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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 Yes Plus Health Insurance - UIN-RELHLGP21524V022021

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An ISO 9001:2015 Certified Company

A RELIANCE CAPITAL COMPANY

1. Preamble

Conditions applicable to the *Master Policy Holder:*

The **Master Policy Holder** as mentioned in the **Certificate of Insurance** to this **Policy** has

- by way of requesting to Reliance General Insurance Company Limited (hereinafter called "the **Company**") for issuance of the **Master Policy** under which this Policy has been issued, has disclosed all the relevant information required by the **Company** for deciding on the issuance of **Master Policy** and
- Agreed that all **Certificates** of Insurance are issued as per the terms and conditions as agreed upon in the **Master Policy**

*Conditions applicable to the **Certificate Holder**:*

The **Certificate Holder** mentioned so in the **Certificate of Insurance** to this **Policy** has:

- by way of submitting a Proposal, applied to Reliance General Insurance Company Limited (hereinafter called "the **Company**") for this insurance **Policy**, and has disclosed all the relevant information required by the **Company** for deciding on the question of acceptance of this proposal and issuance of the **Policy**.
- paid appropriate premium and has agreed to undertake to pay subsequent premiums, if any, by their due dates and
- agreed and understood that the **Certificate of Insurance** will be governed by the terms and conditions of the **Master Policy**

Conditions applicable to the Company:

***The* Company**, upon accepting the Proposal and receiving all the premiums by their due dates and realization thereof, undertakes that if during the **Policy Period** as specified in the **Certificate of Insurance**, any **Claim** occurs which becomes admissible and payable under this **Policy** then the Company shall pay for such Claim as per the terms, conditions, coverage, exclusions and definitions as mentioned in this **Policy**.

2. Definitions

The terms defined below have the meanings as ascribed to them below wherever they appear in this **Policy** and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

i. **Accident:** means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.

ii. **Act:** means the Insurance **Act**, 1938 (4 of 1938)

iii. **Age:** means the completed age as on last birthday.

iv. **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

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

vi. **Annexure:** means a document attached and marked as **Annexure** to this **Policy**.

vii. **Any one illness:** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

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

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

x. **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 forcarrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

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

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

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

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

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

a) Central or State Government **AYUSH Hospital**; or

b) Teaching **Hospital** attached to **AYUSH** colleges recognized by the Central Government/Central

Council of Indian Medicine/Central Council for Homeopathy; or

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

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

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

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

xiii. **Break in Insurance/Policy means** the period of gap that occurs at the end of the existing Policy Period, when the premium due for renewal on a given Policy is not paid on or before the premium renewal date or within 30 days thereof.

xiv. **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.

xv. **Certificate of Insurance:** The Policy Schedule issued to the Certificate Holder / Insured in line with the terms and conditions as agreed upon in the Master Policy attached to and forming part of this insurance contract mentioning details including but not limited to, details of the Insured Persons, Certificate Period Start Date, Certificate Period End Date, coverage, sections and benefits applicable, the Sum Insured, the Aggregate Deductible, the Policy Period, premium paid (including duties, taxes and levies thereon).

xvi. **Certificate Period End Date:** Certificate Period End Date means the Date and Time at which the coverage expires for Insured and is appearing in the Certificate of Insurance.

xvii. **Certificate Period Start Date** means the Date and Time at which the Insured is enrolled under the Policy is the Certificate Period Start Date as appearing in the Certificate of Insurance. It must lie within the Master Policy Period.

xviii. **Child:** means Policyholder's biological or legally adopted son or daughter, whose completed age is between 91 days to 25 years as on Policy Period Start Date.

xix. **Claim:** means a demand made by the Policyholder or on his/her behalf, for payment under any Benefit, as covered under the Policy.

xx. **Company:** means Reliance General Insurance Company Limited.

xxi. **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.

xxii. **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"

xxiii. **Condition Precedent:** means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

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

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

b) **External Congenital Anomaly: Congenital Anomaly** which is in the visible and accessible parts of the body.

xxv. **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 Claim amount. A Co-Payment does not reduce the Sum Insured.

