RELIANCE GENERAL INSURANCE | Live Smart

# RELIANCE HEALTHWISE POLICY WORDINGS

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IRDAI Registration No. 103.
Reliance General Insurance Company Limited.
Registered and Corporate Office: Reliance Center, South Wing, 4th Floor, Santacruz (East), Off. Western Express Highway, Mumbai 400 055.
Corporate Indentity No. U66603MH2000PLC128300.
Reliance HealthWise Policy
UIN - RELHLIP21522V032021
 RGI/MCOM/CO/RELIANCE-HWP-PW/Ver. 1.0/15102020
An ISO 9001:2015 Certified Company

A RELIANCE CAPITAL COMPANY

## PREAMBLE

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

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

## 1. DEFINITIONS

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Policy Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meanings set forth:

1. **"Accident"** An Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. "**Act"** means the Insurance Act 1938
3. **"Age"** The completed age of the Insured Person as on his last Birthday
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"** 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"** 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"** An 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. **"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.
14. **"Cashless facility"** means a facility extended by 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.

15. **"Child"** means biological or legally adopted son or daughter of the Insured Person whose completed age is less than 25 years as on the Policy Period Start Date

16. **"Claim"** a demand made by the Insured Person or on his behalf, for payment under "Scope of Cover" 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"** 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 Insurer'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."Cosmetic Surgery" Surgery / treatment which is primarily done for the enhancement of appearance through surgical and medical techniques. It concerns with maintaining normal appearance, restoring or enhancing it.

23. **"Cumulative Bonus"** means any increase or addition in the **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 supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

    i. has qualified nursing staff under its employment;
    ii. has qualified medical practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. maintains daily records of patients and 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 Anesthesia in a **Hospital/Day care** centre in less than 24 hours because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

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

    Day Care Treatment shall only include procedures listed in Annexure "D

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.

27. **"Dependent"** means financially dependent on the Insured Person and does not have independent source of income.

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

29. **"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.

30. **"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**

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

    i. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
    ii. the patient takes treatment at home on account of non-availability of room in a Hospital.

32. **"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.

33. **"Family"** means the Insured Person, his/her lawful

spouse and maximum of two dependent children below the age of 25 years.

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

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

    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance Company's authorized personnel

36. **"Hospitalisation"** means admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

37. **"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

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

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

    i. **Acute condition** - Acute condition is a disease, illness or injury that is likely to 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 **Chronic condition** - A chronic condition is defined as 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, visible and evident means which is verified and certified by a Medical Practitioner.

41. **"Inpatient Care"** 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. **"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

44. **"Maternity Expenses"** Maternity expenses means;

    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**);
    ii. expenses towards lawful medical termination of pregnancy during the policy period

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

46. **"Medical Expenses"** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no

more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

47. **"Medical Practitioner"** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

    The registered practitioner should not be the insured or close member of the family.

    **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.**

48. **"Mental Illness"** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize 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.

49. **"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 Person;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

52. **"New Born Baby"** means baby born during the Policy Period and is aged up to 90 days

53. **"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/ Insured Person. Nominee for all other Insured Person(s) shall be the Policyholder himself.

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

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

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

57. **"Plan"** means a specific set or sub-set of coverages, limits, Deductibles, Co-pays, terms and conditions as pre-defined under this Policy. The three plans Standard, Silver and Gold plan available under this product are summarized in Section 7 COVERAGE SUMMARY. The applicable plan under this Policy is as selected by the Policyholder and specified in the Policy Schedule

58. **"Policy"** The Company's contract of insurance with the Policyholder providing cover as detailed in the Policy Terms and Conditions, the Proposal form, Policy Schedule, Endorsements, if any and Annexures, which form part of the contract and must be read together

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

60. **"Policyholder"** means the person who is the proposer and whose name specifically appears in the Policy Schedule as such

61. **"Policy Period"** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date and as specifically appearing in the Policy Schedule.

62. **"Policy Period End Date"** the date on which the Policy expires, as specifically appearing in the Policy Schedule

63. **"Policy Period Start Date"** the date on which the Policy commences, as specifically appearing in the Policy Schedule

64. **"Post-hospitalisation Medical expenses"** Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

65. **"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

66. **"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

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

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

    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

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

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

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

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

71. "**Qualified nurse"** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State of India.

72. **"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.

73. **"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.

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

75. **"Senior Citizen"** means any person who has completed sixty or more years of age as on the date of commencement/Policy Period Start Date or renewal of policy.

76. **"Sum Insured"** means the sum as specified in the Policy Schedule, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy Period.

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

78. **"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.

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

## 2. SCOPE OF COVER

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

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

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

The total payment under all benefits under the Policy shall not exceed the Sum Insured mentioned in the Policy Schedule (and the additional Critical Illness Sum Insured if applicable).

