RELIANCE - GROUP MEDICLAIM SUPER TOP UP INSURANCE PLAN A: NON-EMPLOYER EMPLOYEE RELATIONSHIP - POLICY WORDINGS

SECTION 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.

SECTION 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.

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

2) **Act** means the Insurance Act,1938.

3) **Age** or Aged means "Age as on last birthday" as determined on the date of first Policy issuance or at Renewal. In case of change in Age during the proposal stage then "Age" shall be determined on the date of Proposal Form submission would be considered for premium calculation.

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

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

6) **Annexure** means a document attached and marked as Annexure to this Policy.

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

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

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

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

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

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

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

11) **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).

12) **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.

13) **Break in Insurance/Policy** Break in policy means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

14) **Cashless Facility** means a facility extended by the insurer or TPA on behalf of the insurer to the Insured, where the payments for the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

15) **Certificate of Insurance** means 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).

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

17) **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.

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

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

20) **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"

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

22) **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.

23) **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.

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

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

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.

26) **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, and which would have otherwise required Hospitalization of more than 24 hours.

b. Treatment normally taken on an OPD basis is not included in the scope of this

c. definition.

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

27) **Deductible** means a cost-sharing requirement under this Policy which provides that the Company shall not be liable for a specified monetary rupee amount, or for a specified number of days or hours, which will apply before any benefit are payable by Company for every Claim made under the Policy. 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.

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

29) **Dependent Child** means Insured Person's biological or legally adopted son or daughter, whose completed age is between 3 months to 25 years as on Policy Period Start Date, and who

is unmarried and financially dependent on the Insured Person and does not have an independent source of income

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

31) **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.

32) **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.

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

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

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

34) **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.

35) **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 maximum six Dependent Children (biological or adopted) upto the age of 25 years.

36) **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

37) **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 than 10,00,000 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;

38) **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.

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

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

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

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

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

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

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

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

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

45) **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.

46) **Maternity Expenses** means;

a. Medical Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization), and neo-natal Medical Expenses incurred during the same Hospitalization;

b. Expenses towards lawful medical termination of pregnancy.

47) **Master Policy Holder** means an entity, who facilitates selling and solicitation of this Policy and there is a clearly evident relationship between the entity and the Insured Person 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.

48) **Master Policy Period** means 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.

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

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

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

52) **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.

53) **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.

54) **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 should not be the Policyholder/Insured or their close Family member.

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

55) **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.

56) **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

57) **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.

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

59) **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.

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

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

62) **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.

63) **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.

64) **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.

65) **Policy Period** 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.

66) **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

67) **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

68) **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.

69) **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.

70) **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.

71) **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.

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

73) **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.

74) **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.

75) **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.

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

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

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

79) **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.

80) **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.

81) **Terrorism/Terrorism Incident:** Terrorism 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

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

83) **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.

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

SECTION 3: SCOPE OF COVER

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.

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

3A: Built-in Covers

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/ Insured Person 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/Insured Person 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/ Insured Person 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 continuous and completed days, during the Policy Period,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.

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

- Asthma
- Bronchitis
- Chronic Nephritis and Chronic Nephritic/Nephrotic Syndrome
- Diarrhoea and all types of Dysenteries including Gastroenteritis
- 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 Policy Schedule.

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

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

iv. For a covered delivery or termination, Medical Expenses of pre-natal and post-natal hospitalization shall be covered within the Maternity limit of Rs. 1 lakh.

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 Period, 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, Siddha, and 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 AYUSH 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. Treatment like Panchakarma and all the variants of Panchakarma.

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 Inpatient 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 Treatment of 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: 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 Sections 3.1 and 3.2

3 B Optional Covers

3.8 Benefit-8: Personal Accident

The covers listed below are Optional Personal Accident covers and are available to the Insured persons except Dependent Children as defined under the Policy. For the covers opted and specified in the Certificate of Insurance, the Company shall be liable to pay the Insured Person/Nominee/Legal Heir/Assignee as stated in the Certificate of Insurance, for claims subject to below mentioned terms and conditions.