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

xxvii. **Day Care Centre:** means any institution established for Day care treatment of illness and/or injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered an-d qualified Medical Practitioner and must comply with all minimum criterion as under –

a) Has qualified nursing staff under its employment;

b) has qualified medical practitioner/s in charge;

c) has fully equipped operation theatre of its own where surgical procedures are carried out;

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

xxviii. Day Care Treatment: means medical treatment, and/or surgical procedure which is:

a) Undertaken under General or Local Anaesthesia in a **Hospital/Day Care Centre** in less than 24 hrs because of technological advancement

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

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

Day Care Coverage is limited to list specified under Annexure-D in this **Policy**

xxix. Deductible: means a cost-sharing requirement under this Policy that provides that the Company 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 benefit are payable by **Company**. A Deductible does not reduce the Sum Insured.

Deductible under this **Policy** is **Aggregate Deductible**. For a claim to become payable, the sum of all admissible claims under the **Policy**, subject to **Policy** terms and conditions, in a given **Policy Period** has to exceed the **Aggregate Deductible** as mentioned in the **Certificate of Insurance**.

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

xxxi. Dental Treatment: means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

xxxii. 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.

xxxiii. 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.

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

a. The condition of the patient is such that he/she is not in a condition to be removedto a Hospital, or

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

xxxv. 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.

xxxvi. Family: means as defined in the Certificate of Insurance. For the Purpose of this Policy, it shall include the Policyholder, his/her legally wedded Spouse and Dependent Children who are not above 25 years of age.

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

xxxviii. 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:

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

b) has at least 10 Inpatient beds in towns having a population of less than10,00,000 and at least 15 Inpatient beds in all other places;

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

d) has a fully equipped operation theatre of its own where surgical procedures are carried out;

e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

xxxix. Hospitalization: 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.

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

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

b) **Chronic Condition -** is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

xli. **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.

xlii. **Inpatient Care/Inpatient Treatment:** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

xliii. **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 Certificate of Insurance and with respect to whom the premium has been received by the Company.

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

xlv. **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.

xlvi. **Inpatient Treatment/Care:** means treatment for which the Insured person has to stay in a Hospital for more than 24 hours for a covered event.

xlvii. **Maternity Expenses:** means;

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

b. expenses towards lawful medical termination of pregnancy.

xlviii. **Master Policy Holder:** Master Policy Holder is Yes Bank Limited (YBL), who facilitates selling and solicitation of this Policy and has agreed on the coverage, premiums, terms and conditions. These pre-agreed terms and conditions form the Master Policy and shall be the basis of the coverage offered to the Certificate Holder/ Insured.

xlix. **Master Policy Period:** The period commencing from the Master Policy Period Start Date and ending on the Master Policy Period End Date and as specifically appearing in the Master Policy or the date of cancellation / termination of the Master Policy, whichever is earlier.

l. **Master Policy Period End Date:** means the date and time on which the Master Policy expires, as specifically appearing in the Master Policy

li. **Master Policy Period Start Date:** means the date and time on which the Master Policy commences, as specifically appearing in the Master Policy

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

liii. **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 Hospital or doctors in the same locality would have charged for the same medical treatment.

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

a) is required for the medical management of the illness or injury suffered by the Insured;

b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical

c) care in scope, duration, or intensity;

d) must have been prescribed by a Medical Practitioner;

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

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

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

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

lvii. **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.

lviii. **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 by a cashless facility.

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

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

lxi. **Non- Network Provider:** means any Hospital, Day Care Centre or other provider that is not part of the network.

lxii. **Notification of Claim:** means the process of intimating a Claim to the insurer or TPA through any of the recognized modes of communication.

lxiii. **OPD Treatment:** means the one in which the Insured Person 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 Inpatient.

lxiv. **Policy:** means the Company's contract of insurance with the Policyholder or alternatively, the Certificate Holder providing cover as detailed in this Policy Terms & Conditions, the Proposal Form, Master Policy, Policy Schedule or Certificate of Insurance, Endorsements if any and Annexures, form part of the contract and must be read together.

lxv. **Policyholder:** means the person who is the Proposer and whose name specifically appears in the Policy Schedule or Certificate of Insurance as such. The Policyholder can alternatively be called as Certificate Holder.