### 2A Basic Covers

#### 2.1 In Patient Hospitalization

This benefit covers Medical Expenses incurred by the Insured Person during the Policy Period on In-Patient Hospitalisation (including AYUSH Hospitalization) for illness / injury contracted or sustained by the Insured

Person. Medical Expenses shall include:

i. Room Rent
ii. Nursing Expenses
iii. Intensive Care Unit (ICU) Charges
iv. Fees of Medical Practitioner including Surgeon and anesthetist
v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
vi. Medicines, drugs and consumables
vii. Diagnostics procedures
viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure unless specifically excluded

**2.2 Domiciliary Hospitalisation**

This benefit covers payment of Medical Expenses incurred during the Policy Period for Medically Necessary Treatment pertaining to Domiciliary Hospitalisation of the Insured Person provided that:

i. The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case the Company will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and
ii. The payment under Domiciliary Hospitalisation benefit shall be limited to 10% of the Sum Insured, and shall, in no case cover expenses incurred for:

a. Treatment of any of the following illness / injury:

- Asthma
- Bronchitis
- Chronic nephritis and nephritic syndrome
- Diarrhea & all types of dysenteries including gastroenteritis
- Diabetes mellitus and insipidus
- Epilepsy
- Hypertension
- Influenza, cough and cold
- All psychiatric or psychosomatic disorders
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
- Arthritis, Gout and Rheumatism.

Domiciliary Hospitalisation benefit also covers Medical Expenses on Qualified Nurses engaged on the written medical advice of the attending Medical Practitioner.

**2.3 Day care treatment**

This benefit covers, up to the Sum Insured, the Medical Expenses incurred for medically necessary treatment pertaining to Day Care treatment of the Insured Person, on the written advice of a Medical Practitioner.
The list of covered Day Care Treatments is appended as per Annexure D.

**2.4 Pre-Hospitalisation Medical Expenses**

This benefit covers relevant Pre-Hospitalisation Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule.

**2.5 Post-Hospitalisation Medical Expenses**

This benefit covers relevant Post-Hospitalisation Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule.

**2.6 Pre-Existing Disease**

This Policy covers relevant Medical Expenses of the Insured Person incurred from the 3rd continuous year/5th continuous year of the Policy with the Company (depending upon the plan chosen and as specified in the Policy Schedule), for Medically Necessary Treatment of Pre-Existing Disease, subject to all other terms and conditions under the Policy .
This cover may be made available earlier than 3rd or 5th continuous Policy year in accordance with any reduction applicable to the Section 3.1 Pre-Existing Disease Waiting Period according to the terms and conditions of the Policy.

**2.7 Critical illness**

This benefit, if applicable to the chosen plan and specified in the Policy Schedule, provides for an additional amount equivalent to the Sum Insured opted under In-patient Hospitalisation, towards treatment of listed Critical Illnesses. For the purposes of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence and first diagnosis occurs more than 30 days after the Policy Period Start Date and shall only include those defined hereunder.

**1. Cancer of Specified Severity**

i. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
ii. The following are excluded –

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

HPFs;

i. All tumors in the presence of HIV infection.

**2. Open Chest CABG**

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

ii. The following are excluded:

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

**3. Myocardial Infarction (First Heart Attack of specific severity)**

i. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

b. New characteristic electrocardiogram changes

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

ii. The following are excluded:

b. Other acute Coronary Syndromes

c. Any type of angina pectoris

d. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

**4. Kidney Failure requiring Regular Dialysis**

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

**5. Multiple Sclerosis with persisting symptoms**

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

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

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



The actual undergoing of a transplant of:

i. One of the following organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cell

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

**7. Stroke resulting in permanent symptoms**

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

ii. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

**8. Aorta Graft Surgery**

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:

i. Computerised tomography (CT) scan

ii. Magnetic resonance imaging (MRI) scan

iii. Echocardiography (an ultrasound of the heart)

iv. Abdominal ultrasound (for associated abdominal aneurysms)

v. Angiography (an x-ray of the blood vessels)

**9. Permanent Paralysis of Limbs**

Total and irrecoverable 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.

**10. Primary (Idiopathic) Pulmonary Hypertension**

i. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

ii. The NYHA Classification of Cardiac Impairment are as follows:
   a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   b. Class IV: Unable to engage in any physical activity without discomfort.
   Symptoms may be present even at rest.

iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

**2.8 Donor Expenses**

This benefit covers the Medical expenses incurred during the Policy Period towards the In-patient Hospitalisation of donor, in case of a major organ transplant ,subject to the overall limit of the Sum Insured and Plan opted and specified in the Policy Schedule, provided that

i. The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.
ii. The Company has admitted the Insured Person's Hospitalization claim under the Policy.
iii. The organ donated is for the use of the Insured Person
iv. Company shall not pay the donor's Pre and Post Hospitalization Expenses

**2.9 Cost of health check up**

The Company shall provide Reimbursement of the cost of medical check-up up to 1% of average Sum Insured for Individual Policies and up to 1.25% of Sum Insured for Floater covers, once at the end of a block of four consecutive and continuous Policy years provided there are no claims reported under the Policies by any Insured Person, during this block. The limit specified for Individual Policies applies to each Insured Person, and that specified for floater cover is the overall limit available for all members.

