offered by a Hospital or by an Ambulance service provider on Inpatient hospitalization.	Rs. 3500 per hospitalization (Within the Sum Insured limits)	Rs. 3500 per hospitalization(Within the Sum Insured limits)

Emergency Air Ambulance Cover	The cover indemnifies the Insured Person for expenses incurred on availing Air Ambulance services from the place of first occurrence of the Illness / Accident to the nearest Hospital	Maximum upto Rs. 2 lakhs for Policies having Sum Insured less than Rs. 10 lakhs and Rs. 5 lakhs for Policies having Sum Insured greater than and equal to Rs. 10 lakhs Available once in each Policy Year	Maximum upto Rs. 2 lakhs for Policies having Sum Insured less than Rs. 10 lakhs and Rs. 5 lakhs for Policies having Sum Insured greater than and equal to Rs. 10 lakhs Available once in each Policy Year
Modern Treatments	This cover indemnifies the insured for the medical expenses incurred on treatment of listed Modern Treatments	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible
Additional Item Cover	This cover indemnifies the Insured Person for Reasonable and customary expenses incurred towards Optional Items listed in Annexure A	Within the Sum Insured subject to Annual Aggregate Deductible	Within the Sum Insured subject to Long Term Aggregate Deductible

Personal Accident	
Waiver of Deductible for Accidental Claims	This cover waives off the General Exclusion no. 5 (15) - 'Deductible' for Accidental Hospitalization Claims

Renewal Benefits	
Waiver of Premium - On first Diagnosis of Critical Illness	This benefit automatically waives off the renewal Policy premium for one year for the next renewalin case of Diagnosis of any of the listed Critical Illness. For long term policies, the Company shall waive one-year proportionate renewal Policy premium of the next renewal. This benefit is provided once in the lifetime of the Insured Person
Cumulative Bonus	This renewal benefit will provide 10% of expiring Policy Year Base Sum Insured as Cumulative Bonus at the end of a claim free Policy Year , subject to a maximum of 50% of Base Sum Insured

Health Check Up	After every 3 consecutive and continuous Policy Years, this benefit shall provide of the listed medical check up expenses. The benefit is limited to Rs. 3000 for policies with Deductible less than 10 lakhs and upto Rs. 5000 for policies with Deductible greater than and equal to 10 lakhs. The benefit shall be available on Cashless basis only.	
Deductible-Buy Back (Optional Benefit)*	At the end of four consecutive and continuous Hospitalization - free Policy Years, if the Policyholder avails the option to buy back the Deductible amount then no Deductible shall apply on such renewal and the Base Sum Insured under the Policy shall be sum of expiring Policy's Base Sum Insured and expiring Policy's Deductible.	
Global Cover		
Worldwide Emergency Cover	This cover indemnifies the Insured Person for the Medical Expenses incurred on Medical Emergency Inpatient, Day Care or outpatient treatment, whilst overseas.	Within the Sum Insured subject to a deduction of USD 100 on each and every claim. Available for up to 45 days of international travel on cumulative basis

The maximum liability of the Company to pay the claims under the Policy is limited to the sum of Sum Insured and Cumulative Bonus. Additionally, the Company shall indemnify the Insured Person as per limits specified above under Benefit-11- Waiver of Premium-On first Diagnosis of Critical Illness and Benefit-13-Health Check Up; and upto the Deductible amount under Benefit-10-Waiver of Deductible for Accidental Claims.

*If Policyholder opts Benefit-14-Deductible Buy back under the Policy then

I Benefit - 10: Waiver of Deductible for Accidental Claims shall not be applicable under the Policy.

ii. Benefit -13 - Health Checkup shall be limited to Rs. 5000.

Illustration -Working of Plan A and Plan B

The working for Plan A and Plan B is explained below

Policy Details	
Sum Insured (INR)	3 lakhs
Deductible (INR)	2 lakhs
Policy Period	2 years
Policy Start Date	23 - 11 - 2020
Policy End Date	22 - 11 - 2022

Policy Year	**Illness/ Hospitalization No.**	**Date of admission**	**Medical Expenses**	**Payable claim amount**	
				Plan A	**Plan B**
Policy Year 1 (23-11-2020 to 22-11-2021)	Claim1	12-01-2021	1,00,000	-	-
-	Claim 2	02-04-2021	2,00,000	1,00,000	1,00,000
End of Policy Year 1 (Sum Insured Replenished in both cases>>	-	-	-	Deductible reset>>	No deductible reset>>
Policy Year 2 (23-11-2021 to 22-11-2022)	Claim 3	28-12-2021	2,00,000	-	2,00,000
-	Claim 4	27-06-2022	1,00,000	1,00,000	1,00,000
Total: Policy Year 1 & Policy Year 2 (23-11-2020 to 22-11-2022)	-	-	6,00,000	2,00,000	4,00,000
End of Policy Year2: Sum Insured Replenished in both cases>>	-	-	-	Deductible reset>>	Deductible reset>>

In above chart

- The Policy has a Sum Insured of 3 lakhs which replenishes every year
- The Deductible of Rs. 2 lakhs, resets every year for Plan A (Annual Aggregate Deductible) and resets at the end of the Policy term (2 years) for Plan B (Long term Aggregate Deductible)
- Hence there is no difference in outcomes for plans A and B for the first year of the policy, where claim becomes payable once the expenses cross Rs. 2 lakhs in aggregate
- The Policyholder in Plan B gets a higher claim payment in year 2 since the Deductible is not reset. It is important to note that Sum Insured is replenished at the year-end in all cases.

Illustration for Benefit-Waiver of Deductible for Accidental Claims

Case 1

Policy type: Floater

No. of Insured - 2 Adults

Sum Insured - 10 lakhs

Deductible - 5 lakhs

Policy Period - 1 year

Policy Start Date - 1/1/2020

Policy End Date - 31/12/2020

Accident1 happens on 15/5/2020

During the Policy Year Insured person 1 met with an Accident and was hospitalized for it. The Claim amount is Rs. 12 lakhs

The total Amount payable for this claim (assuming no further deductions need to be applied on 12 lakhs):

5 lakhs from Waiver of Deductible for Accidental Claims + 7 lakhs from Sum Insured = 12 lakhs

Balance Sum Insured = Rs. 3 lakhs

Balance Aggregate Deductible = 0 (The Aggregate Deductible is considered to have been completely exhausted by the accident claim. No deductible will apply on future claims in the same Policy Year)

Case 2

Policy type: Floater

No. of Insured - 2 Adults

Sum Insured - 10 lakhs

Deductible - 5 lakhs

Policy Period - 1 year

Policy Start Date - 1/1/2020

Policy End Date - 31/12/2020

Accident1 happens on 15/5/2020

During the Policy Year Insured person 1 met with an Accident and was hospitalized for it. The Claim amount is Rs. 3 lakhs

The total Amount payable for this claim (assuming no further deductions need to be applied on 3 lakhs):

3 lakhs from Waiver of Deductible for Accidental Claims + 0 lakhs from Sum Insured = 3 lakhs

Balance Sum Insured = Rs. 12 lakhs

Balance Aggregate Deductible = Rs. 2 lakhs (Rs. 3 lakhs from the Aggregate Deductible is considered to have been exhausted by the accident claim. The balance Rs. 2 lakhs deductible will apply for future illness claims in the same Policy Year)

ANNEXURE-A- ATTACHED TO POLICY WORDINGS

List I - Optional Items

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-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
Kerala, Lakshadweep, Mahe-a part of Pondicherry.	**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
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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