lxvi. **Policy Period/Policy Year:** means a period beginning from the Certificate Period Start Date, as specified in Certificate of Insurance; and ending on the Certificate Period End Date as specified in the Certificate of Insurance or on the date of cancellation of the Policy, whichever is earlier.

lxvii. **Portability:** means the right accorded by 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.

lxviii. **Pre-Existing Disease:** means any condition, ailment or injury or disease:

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

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

lxix. **Pre-Hospitalization Medical Expenses:** means Medical Expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:

a) such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

b) the Inpatient Hospitalization Claim for such Hospitalization is admissible by the Insurance Company.

lxx. **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:

a) such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and

b) The inpatient Hospitalization Claim for such Hospitalization is admissible by the insurance Company.

lxxi. **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.

lxxii. **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.

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

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

lxxv. **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.

lxxvi. **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.

lxxvii. **Room Rent:** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

lxxviii. **Sum Insured:** means

a) For an Individual Policy, the amount specified as Sum Insured in the Certificate of Insurance against each Insured Person which shall become part of the Sum Insured for that Insured Person during the Policy Year.

b) For a Floater Policy, the amount specified as Sum Insured in the Certificate of Insurance which shall become part of the Sum Insured for all Insured Persons put together during the Policy Year.

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

lxxx. **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.

lxxxi. **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.

lxxxii. **Terrorism/Terrorism Incident:** means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not.

Robberies or other criminal acts primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of Terrorism

lxxxiii. **Third Party Administrators or TPA:** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged for a fee or remuneration by the Company, for the purpose of providing health services as defined in those Regulations.

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

3. Scope of Cover

All **Certificates of Insurance** issued under this Master Policy will be subject to terms and conditions as agreed upon in the **Master Policy**.

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed herein, to compensate the **Certificate Holder** as per the covers and benefits opted in the **Master Policy**.

The Company shall indemnify the **Certificate Holder** up to the **Sum Insured** mentioned in **the Certificate of Insurance**, if the sum of all admissible claims under the **Policy** exceeds the **Aggregate Deductible** subject to other terms and conditions of this **Policy**

3.1 Benefit-1: Medical Expenses

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

3.1.1 InPatient Treatment

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

- Room Rent
- Nursing
- Intensive care Unit (ICU),
- Medical Practitioner(s),

- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances,
- Medicines, drugs and Consumables
- Diagnostic procedures
- The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

3.1.2. Pre- Hospitalization

The **Company** will indemnify the **Policyholder/ Insured Peron** for the **Medical Expenses** incurred in the 60 days immediately before the **Policyholder/Insured Person** was Hospitalized, provided that:

i. Such **Medical Expenses** are incurred in respect of the same condition for which **Insured Person** has taken Inpatient Treatment, and

ii. **Company** has accepted the **Claim** for these Inpatient Treatment expenses under Scope of Cover- Section **3.1.1 InPatient Treatment**

3.1.3. Post Hospitalization

The **Company** will indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred in the 90 days immediately after the **Insured Person** was discharged post **Hospitalization** provided that:

I. Such costs are incurred in respect of the same condition for which the **Insured Person** has taken Inpatient Treatment, and

ii. **Company** has accepted the **Claim** for these Inpatient Treatment expenses under Scope of Cover Section **3.1.1 InPatient Treatment**.

3.1.4. Day Care Treatment

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

3.2 Benefit-2: Domiciliary Hospitalization

The **Company** will indemnify the **Insured Person**(s) for the **Medical Expenses** incurred during **Domiciliary Hospitalization** as defined under this Policy, provided that the condition for which the medical treatment is required continues for at least **three days**, in which case the **Company** will pay the **Reasonable and Customary** charges of any necessary medical treatment for the entire period, subject to the **Aggregate Deductible**.