**2.10 Modern Treatment**

This benefit covers the Insured Person upto 50% of Sum Insured for the Medical Expenses incurred during the Policy Period on In Patient Hospitalisation or DayCare Treatment or Domiciliary Hospitalisation for the below mentioned Modern Treatment Methods:

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy-Monoclonal Antibody to be given as injection
vi. Intra Vitreal injections
vii. 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: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Sections 2.1 to 2.15

**2B. <u>Value Added Covers</u>**

Benefits under this Section are Value added services payable up to the limit as specified in the Policy Schedule and shall not exceed the Sum Insured opted by the Insured during the Policy Period. Benefits under each value added cover shall be available separately to each Insured Person and available per Hospitalization.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers.

**2.11 Daily Hospitalization Allowance**

This benefit provides for payment to the Insured Person of Daily Hospital Allowance up to limits specified in the Policy Schedule in case of hospitalization exceeding 3 days.

**2.12 Nursing Allowance**

This benefit provides an allowance up to the limit as specified in the Policy Schedule for services of a Qualified Nurse at the Insured Person's residence or the Hospital on the medical advice which is confirmed as medically necessary by the attending Medical Practitioner and the same relate directly to an illness / injury for which the Company has admitted a Hospitalization claim for Insured Person.

**2.13 Local Road Ambulance Service**

This benefit indemnifies the Insured Person for Reasonable and Customary charges up to the limit as specified in the Policy Schedule incurred for his / her transportation by Ambulance to the Hospital for which a claim is admitted by the Company under Benefits 2.1 or 2.3 of this Policy.

**2.14 Recovery Benefit**

This Policy provides for payment of the sum as specified in the Policy Schedule in the event that a covered Hospitalization of the Insured Person exceeds a period of 10 days. This benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy Period. It is subject to overall limit of the Sum Insured.

**2.15 Expenses on accompanying person**

This benefit provides a per day amount to Insured Person as specified in the Policy Schedule, for the expenses incurred by the accompanying person during In-Patient Hospitalization of the Insured Person for which the Company has admitted a claim under Benefit 2.1 of this Policy.

## 3. WAITING PERIOD

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

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

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

### 3.1 Pre-Existing Diseases (Code- Excl 01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24/48 months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
iii. If the Insured Person is continuously covered without any Break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 24/48 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 us.

### 3.2 Specific Waiting Period (Code- Excl 02)

Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage, as may be the case after

i. the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If 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.



**12 months waiting period list:**

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- Dilation and curettage
- Hernia, hydrocele, congenital internal anomaly/ diseases, fistula in anus, sinusitis
- Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant / adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Gastric and Duodenal ulcers

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

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently

## 4. EXCLUSIONS

### 4.1 General Exclusions

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

**i. Investigation & Evaluation (Code: Excl04)**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

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

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

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

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

Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols
c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI);
   - greater than or equal to 40 or
   - greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
     - Obesity-related cardiomyopathy
     - Coronary heart disease
     - Severe Sleep Apnea
     - Uncontrolled Type2 Diabetes

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

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

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

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

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

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

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

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

**viii. Excluded Providers (Code: Excl 11):**

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

**ix. Substance Abuse and Alcohol (Code: Excl12):**

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

**x. Wellness and Rejuvenation (Code:Excl13):**

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.





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

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure

**xii. Refractive Error (Code: Excl 15):**

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

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

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

**xiv. Sterility and Infertility (Code: 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

**xv. Maternity Expenses (Code - Excl 18)**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

**xvi. Circumcision:**

Circumcision unless necessary for treatment of an illness not excluded hereunder, or, as may be necessitated due to an accident.

**xvii. Dental Treatment:**

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

**xviii. Treatment outside Discipline:**

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

**xix. Hearing Aids and Spectacles:**

Any charges incurred on hearing aids, cost of spectacles,contact lenses and routine eye and ear examinations

**xx. Documentation charges:**

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

**xxi. Artificial Life Support Equipment:**

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

**xxii. RMO charges, service charges and alike:**

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

**xxiii. STDs:**

Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, , Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

**xxiv. External durable medical equipment:** Any expenses incurred on corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.)and oxygen concentrator for asthmatic condition

**xxv. Transplant other than from human body:**

Expenses incurred on organ transplant surgery involving organs not harvested from a human body

**xxvi. Sleep Apnea:**

Any treatment related to sleep apnea, general debility convalescence,

**xxvii. External Congenital Anomaly:**

Treatment of External Congenital Anomaly.