3.8.1 Accidental Death

If Insured Person shall sustain an injury , resulting solely and directly, from an Accident during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the Insured Person, then the Company shall be liable to pay the Personal Accident Sum Insured to Nominee /Legal Heir/Assignee as stated in the Certificate of Insurance.

3.8.2 Permanent Total Disability

In the event of opting this cover, if such Insured Person shall sustain any injury, resulting solely and directly, from an Accident during the Policy Period and if such injury shall, within twelve calendar months of its occurrence, be the sole and direct cause of

I. The total and irrecoverable loss of:

a. Sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand and one entire foot, or of such loss of sight of one eye and such loss of one entire hand or one entire foot, or

b. Use of two hands or two feet, or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot,

OR

II. Immediate, permanent, total and absolute disablement of the Insured Person from engaging in, being occupied with or giving attention to any employment or occupation of any description whatsoever then the Company shall be liable to pay the Personal Accident Sum Insured to Insured Person/ Nominee/Legal Heir/Assignee as stated in the Certificate of Insurance.

3.8.3 Permanent Partial Disability

In the event of opting this cover, if such Insured Person shall sustain any injury, resulting solely and directly, from an Accident during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and/or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the Company shall be liable to pay a percentage of the Personal Accident Sum Insured as indicated below, to the Insured Person/Nominee /Legal Heir/Assignee as stated in the Certificate of Insurance:

Description of loss	Percentage of Personal Accident Sum Insured
Loss of Sight of one eye, or of the actual loss by physical separation of one entire hand or of one entire foot / leg	50%
Loss of Use of a hand or a foot / leg without physical separation	50%
Loss of toes	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost each	1%
Loss of hearing - both ears	75%
Loss of hearing - one ear	30%
Loss of four fingers and thumb of one hand	40%
Loss of four fingers	35%
Loss of thumb - both phalanges	25%
Loss of thumb - one phalanx	10%
Loss of index finger - three phalanges or two phalanges or one phalanx	10%

Loss of middle finger - three phalanges or two phalanges or one phalanx	6%
Loss of ring finger - three phalanges or two phalanges or one phalanx	5%
Loss of little finger - three phalanges or two phalanges or one phalanx	4%
Loss of metacarpals - first or second (additional) or third, fourth or fifth (additional)	3%
Any other permanent partial disablement	Percentage as assessed by a panel doctor of the Company

3.8.4 Burns and Broken Bones

In the event of opting this cover, if such Insured Person shall sustain any burn injury or any injury , resulting solely and directly, from an Accident during the Policy Period, and if such injury shall within ninety days of its occurrence be the sole and direct cause of burn injuries or fracture as listed below, then the Company shall be liable to make payment as per details indicated below, to the Insured Person/Nominee /Legal Heir/ Assignee as stated in the Certificate of Insurance:

Benefit name	Injury	Option (I)	Option (ii)	Option (iii)
Broken Bones*	Category Site of fracture	Rs.	Rs.	Rs.
Category 1	Hip or Pelvis (excluding thigh or coccyx)	60000	40000	25000
Category 2	Thigh or Heel	150000	100000	70000
Category 3	Lower leg, skull	100000	70000	50000
Category 4	Colles type fracture of the lower arm, clavicle, ankle, lbows, upper or lower arm (including wrist)	60000	40000	25000
Category 5	Shoulder blade, knee cap, sternum, hand (excluding fingers and wrist), foot (excluding toes or heel)	85000	60000	40000
Category 6	Spinal Column (Vertebrae but excluding coccyx)	190000	130000	85000
Category 7	Lower Jaw	45000	30000	20000
Category 8	Rib or ribs, cheekbone, coccyx, upper jaw, nose, toe or toes, finger or fingers	60000	40000	25000
Category 10	Internal Injuries	60000	40000	25000
Total Payout limit for Broken Bones during each Policy Period		250000	150000	100000

Burns: Second or Third Degree burns on	% of Personal Accident Sum Insured**
Atleast 27% of body surface	100%
Atleast 18% of body surface	80%
Atleast 9% of body surface	40%
Atleast 4.5% of body surface	20%

*No benefit will be paid before any fracture is recognized medically and a Medical Practitioner has established the extent and nature of the fracture.