However, the **Domiciliary Hospitalization** benefits under any circumstances shall not cover any **Medical Expenses** incurred by **Insured Person** for treatment of any of the following diseases:

- Asthma
- Bronchitis
- Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome

- Diarrhoea and all types of Dysenteries including Gastro-enteritis
- Epilepsy
- Influenza, Cough and Cold
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and Upper Respiratory Tract Infection including
- Laryngitis and Pharyngitis
- Arthritis, Gout and Rheumatism

3.3 Benefit-3: Maternity Cover

The **Company** will indemnify the **Policyholder/Insured Person** up to Rs. 1 lakh for **Maternity Expenses** incurred on **Inpatient Treatment** during the **Policy Period** subject to the following:

i. The **Company** will cover the **Maternity Expenses** in excess of annual **Aggregate Deductible** as specified under the **Certificate of Insurance**.

ii. This benefit shall become available only after the expiry of 12 months from the date of inception of the first **Policy** with the **Company**.

iii. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the I**nsured Person**.

3.4 Benefit-4: Organ Donor

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

i. The organ donated is for the use of the **Insured Person**, and

ii. **Company** shall not pay the donor's **Pre** and **Post Hospitalization Expenses**

iii. **Company** has accepted **Inpatient Hospitalization Claim** under Scope of Cover- Benefit **3.1.1 InPatient Treatment**.

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

3.5 Benefit-5: AYUSH treatment

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

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

i. Treatment other than **Inpatient Treatment** or **Day Care Treatment**

ii. **Medical Expenses** incurred for evaluation, Investigation only.

iii. Treatment availed outside India.

iv. Treatment at a healthcare facility which is NOT an A**YUSH Hospital** or **AYUSH Day Care Centre**.

v. **Pre-Post Hospitalization** expenses

vi. All preventive and rejuvenation treatments (non-curative in nature), or treatments that are not **Medically Necessary**. This includes but not limited to treatments at Spa, Massages and Health Rejuvenation Procedure.

3.6 Benefit-6: Ambulance Cover

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

i. Such life-threatening emergency condition is certified by the **Medical Practitioner**.

ii. **Company** has accepted I**npatient Hospitalization Claim** under Scope of Cover- Section **3.1.1 InPatient Treatment**

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

3.7 Benefit-7: Modern Treatment Methods

The **Company** will indemnify the **Insured Person** up to 50% of Sum Insured subject to Aggregate **Deductible** for the **Medical Expenses** incurred during the **Policy Period** on **Inpatient Treatment** or **Day Care Treatment** or **Domiciliary Hospitalization** for below mentioned Modern Treatment Methods:

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain Stimulation
- Oral Chemotherapy
- Immunotherapy-Monoclonal Antibody to be given as injection
- Intra Vitreal injections
- Robot surgeries
- Stereotactic radio surgeries
- Bronchial Thermoplasty
- Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
- IONM- (Intra Operative Neutro Monitoring)
- Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

The claim under this benefit shall be subject to all other terms under Benefits 1 to 6.

4. Waiting Period

The Waiting Periods as defined in Clause 4.1, 4.2 & 4.3 shall be aplicable individually for each **Insured Person** and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

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.

4.1 Pre-Existing Disease (Code: Excl01)

a) Expenses related to the treatment of a **Pre-existing Disease** (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first **Policy** with the **Company**

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

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

d) Coverage under the **Policy** after the expiry of 24 months for any **Pre-Existing Disease** is subject to the same being declared at the time of application and accepted by the **Company**

4.2 Specified disease/procedure waiting period code (Code : Excl02)

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

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

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

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

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

f) List of specific diseases/procedures in respect of which 24 months waiting period is imposed is mentioned below:

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

4.3 First 30 Days Waiting Period (Code:Excl03)

a) 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.

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

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

5. Exclusions (Applicable to all benefits under the Policy)

5.1 General Exclusions

The **Company** shall have no liability and no **Claim** shall be admissible in respect of any **Insured** Person under any benefit(s) where such liability or Claim arises directly or indirectly due to any of the following:

i. Investigation & Evaluation (Code:Excl04)

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

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

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

xviii. Non-Medically Necessary Treatment

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

xix. Non-medical expenses

Any non-medical expenses mentioned in **Annexure A**.

xx. Outpatient treatment

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

xxi. Overseas treatment

Any treatment taken by Insured Person availed outside India.

xxii. Non-Reasonable & Customary Charges

Any Medical Expenses which are not reasonable and Customary Charges.

xxiii. Self-injury or suicide:

Any intentional self-inflicted Injury, suicide or attempted suicide.

xxiv. 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.

xxv. 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.

xxvi. Wilful Act/Negligence:

Wilful acts or wilful gross negligence of the Insured Person.