**xxviii. Self-injury:**

Any intentional self-inflicted Injury

**xxix. Vaccination and Immunization:**

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

**xxx. Prostheses:**

Prostheses, corrective devices and medical appliances, which are not, required intra-operatively or for the disease/ illness/ injury for which the Insured Person was hospitalised.

**xxxi. Donor Transplant Expenses:**

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

**xxxii. Non-Allopathy:**

Any expenses related to Non-allopathic treatment, except for AYUSH treatment.





**xxxiii. Overseas Treatment :**

Treatment received outside India

**xxxiv. Non-medical expenses:**

Any non-medical expenses mentioned in Annexure A”

**xxxv. Nuclear Attack:**

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

a. Nuclear attack/ weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b. Chemical attack/ weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack/ weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/ or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

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

**xxxvi. War:**

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

**4.2 Permanent Exclusion**

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 specified as an Annexure-F

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

### 5.1 Claims Intimation

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

i. planned Hospitalization, the Company should be notified of such admission at least 48 hours prior to the planned date of admission.
ii. Emergency Hospitalization, the Company should be notified of such admission within 24 hours of such admission.

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

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

### 5.2 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 Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

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

a. Pre-authorization : Prior to Hospitalization, the Policyholder/ Insured Person must call the call center of the Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.
b. The Company will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the Company will confirm such Cashless authorization / rejection in writing or by other means.
c. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
d. The Company reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.
e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.
f. There can be instances where the Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the Company which will be considered subject to the Policy Terms &Conditions.
g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 5.4 with the Network Hospital.

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

**ii. Re-imbursement:**

In case of any Claim under the Benefits, where Cashless Facility is not availed, the list of documents as mentioned in Clause 5.4 shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

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

i. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.
ii. Forthwith intimate / file / submit a Claim in accordance with Clause 5 of this Policy.
iii. Forthwith pay the entire premium for the cover period in case of EMI applicable
iv. If so requested by the Company, the Insured Person will have to submit himself for a medical examination by the Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.
v. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the Company's website or call center before availing the Cashless services.
vi. On occurrence of an event which will lead to a Claim under this Policy, the Policy holder/ Insured Person shall :
   a. Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
   b. Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

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

### 5.4 Claim Documents

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

i. Duly completed and signed Claim Form, in original
ii. Medical Practitioner's referral letter advising Hospitalization
iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner
v. Original bills from pharmacy / chemists
vi. Original pathological / diagnostic test reports and payment receipts
vii. Indoor case papers
viii. Ambulance receipt and bill
ix. First Information Report/ Final Police Report, if applicable
x. Post mortem report, if available
xi. Any other document as required by the Company to assess the Claim

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

Note :

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

### 5.5 Proportionate Deductions

Subject to the other Terms and Conditions of this Policythe 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 Benefit-2.1 (i.e. In-Patient Hospitalisation) barring the below mentioned expense break ups:

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

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

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

**Proportionate Deduction is subject to the following:**

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

**5.6 Payment Terms**

i. This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.
ii. Claims shall not be admissible under this Policy unless the Company has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.
iii. The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure D (List of Day Care Treatments).
iv. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.
v. The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
vi. For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.
vii. For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.
viii. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form

## 6 TERMS AND CONDITIONS

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

**6.2 Condition Precedent to Admission of Liability**

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

**6.3 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.

**6.4 Complete Discharge**

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

**6.5 Reasonable Care**

The Insured Person shall take all reasonable steps to safeguard the interests of the Insured Person against accidental loss or damage that may give rise to a claim.

**6.6 Material change**

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

### 6.7 Records to be maintained

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

### 6.8 No constructive Notice

Any knowledge or information of any circumstance or condition in connection with the Insured Person in possession of any official of the Company shall not be notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

### 6.9 Special Provisions

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

### 6.10 Multiple Policies

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

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

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

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

### 6.11 Fraud

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

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

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

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

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

### 6.12 Cancellation (other than Free-look)

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 on short period basis as detailed below

| Period on risk | % of Premium Refunded |
|---|---|
| Up to 1 month | 75% |
| Up to 3 months | 50% |
| Up to 6 months | 25% |
| Exceeding six months | Nil |

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.

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

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

### 6.13 Cause of Action

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India and in Indian Rupees only.

### 6.14 Policy Disputes

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

### 6.15 Withdrawal of Policy

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

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

### 6.16 Migration

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

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

### 6.17 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)

### 6.18 Moratorium Period

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

### 6.19 Overriding effect of 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.

### 6.20 Floater Policy

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Policy Schedule, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy Period, upto the limit of Sum Insured specified in the Policy Schedule.