** The % defined above is on the basis of Rules of Nine used in medical literature.

Specific Conditions related to Section 3B :Optional Cover (Personal Accident)

i. For opting any other cover under Section 3.8, it is mandatory to opt for 3.8.1 Accidental Death

ii. The benefit of claim under Benefit 3.8.1 and 3.8.2 is payable only once for any Insured Person. Accordingly, if the Insured Person/Nominee / Legal Heir / Assignee reports a claim under either Benefit 3.8.1 or 3.8.2 and the same is admitted by the Company, then no further claim shall be payable under either of these Benefits and Section 3.8 Personal Accident shall become inoperative for that Insured Person.

iii. The total payout for all claims under Sections 3.8.1, 3.8.2 and 3.8.3 in any one Policy Period shall be limited to the Personal Accident Sum Insured specified in the Certificate of Insurance.

iv. In case of more than one fracture occurring due to a single accident, the claim under Benefit 3.8.4 Burns and Broken Bones shall be payable against the highest applicable payout category listed in the table.

v. The following definitions shall apply to Section 3.8:

a. Coccyx means the bottom part of the vertebral column, consisting of 3-5 fused or semi fused bones

b. Colles' fracture means an extension fracture of the distal end of the radius just above the wrist to due to trauma.

c. Complete fracture means a type of fracture due to trauma, where in a bone breaks into two or more parts

d. Compound fracture means a type of fracture due to trauma, where in a bone snaps into two or more pieces and the bone breaks through the skin

e. Compression fracture means Crushing fracture of the vertebrae. A vertebral compression fracture occurs when the block-like part of an individual bone of the spine (vertebra) become compressed due to trauma.

f. Multiple Fracture means more than one fracture in the same bone

g. Physical Separation of a hand means separation at or above the wrist and of the foot means at or above the ankle.

h. Rules of nine means a method of estimating the extent of burns, expressed as a percentage of total body surface. In this method, the body is divided into sections of 9 percent, or multiples of 9 percent, each:

- Head and neck, 9 percent;
- Anterior trunk,18 percent;
- Posterior trunk,18 percent;
- Each upper limb 9percent;
- Each lower limb, 18 percent;
- Genitalia and perineum, 1 percent

i. Second degree Burns means Burns which penetrate the epidermis and affect the dermis (lower layer of skin) which causes pain, redness, swelling and blistering

j. Third Degree Burns means full skin thickness burns and penetrate the dermis and affected deeper tissues. They result in white or blackened, charred skin that may be numb.

Specific Exclusions applicable to Section 3B :Optional Cover (Personal Accident) The Company shall not be liable to make any payment under any benefits under Section 3.8 (Personal Accident) if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:

a. Suicide or self inflicted Injury.

b. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time.

c. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of the Company's risk, if not accepted and endorsed by the Company on the Policy Schedule.

d. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.

e. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.

f. Body or mental infirmity or any Illness except where such condition arises directly as a result of an Accident during the Policy Period.

g. Nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

h. Insured Person committing or attempting to commit a breach of law with criminal intent.

i. 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.

j. No claim shall be payable under Section 3.8 against any Pre-Existing Disability/Accidental injury. Pre-Existing Disability / Accidental injury means any disability or injury present prior to the commencement of Policy Period, or resulting from an Accident which occurred prior to the commencement of Policy Period; whether or not the same has been treated, and any illness, complication or ailment arising out of or connected to such disability, injury or Accident.

k. No claim shall be payable under Benefit 3.8.4 Burns and Broken Bones, arising directly or indirectly due to any of the following:

- Any fracture due to osteoporosis or a malignant disease
- Any hair line fracture.

SECTION 4: WAITING PERIOD

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

i. 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 24/36 months (as specified in Policy Schedule)of continuous coverage after the date of inception of the first Policy with Insurer

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

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

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

ii. Specified disease/procedure waiting period (Code: 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 us. This exclusion shall not be applicable for claims arising due to an accident.

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

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

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

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

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

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

iii. 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

SECTION 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:

1) 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.