5.2 Permanent Exclusions

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

6. Claims Intimation, Assessment and Management

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

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

6.1 Claim Intimation

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

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

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

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

a) **Policy** Number

b) Name of the **Policyholder**

c) Nam-e of the **Insured Person** in whose relation the **Claim** is being lodged

d) Nature of Illness / Injury

e) Name and address of the attending **Medical Practitioner** and **Hospital**

f) Date of Admission

g) Any other information as requested by the **Company**

6.2 Claim Procedure

I. Cashless:

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

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

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

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

c) If the procedure above is followed and the **Insured Person's** request for **Cashless** facility is authorized, the **Insured Person** will not be required to pay for the **Hospital-ization** Expenses which are

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

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

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:Excl07)

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

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

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

vi. Hazardous or Adventure sports (Code:Excl09)

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

vii. Breach of law (Code: Excl10)

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

viii. Excluded Providers (Code:Excl11)

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by 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: Excl15)

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

xiii. Unproven Treatments (Code: Excl16)

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

xiv. Sterility and Infertility (Code: Excl17)

Expenses related to 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. Aggregate Deductible

Company is not liable for any payments unless the Medical Expenses exceeds the annual Aggregate Deductible for all Hospitalization expenses under this Policy.

xvi. Dental Treatments

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

xvii. External Congenital Anomaly

External Congenital Anomaly.

covered under this **Policy** and fall within the **Company's** liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

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

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

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

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

Note:

- Under **Cashless** facility, the **TPA/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 **TPA/Company**. In such cases, the **TPA/Company** will directly settle all eligible amounts as per the **Policy** Terms & Conditions with the **Network Hospital** to the extent the **Claim** is covered under the **Policy**.
- The **Company**, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for **Cashless** services available under the **Policy**. Before availing the **Cashless** service, the **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-6.5 shall be provided by the Insured Person, to **TPA/Company** immediately but not later than 30 days of discharge from the Hospital, at the **Policyholder's/ Insured Person's** expense to avail the **Claim**.

6.3 Responsibility of Certificate Holder

i. The **Certificate Holder / 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-6 of this **Policy**.

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

iv. The **Certificate Holder / Insured Person** is required to check the applicable list of Network **Hospitalization** the **TPA/Com-pany's** website or call centre before availing the **Cash-less** services.

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

vi. On occurrence of an event which will lead to a **Claim** under this **Policy**, the **Certificate Holder or 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 **Certificate holder / Insured Perso**n does not comply with the provisions of these conditions all benefits under this **Policy** shall be forfeited at the **Company's** option.

6.4 Responsibility of Master Policyholder

a) Collect the premium from **Insured Person** and transfer the premium in the account of the **Company** within a pre-agreed time duration.

b) Provide the details of the **Certificate Holder** or **Certificate Holder's Family** members in the format agreed upon as **Proposal Form** for Insurance.

6.5 Claim Documents

The **Policyholder/ Insured Person** shall submit to the **TPA/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. **Ambulance** receipt and bill

Company has requested to establish its liability for the **Claim**, its circumstances and its quantum unless the **Master Policyholder / Insured Person** have complied with the obligations under this **Policy**.

iii. The **Company** shall not indemnify the **Insured Person** for any period of **Hospitalization** of less than 24 hours except for the **Day Care Treatment**, 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. For **Cashless Claims**, the payment shall be made to the **Network Hospital / TPA** whose discharge would be complete and final.

vi. For the Reimbursement **Claims**, the **TPA/Company** will pay the **Master Policyholder/Insured Person**.