Where the Policy is issued on Floater basis, the Policy can cover only the Insured Person, his/her lawful spouse and 2 dependent children who are upto the age of 25 years. A Floater Policy cannot cover any other person apart from the above category of persons.

### 6.21 Pre-policy health check-up

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

### 6.22 Free Look Period

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

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

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

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

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

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

### 6.23 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under

obligation to give any notice for renewal.

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

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

iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

vi. Renewal Discount equivalent to 5%, on cumulative basis, of renewal premium for each continuous claim free year will offered as No Claim Bonus subject to maximum upto 20%, where the Policy which is claim free & is renewed without a break. In case of claim all discount shall be forfeited at renewal

**6.24 Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

**6.25 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 referable 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.

**6.26 Limitation Period**

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

**6.27 Alterations in the Policy**

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

**6.28 Communication**

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

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

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

**6.29 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

**6.30 Redressal of Grievance**

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

**Website:** www. Relianceada.com

**Toll free:** 1800-3009

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

**E-mail:** rgicl.services@relianceada.com

**Fax:** +91 22 3303 4662

Courier: Any branch office, the correspondence address, during normal business hours.

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

Insured Person may also approach the grievance cell

at any of the Company's branches with the details of grievance.

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

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

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

(For updated details of grievance officer, kindly refer the link.
https: / / reliance general.co.in/ Insurance/About -Us/ Grievance- Redressal.aspx

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
The contact details of the Insurance Ombudsman offices have been provided as Annexure-B
Grievance may also be lodged at IRDAI Integrated Grievance Management System https://igms. irda.qov. in/

## 7. COVERAGE SUMMARY

| Particulars | Standard Plan | Silver Plan | Gold Plan |
|---|---|---|---|
| **Base Cover** | | | |
| In-patient Hospitalisation | Covers In-patient Hospitalisation up to the Sum Insured. | | |
| Domiciliary Hospitalisation | Limited to 10% of Sum Insured, for medical expenses incurred for availing Medical treatment at home which would have otherwise required hospitalisation | | |
| Day care treatment | Covered as listed in Annexure D | | |
| Pre-Hospitalisation Medical Expenses | 30 days | 60 days | 60 days |
| Post-Hospitalisation Medical Expenses | 60 days | 90 days | 90 days |
| Pre-Existing Disease coverage | 5th Policy Year onward | 3rd Policy Year onward | 3rd Policy Year onward |
| Critical Illness | Not covered | Not covered | Covered for an additional amount equivalent to the Sum Insured |
| Donor Expenses | Not covered | Covered within the Sum Insured limit | Covered within the Sum Insured limit |
| Cost of Health Check-up | Reimbursement of cost of medical check-up upto 1% of average Sum Insured for individual policies and upto 1.25% for Floater covers, once at the end of a block of four consecutive years provided there are no claims reported under the policies by any member, during the block. | | |
| Modern Treatment | Covered upto 50% of Sum Insured | | |

| Particulars | Standard Plan | Silver Plan | Gold Plan |
|---|---|---|---|
| **Value Added Covers** | | | |
| Daily Hospitalisation Allowance | Not covered | Not covered | Rs. 250 per day, upto 7 days, starting from day 4 to day 10. In case of listed Critical Illness, said allowance will be payable upto 14 days. |
| Nursing Allowance(Per day amount) | Not covered | Rs.250 per day for a maximum period of 5 days | Rs.300 per day for a maximum period of 5 days. In case of listed Critical Illness, the said reimbursement will be extended to maximum of 10 days |
| Local Road Ambulance Service (maximum of) | Upto Rs. 500/- | Upto Rs. 750/- | Upto Rs. 1000/- |
| Recovery Benefit | Not covered | Covered -If in case an insured person is hospitalized for more than 10 days, a lump-sum of Rs. 10,000/- will be paid. | |
| Expenses on accompanying person(per day amount) | Rs. 200/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time | Rs. 250/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time | Rs. 300/- per day for a maximum period of 5 days subject to Insured Person is hospitalized for a period of 5 days at a given time |