2) Rest Cure, rehabilitation and respite care (Code: Excl05)
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3) Obesity/ Weight Control (Code: Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the Doctor
   b. The surgery/Procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI);
      - Greater than or equal to 40 or
      - Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        - o Obesity-related cardiomyopathy
        - o Coronary heart disease
        - o Severe Sleep Apnea
        - o Uncontrolled Type2 Diabetes
4) 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
5) 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.
6) 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, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
7) 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.
8) 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)
9) Substance Abuse and Alcohol (Code: Excl12): Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
10) Wellness and Rejuvenation (Code: Excl13): Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
11) Dietary Supplements & Substances (Code: 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.
12) Refractive Error (Code: Excl15): Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
13) Unproven Treatments-Code (Code: Excl16): Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14) 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
15) Aggregate Deductible: Company is not liable for any payments under this Policy unless the Medical Expenses incurred during the Policy Period exceeds the Aggregate Deductible.
16) Dental Treatments: Dental Treatments of any kind, unless requiring Hospitalisation due to an Accident.
17) External Congenital Anomaly: External Congenital Anomaly
18) Treatment other than Medically Necessary Treatment: Any treatment or part of a treatment that is not Medically Necessary Treatment.
19) Non-medical expenses: Any non-medical expenses mentioned in Annexure A.
20) Nuclear and radiological emissions, acts of terrorism
21) Outpatient treatment: Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.
22) Overseas treatment: Any treatment taken by Insured Person availed outside India.
23) Charges other than Reasonable & Customary Charges: Any Medical Expenses which are not reasonable and Customary Charges.
24) Self-injury or suicide: Any intentional self-inflicted Injury, suicide or attempted suicide.
25) 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/she is licensed or any kind of self-medication.

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26) 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.

27) 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) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

SECTION 6: CLAIMS PROCEDURE

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the Condition Precedent to the admissibility of the Claim. Upon the discovery or happening of any disease or Illness / Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to the admissibility of the Claim, the Insured Person shall undertake the following:

6.1 Claim Intimation

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

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

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

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

a. Policy Number

b. Name of the Policyholder

c. Name of the Insured Person in whose relation the Claim is being lodged

d. Nature of Illness / Injury

e. Name and address of the attending Medical Practitioner and Hospital

f. Date of Admission

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 Insured Person and the TPA/Company will confirm such Cashless authorization / rejection in writing or by other means.

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

d. The Company/TPA (On behalf of Company) reserves the right to review each Claim for Hospitalization expenses and coverage will be determined according to the terms and conditions of this Policy. The Insured Person shall, in any event, be required to settle all other expenses, co-payment (if applicable) and / or 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 Claim Documents 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 Claim Documents shall be provided by the Insured Person, to TPA/Company immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

6.3 Responsibility of Certificate Holder

a. 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.

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

c. 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.

d. The Certificate Holder/ Insured Person is required to check the applicable list of Network Hospitalization the TPA/Company's websiteor call centre before availing the Cashless services.

e. 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.

f. On occurrence of an event which will lead to a Claim under this Policy, the Certificate Holder or Insured Person shall:

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

6.4 Responsibility of Policyholder (i.e. Employer)

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

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

i. Duly completed and signed Claim Form, in original

ii. Medical Practitioner's referral letter advising Hospitalization

iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation

iv. Original bills, receipts and discharge card from the Hospital/ Medical Practitioner

v. Original bills from pharmacy / chemists

vi. Original pathological / diagnostic test reports and payment receipts

vii. Ambulance receipt and bill

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

ix. Post mortem report, if applicable

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, as per the provisions of the IRDAI's 'Modified Guidelines on Product Filing in Health Insurance Business – Norms on Proportionate Deductions' Dated 11th June 2020, The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- 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.
- The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sublimit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in section 3.1.1(i.e. Inpatient Treatment) barring the below mentioned expense break ups:

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- 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	Payable claim amount	F – Deductions for Policy Deductibles and Limits

Proportionate Deduction is subject to the following:

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

6.7 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 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 initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Company shall settle the Claim within 45 days from the date of receipt of last necessary document.

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

SECTION 7: GENERAL TERMS AND CLAUSES (APPLICABLE TO ALL BENEFITS UNDER THE POLICY):

1) Disclosure to information

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

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

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

2) Risk-level Loading

A risk loading may be applied on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual will not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person.