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

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

7. Standard Terms and Conditions (applicable To All Benefits under the Policy):

7.1 Disclosure of information

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

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

The Company may, at its discretion, choose to continue the health insurance coverage to the **Policyholder** in certain circumstances or their combinations as detailed below, subject to terms and conditions of the Policy.

a. If the non-disclosed condition or disease is from the list of Permanent exclusions specified in Section **5.2 Permanent Exclusions** above the Company may take consent from the Policyholder or Insured person and permanently exclude the disease and continue with the Policy.

b. If the non-disclosed condition is other than from the list of Permanent Exclusions, then the Company may, at its discretion, incorporate additional waiting period of not exceeding 48 months for the said undisclosed disease or condition from the date that the non-disclosure was detected by the Company, and continue with the Policy after obtaining the consent of the Policyholder or Insured Person. The additional waiting period referred above shall be imposed, only in those cases where had the medical condition/disease been disclosed by the policyholder or the Insured person at the point of underwriting, the Company would have imposed the waiting period at the time of underwriting.

c. For non-disclosed condition the Company may allow to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, the Company may levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, if the undisclosed condition is surfaced before expiry of the policy term, the Company may charge the extra premium or loading referred herein retrospectively from the first year of issuance of the policy or renewal, whichever is later.

d. The above mentioned three options will not prejudice the rights of the Company to invoke the cancellation clause of 'Disclosure of Information' norm under the policy for non-disclosure/misrepresentation subject to Company's underwriting policy.

7.2 Moratorium Period

After completion of eight continuous years under this Policy, no look back shall be applied. This period of eight years is called as Moratorium period. The moratorium would be applicable for Sum Insured of the first Policy and subsequently completion of eight continuous years would be applicable from the date of enhancement of Sum Insured only on the enhanced limits. After expiry of the Moratorium Period, no health insurance 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

7.3 Duty of disclosure

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

viii. First Information Report/ Final Police Report, if applicable

ix. Post mortem report, if applicable

x. 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:

a) Claim once paid under one Benefit cannot be paid again under any other Benefit.

b) All invoices / bills should be in Insured Person's name.

6.6 Proportionate Deductions

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

i. The **Insured Person** chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the **Hospital** is more expensive than the eligible room category as per the terms and conditions of the **Policy**.

ii. The **Insured Person** chooses a room category in which the room rent charges are more than the applicable **Base Sum Insured** sub-limit (in percentage or Rupee terms) on the room rent as per the **Policy** terms and condition-s.

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

i. Cost of Pharmacy and Consumables

ii. Cost of Implants and Medical Devices

iii. Cost of Diagnostics

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

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

Proportionate Deduction is subject to the following:

i. Apart from the **Associate Medical Expenses**, no other expenses will be proportionately reduced

ii. If the given **Hospital** do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, 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.

6.7 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 **TPA/Company** has been provided with the complete documentation / information which the

7.4 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.

7.5 Aggregate Deductible

The Company is not liable for any payment unless the Medical Expenses admissible under the Policy exceed the annual Aggregate Deductible Limit. Deductible shall be applicable on annual aggregate basis for all Hospitalization expenses during the Policy.

7.6 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.

7.7 Arbitration Clause

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

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

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

7.8 Complete discharge

Any payment to the Policyholder, Insured Person or his/her the nominee r 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.

7.9 Multiple Policies

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

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

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

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

7.10 Cause of Action

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

7.11 Fraud

If a 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/ their behalf to obtain any benefit under this Policy, all benefits 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

7.4 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.

7.5 Aggregate Deductible

The Company is not liable for any payment unless the Medical Expenses admissible under the Policy exceed the annual Aggregate Deductible Limit. Deductible shall be applicable on annual aggregate basis for all Hospitalization expenses during the Policy.

7.6 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.

7.7 Arbitration Clause

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

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

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

7.8 Complete discharge

Any payment to the Policyholder, Insured Person or his/her the nominee r 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.

7.9 Multiple Policies

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

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

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

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

7.10 Cause of Action

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

7.11 Fraud

If a 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/ their behalf to obtain any benefit under this Policy, all benefits 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

Policy Tenure->	1year
Cancellation date up to (x months) From Policy Period Start Date	Refund
Upto1month	75.0%
Upto3months	50.0%
Upto6months	25.0%
Beyond6 Months	0%

7.12 Limitation Period

In no case whatsoever the **Company** shall be liable for any Claim under this Policy, if the requirement of Clause -6 **Claims Intimation, Assessment and Management** 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.