**ANNEXURE - A**

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

| Sr. No | Item |
|---|---|
| 1 | BABY FOOD |
| 2 | BABY UTILITIES CHARGES |
| 3 | BEAUTY SERVICES |
| 4 | BELTS/ BRACES |
| 5 | BUDS |
| 6 | COLD PACK/HOT PACK |
| 7 | CARRY BAGS |
| 8 | EMAIL / INTERNET CHARGES |
| 9 | FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) |
| 10 | LEGGING S |
| 11 | LAUNDRY CHARGES |
| 12 | MINERAL WATER |
| 13 | SANITARY PAD |
| 14 | TELEPHONE CHARGES |
| 15 | GUEST SERVICES |
| 16 | CREPE BANDAGE |
| 17 | DIAPER OF ANY TYPE |
| 18 | EYELET COLLAR |
| 19 | SLINGS |
| 20 | BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES |
| 21 | SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED |
| 22 | TELEVISION CHARGES |
| 23 | SURCHARGES |
| 24 | ATTENDANT CHARGES |
| 25 | EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) |
| 26 | BIRTH CERTIFICATE |
| 27 | CERTIFICATE CHARGES |
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CERTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPY ES CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING AIDS CHARGES |
| 35 | OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) |

| | |
|---|---|
| 36 | SPACER |
| 37 | SPIROMETRE |
| 38 | NEBULIZE R KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/ SHORT/ HINGED) |
| 46 | KNEE IMMOBILIZER/SHOULDER IMMOBILIZER |
| 47 | LUMBO SACRAL BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPE CIAL NURSING CHARGES |
| 53 | SUGAR FREE TABLETS |
| 54 | CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |
| 58 | ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT,RECOVERY KIT, ETC) |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |
| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |

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

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

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

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

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

| Sr. No | Item |
|---|---|
| 1 | ADMISSION/REGISTRATION CHARGES |
| 2 | HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE |
| 3 | URINE CONTAINER |
| 4 | BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES |
| 5 | BIPAP MACHINE |
| 6 | CPAP/ CAPD EQUIPMENTS |
| 7 | INFUSION PUMP - COST |
| 8 | HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC |
| 9 | NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES |
| 10 | HIV KIT |
| 11 | ANTISEPTIC MOUTHWASH |
| 12 | LOZENGES |
| 13 | MOUTH PAINT |
| 14 | VACCINATION CHARGES |
| 15 | ALCOHOL SWABES |
| 16 | SCRUB SOLUTION/STERILLIUM |
| 17 | Glucometer & Strips |
| 18 | URINE BAG |

## Annexure D - List of Day Care Procedures

**1. Microsurgical operations on the middle ear**

1. Stapedotomy to treat various lesions in middle ear
2. Revision of a stapedectomy
3. Other operations on the auditory ossicles
4. Myringoplasty (post-aura/endaural approach aswell as simple Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrumperforation/ reconstruction of the auditoryossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

**2. Other operations on the middle & internal ear**

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) ofthe inner ear
18. Other operations on the middle and inner ear
19. Removal of Keratosis Obturans

**3. Operations on the nose & the nasal sinuses**

20. Excision and destruction of diseased tissue of thenose
21. Operations on the turbinates (nasal concha)
22. Other operations on the nose
23. Nasal sinus aspiration Foreign body removal fromnose

**4. Operations on the eyes**

24. Incision of tear glands
25. Other operations on the tear ducts
26. Incision of diseased eyelids
27. Correction of Eyelid Ptosis by Levator PalpebraeSuperioris Resection (bilateral)

28. Correction of Eyelid Ptosis by Fascia Lata Graft(bilateral)
29. Excision and destruction of diseased tissue of theeyelid
30. Operations on the canthus and epicanthus
31. Corrective surgery for entropion and ectropion
32. Corrective surgery for blepharoptosis
33. Removal of a foreign body from the conjunctiva
34. Removal of a foreign body from the cornea
35. Incision of the cornea
36. Operations for pterygium
37. Other operations on the cornea
38. Removal of a foreign body from the lens of the eye
39. Removal of a foreign body from the posteriorchamber of the eye
40. Removal of a foreign body from the orbit andeyeball
41. Operation of cataract
42. Diathermy/Cryotherapy to treat retinal tear
43. Anterior chamber Paracentesis/Cyclodiathermy/Cyclocryotherapy/Goniotomy/Trabeculotomy andFiltering and Allied Operations to treat glaucoma
44. Enucleation of Eye without Implant
45. Dacryocystorhinostomy for various lesions ofLacrimal Gland
46. Laser Photocoagulation to treat Ratinal Tear

**5. Operations on the skin & subcutaneous tissues**

47. Incision of a pilonidal sinus
48. Other incisions of the skin and subcutaneoustissues
49. Surgical wound toilet (wound debridement) andremoval of diseased tissue of the skin and subcutaneous tissues
50. Local excision of diseased tissue of the skin andsubcutaneous tissues
51. Other excisions of the skin and subcutaneoustissues
52. Simple restoration of surface continuity of the skinand subcutaneous tissues
53. Free skin transplantation, donor site
54. Free skin transplantation, recipient site
55. Revision of skin plasty
56. Other restoration and reconstruction of the skinand subcutaneous tissues.
57. Chemosurgery to the skin.
58. Destruction of diseased tissue in the skin andsubcutaneous tissues
59. Reconstruction of Deformity/Defect in Nail Bed

**6. Operations on the tongue**

60. Incision, excision and destruction of diseasedtissue of the tongue
61. Partial glossectomy
62. Glossectomy
63. Reconstruction of the tongue
64. Other operations on the tongue

**7. Operations on the salivary glands & salivary ducts**

65. Incision and lancing of a salivary gland and asalivary duct
66. Excision of diseased tissue of a salivary gland anda salivary duct
67. Resection of a salivary gland
68. Reconstruction of a salivary gland and a salivaryduct
69. Other operations on the salivary glands andsalivary ducts

**8. Other operations on the mouth & face**

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

**9. Operations on the tonsils & adenoids**

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

**10. Operations on the breast**

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

**11. Operations on the digestive tract,Kidney and Bladder**

91. Incision and excision of tissue in the perianalregion
92. Surgical treatment of anal fistulas
93. Surgical treatment of hemorrhoids
94. Division of the anal sphincter (sphincterotomy)
95. Other operations on the anus
96. Ultrasound guided aspirations
97. Sclerotherapy, etc.
98. Laparotomy for grading Lymphoma withSplenectomy/ Liver/Lymph Node Biopsy
99. Therapeutic Laparoscopy with Laser
100. Cholecystectomy and Choledocho-Jejunostomy/Duodenostomy/Gastrostomy/Exploration Common Bile Duct
101. Esophagoscopy, gastroscopy, duodenoscopywit h polypectomy / removal of foreign body/diathermy of bleeding lesions

102. Lithotripsy/Nephrolithotomy for renal calculus
103. Excision of renal cyst
104. Drainage of Pyonephrosis/Perinephric Abscess
105. Appendicectomy with/without Drainage

**12. Operations on the female sexual organs**

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

**13. Operations on the prostate & seminal vesicles**

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

**14. Operations on the scrotum & tunica vaginalis testis**

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

**15. Operations on the testes**

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





144. Other operations on the testis

**16. Operations on the spermatic cord, epididymis und ductus deferens**

145. Surgical treatment of a varicocele and a hydroceleof the spermatic cord
146. Excision in the area of the epididymis
147. Epididymectomy

**17. Operations on the penis**

148. Operations on the foreskin
149. Local excision and destruction of diseased tissueof the penis
150. Amputation of the penis
151. Other operations on the penis

**18. Operations on the urinary system**

152. Cystoscopical removal of stones
153. Catheterisation of Bladder

**19. Other Operations**

154. Lithotripsy
155. Coronary angiography
156. Biopsy ofTemporal Artery for Various Lesions
157. External Arterio-venous Shunt
158. Haemodialysis
159. Radiotherapy for Cancer
160. Cancer Chemotherapy
161. Endoscopic polypectomy

**20. Operations of bones and joints**

162. Surgery for ligament tear
163. Surgery for meniscus tear
164. Surgery for hemoarthrosis/pyoarthrosis
165. Removal of fracture pins/nails
166. Removal of metal wire
167. Closed reduction on fracture, luxation
168. Reduction of dislocation under GA
169. Epiphyseolysis with osteosynthesis
170. Excision of Bursirtis
171. Tennis Elbow Release
172. Excision of Various Lesions in Coccyx

## ANNEXURE - F

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

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

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| 7 | Chronic Liver diseases | K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD) |
| 8 | Pancreatic diseases | K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis |
| 9 | Chronic Kidney disease | N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083 |
| 10 | Hepatitis B | B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-<br>(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent; |
| 11 | Alzheimer's Disease, Parkinson's Disease | G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer’s disease,<br>unspecified, G20 - Parkinson’s disease. |





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| 12 | Demyelinating disease | G.35 to G 37 |
| 13 | Loss of Hearing | H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified |
| 14. | Papulosquamous disorder of the skin | L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus |
| 15. | Avascular necrosis (osteonecrosis) | M 87 to M 87.9 |