7.13 Claim Settlement (Provision for Penal Interest)

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

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

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

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

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

7.14 Renewal Of Policy

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

i. The Company shall endeavour 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 - insur-ed 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.

Renewal premium may vary and shall be as per the respective **Master Policy** issued by Reliance General Insurance to the Yes Bank Limited as the renewal **Policy** inception date.

7.15 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

7.16 Reasonable Care

The Insured Person shall take all reasonable steps to safeguard the interests of the Insured Person against any Illness or Injury that may give rise to a Claim.

7.17 Material change

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

7.18 Records to be maintained

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

7.19 No constructive Notice

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

7.20 Alteration in the Policy

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

decision of the Company.

7.21 Cancellation/Termination (other than Free Look)

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

Refund % to be applied on Policy Premium

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the Policy.

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.

7.22 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.

7.23 Communication

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

All notifications and declarations for the Company must be in writing and sent to the address specified in the Certificate of Insurance. 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.

7.24 Overriding effect of the Certificate of Insurance

8. Coverage Summary

Benefits	Short Description	Limits
Medical Expenses	Coverage for medical expenses against illness/injury that requires Inpatient and Day Care Treatment up to the sum insured. It also covers Pre and Post Hospitalization for 60 and 90 days respectively.	Sum Insured is limited to the selected combination of aggregate deductible and Sum Insured
Domiciliary Hospitalization	Reasonable and Customary charges are payable for medical treatment incurred during Domiciliary Hospitalization as defined under this Policy, provided that the condition for which the medical treatment is required continues for at least three days.	Sum Insured is limited to the selected combination of aggregate deductible and Sum Insured
Maternity Cover	Coverage up to Rs 1 lakh for the maternity expenses incurred on Inpatient Treatment during the Policy Period. Benefit shall become available only after the expiry of 12 months from the date of inception of the first Policy with the Company. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person	Sum Insured is limited to 1,00,000 and subject to Aggregate Deductible

Organ Donor	This cover will indemnify the Policyholder/Insured Person for the medical expenses (up to the S.I) incurred during Hospitalization, in respect of donor for any organ transplant Surgery conducted on insured person during the Policy period	Sum Insured is limited to the selected combination of aggregate deductible and Sum Insured
AYUSH treatment	Coverage for Medical Expenses which are incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to the Sum Insured The AYUSH treatment should be carried out in an AYUSH Hospital or AYUSH Day Care **Centre** as defined under the **Policy**	Sum Insured is limited to the selected combination of aggregate deductible and Sum Insured
Ambulance Cover	Coverage up to an amount of Rs 3500 per Hospitalization for Expenses incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider	3500 per hospitalization
Modern Treatment Methods	Coverage up to 50%of S.I under this benefit for the medical expenses incurred during the Policy Period on Inpatient or Daycare Treatment of mentioned Modern Treatment Methods in the policy wordings	Sum Insured is limited to 50% of the selected Sum Insured subjected to aggregate deductible

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 as well as simple Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

2. Other operations on the middle & internal ear

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

3. Operations on the nose & the nasal sinuses

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

4. Operations on the eyes

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

5. Operations on the skin & subcutaneous tissues

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

6. Operations on the tongue

60. Incision, excision and destruction of diseased tissue of the tongue
61. Partial glossectomy

62. Glossectomy
63. Reconstruction of the tongue
64. Other operations on the tongue

7. Operations on the salivary glands & salivary ducts

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

8. Other operations on the mouth & face

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

9. Operations on the tonsils & adenoids

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

10. Operations on the breast

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

11. Operations on the digestive tract,Kidney and Bladder

91. Incision and excision of tissue in the perianal region
92. Surgical treatment of anal fistulas
93. Surgical treatment of hemorrhoids
94. Division of the anal sphincter (sphincterotomy)
95. Other operations on the anus
96. Ultrasound guided aspirations
97. Sclerotherapy, etc.
98. Laparotomy for grading Lymphoma with Splenectomy / Liver / Lymph Node Biopsy
99. Therapeutic Laparoscopy with Laser
100. Cholecystectomy and Choledocho-Jejunostomy / Duodenostomy / Gastrostomy / Exploration Common Bile Duct
101. Esophagoscopy, gastroscopy, duodenoscopy wit 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 of Uterus
114. Other operations on the uterine cervix
115. Incision of the uterus (hysterectomy)
116. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
117. Incision of vagina
118. Incision of vulva
119. Culdotomy
120. Operations on Bartholin's glands (cyst)
121. Salpingo-Oophorectomy via Laparotomy

13. Operations on the prostate & seminal vesicles

122. Incision of the prostate
123. Transurethral excision and destruction of prostate tissue

124. Transurethral and percutaneous destruction of prostate tissue

125. Open surgical excision and destruction of prostate tissue

126. Radical prostatovesiculectomy

127. Other excision and destruction of prostate tissue

128. Operations on the seminal vesicles

129. Incision and excision of periprostatic tissue

130. Other operations on the prostate

14. Operations on the scrotum & tunica vaginalis testis

131. Incision of the scrotum and tunica vaginalis testis

132. Operation on a testicular hydrocele

133. Excision and destruction of diseased scrotal tissue

134. Other operations on the scrotum and tunica vaginalis testis

15. Operations on the testes

135. Incision of the testes

136. Excision and destruction of diseased tissue of the testes

137. Unilateral orchidectomy

138. Bilateral orchidectomy

139. Orchidopexy

140. Abdominal exploration in cryptorchidism

141. Surgical repositioning of an abdominal testis

142. Reconstruction of the testis

143. Implantation, exchange and removal of a testicular prosthesis

144. Other operations on the testis

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

145. Surgical treatment of a varicocele and a hydrocele of the spermatic cord

146. Excision in the area of the epididymis

147. Epididymectomy

17. Operations on the penis

148. Operations on the foreskin

149. Local excision and destruction of diseased tissue of the penis

150. Amputation of the penis

151. Other operations on the penis

18. Operations on the urinary system

152. Cystoscopical removal of stones

153. Catheterisation of Bladder

19. Other Operations

154. Lithotripsy

155. Coronary angiography

156. Biopsy ofTemporal Artery for Various Lesions

157. External Arterio-venous Shunt

158. Haemodialysis

159. Radiotherapy for Cancer

160. Cancer Chemotherapy

161. Endoscopic polypectomy

20. Operations of bones and joints

162. Surgery for ligament tear

163. Surgery for meniscus tear

164. Surgery for hemoarthrosis/pyoarthrosis

165. Removal of fracture pins/nails

166. Removal of metal wire

167. Closed reduction on fracture, luxation

168. Reduction of dislocation under GA

169. Epiphyseolysis with osteosynthesis

170. Excision of Bursirtis

171. Tennis Elbow Release

172. Excision of Various Lesions in Coccyx

Annexure F

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

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified 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	Cerebrovas-cular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.

7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer’s disease, unspecified; F00.9 - G30.9Dementia in Alzheimer’s disease, unspecified, G20 - Parkinson’s disease.
12	Demyelinating disease	G.35 to G 37

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

ANNEXURE-B

Ombudsman Office	
Office Details	**Jurisdiction**
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**AHMEDABAD - Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road,Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	**BENGALURU - Smt. Neerja Shah** Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road,JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	**BHOPAL - Shri Guru Saran Shrivastava** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa.	**BHUBANESHWAR - Shri Suresh Chandra Panda** Office of the Insurance Ombudsman, 62, Forest park,Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	**CHANDIGARH - Dr. Dinesh Kumar Verma** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in

Ombudsman Office	
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	**CHENNAI - Shri M. Vasantha Krishna** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi.	**DELHI - Shri Sudhir Krishna** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI - Shri Kiriti .B. Saha** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**HYDERABAD - Shri I. Suresh Babu** Office of the Insurance Ombudsman, 6-2-46, 1st floor, “Moin Court”,Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	**JAIPUR - Smt. Sandhya Baliga** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**ERNAKULAM - Ms. Poonam Bodra** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in

Ombudsman Office	
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA -** Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	**LUCKNOW -** **Shri Justice Anil Kumar Srivastava** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	**MUMBAI -** **Shri Milind A. Kharat** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in

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