## ANNEXURE-B

| Ombudsman Office | |
|---|---|
| **Office Details** | **Jurisdiction** |
| Gujarat, Dadra & Nagar Haveli, Daman and Diu. | **AHMEDABAD - Shri Kuldip Singh**<br>Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road,Ahmedabad – 380 001.<br>Tel.: 079 - 25501201/02/05/06<br>Email: bimalokpal.ahmedabad@ecoi.co.in |
| Karnataka. | **BENGALURU - Smt. Neerja Shah**<br>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.<br>Tel.: 080 - 26652048 / 26652049<br>Email: bimalokpal.bengaluru@ecoi.co.in |
| Madhya Pradesh Chattisgarh. | **BHOPAL - Shri Guru Saran Shrivastava**<br>Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.<br>Tel.: 0755 - 2769201 / 2769202<br>Fax: 0755 - 2769203<br>Email: bimalokpal.bhopal@ecoi.co.in |
| Orissa. | **BHUBANESHWAR - Shri Suresh Chandra Panda**<br>Office of the Insurance Ombudsman, 62, Forest park,Bhubneshwar – 751 009.<br>Tel.: 0674 - 2596461 / 2596455<br>Fax: 0674 - 2596429<br>Email: bimalokpal.bhubaneswar@ecoi.co.in |
| Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh. | **CHANDIGARH - Dr. Dinesh Kumar Verma**<br>Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.<br>Tel.: 0172 - 2706196 / 2706468<br>Fax: 0172 - 2708274<br>Email: bimalokpal.chandigarh@ecoi.co.in |



| Ombudsman Office | |
|---|---|
| Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry). | **CHENNAI - Shri M. Vasantha Krishna**<br>Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.<br>Tel.: 044 - 24333668 / 24335284<br>Fax: 044 - 24333664<br>Email: bimalokpal.chennai@ecoi.co.in |
| Delhi. | **DELHI - Shri Sudhir Krishna**<br>Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.<br>Tel.: 011 - 23232481/23213504<br>Email: bimalokpal.delhi@ecoi.co.in |
| Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. | **GUWAHATI - Shri Kiriti .B. Saha**<br>Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).<br>Tel.: 0361 - 2632204 / 2602205<br>Email: bimalokpal.guwahati@ecoi.co.in |
| Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry. | **HYDERABAD - Shri I. Suresh Babu**<br>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.<br>Tel.: 040 - 67504123 / 23312122<br>Fax: 040 - 23376599<br>Email: bimalokpal.hyderabad@ecoi.co.in |
| Rajasthan. | **JAIPUR - Smt. Sandhya Baliga**<br>Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.<br>Tel.: 0141 - 2740363<br>Email: Bimalokpal.jaipur@ecoi.co.in |
| West Bengal, Sikkim, Andaman & Nicobar Islands. | **ERNAKULAM - Ms. Poonam Bodra**<br>Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.<br>Tel.: 0484 - 2358759 / 2359338<br>Fax: 0484 - 2359336<br>Email: bimalokpal.ernakulam@ecoi.co.in |

| Ombudsman Office | |
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| West Bengal,<br>Sikkim,<br>Andaman &<br>Nicobar Islands. | **KOLKATA -**<br>Shri P. K. Rath<br>Office of the Insurance Ombudsman,<br>Hindustan Bldg. Annexe, 4th Floor,<br>4, C.R. Avenue,<br>KOLKATA - 700 072.<br>Tel.: 033 - 22124339 / 22124340<br>Fax : 033 - 22124341<br>Email: bimalokpal.kolkata@ecoi.co.in |
| Districts of Uttar Pradesh :<br>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 -**<br>**Shri Justice Anil Kumar Srivastava**<br>Office of the Insurance Ombudsman,<br>6th Floor, Jeevan Bhawan, Phase-II,<br>Nawal Kishore Road, Hazratganj,<br>Lucknow - 226 001.<br>Tel.: 0522 - 2231330 / 2231331<br>Fax: 0522 - 2231310<br>Email: bimalokpal.lucknow@ecoi.co.in |
| Goa,<br>Mumbai Metropolitan Region excluding Navi Mumbai & Thane. | **MUMBAI -**<br>**Shri Milind A. Kharat**<br>Office of the Insurance Ombudsman,<br>3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W),<br>Mumbai - 400 054.<br>Tel.: 022 - 26106552 / 26106960<br>Fax: 022 - 26106052<br>Email: bimalokpal.mumbai@ecoi.co.in |



| Ombudsman Office | |
|---|---|
| State of Uttaranchal and the following Districts of Uttar Pradesh:<br>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 -**<br>**Shri Chandra Shekhar Prasad**<br>Office of the Insurance Ombudsman,<br>Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.<br>Tel.: 0120-2514250 / 2514252 / 2514253<br>Email: bimalokpal.noida@ecoi.co.in |
| Bihar,<br>Jharkhand. | **PATNA -**<br>**Shri N. K. Singh**<br>Office of the Insurance Ombudsman,<br>1st Floor,, KalpanaArcade Building,,<br>Bazar Samiti Road,<br>Bahadurpur, Patna 800 006.<br>Tel.: 0612-2680952<br>Email: bimalokpal.patna@ecoi.co.in |
| Maharashtra,<br>Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region. | **PUNE -**<br>**Shri Vinay Sah**<br>Office of the Insurance Ombudsman,<br>Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road,<br>Narayan Peth,<br>Pune – 411 030.<br>Tel.: 020-41312555<br>Email: bimalokpal.pune@ecoi.co.in |