These loadings shall be applied on the premium for the First Policy including subsequent Renewal(s) under Reliance- Group Mediclaim Super Top Up Insurance or on the increased Sum Insured (on request and acceptance for increase in Sum Insured).

The applicable risk loading shall be informed to the Proposer through a counter offer letter, which is required to be responded to, with consent and additional premium (if any), within 7 days of the issuance of such counter offer letter. In case such counter offer is neither accepted nor reverted to within 7 days, the application for insurance shall stand cancelled and refund the premium paid within next 7 days.

Please note that the Certificate of Insurance shall be issued by the Company only after receipt of consent and additional premium (if any).

The application of loading does not mean that the Illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned under Section 4 Waiting Period or specifically mentioned on the Master Policy Schedule or Certificate of Insurance shall be applied on the Illness/condition, as applicable.

3) 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.

4) Moratorium Period

After completion of sixty continuous months under the Policy

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

5) Observance of terms and conditions

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

6) 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) 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.

8) Complete discharge

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

9) Multiple Policies

a. 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.

b. 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.

c. 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.

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

10) Cause of Action

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

11) Fraud

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

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

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

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

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

c. Any other act fitted to deceive; and

d. 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.

12) Limitation Period

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

13) Claim Settlement (provision for Penal Interest)

a. 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.

b. 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.

c. 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.

d. 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).

14) Renewal of Policy

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

b. The Company shall endeavour to give notice for renewal.

However, the Company is not under obligation to give any notice for renewal.

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

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

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

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

g. Renewal of Certificate of Insurance shall be allowed only as long as the Master Policy is in force, and such renewal shall be in line with agreed terms of renewal of the Master Policy.

15) Withdrawal of Policy

a. 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.

b. 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

16) Possibility of Revision of Terms of the Policy Including the Premium

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

17) Migration

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

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

18) Portability

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

For Detailed Guidelines on portability, kindly refer the www.irdai.gov.in

(Circular- IRDA/HLT/REG/CIR/003/012020, dated 01012020)

19) 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.

20) 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.

21) 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.

22) 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.

23) 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.

24) Endorsements (Midterm Addition/Deletion)

a. Mid-Term Addition of Family: Mid-term addition of Family members shall be allowed on pro-rata basis only in the event of following:
   - Newborn baby covered from 90 days
   - Spouse in the event of marriage.

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

c. The Company may at any time terminate coverage to the Policyholder or his/her Family members on grounds as specified in Section 7 Clause (i) Disclosure to information norm, by giving 30 days' notice and by sending an

endorsement to Policyholder's address shown in the Policy Schedule /Certificate of Insurance without refund of premium.

25) Cancellation of Master Policy

a. Master Policy Holder may terminate this Policy at any time by giving Company a written notice, and the Policy shall terminate when such written notice is received by the Company.

b. Company may terminate this Policy on grounds as specified in Clause 1 of Terms and Conditions, upon 15 days' notice by sending an endorsement to Master Policy Holder's address or Email Id shown in the Master Policy Schedule. All existing Certificates of Insurance will not be affected and will continue to be in force until the end of the said Policy Period as mentioned in that Certificate of Insurance.

26) Cancellation of Certificate of Insurance

a. The Policyholder may cancel this Certificate of Insurance by giving 7 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

In case of no claim in the policy,In the event of cancellation by the insured the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

Calculation of Pro-Rata refund:

Return Premium = Total Policy Premium * (1-(Number of Policy days expired/Total Policy Days) For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = 10000 * (1- (243 / 365)) = Rs. 3342.47.

In case of claim in the policy,

Where any claim has been admitted or has been lodged by the person under the Policy, there shall be no refund of premium for the Policy Year in which the claim occurs.

For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000. Considering the claim year is 1st Year (200 days), then no refund shall be made for the Policy Year.

b. The Company may cancel the Certificate of Insurance at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

27) 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.

28) 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 email.

29) Overriding effect of the Certificate of Insurance

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

30) Special Provisions

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

31) Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy. The Insured Person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

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

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

32) Redressal of Grievances

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

Website: www. Relianceada.com

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

E-mail: rgicl.services@relianceada.com

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

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

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

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

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

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

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

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

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

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective

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area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

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

SECTION 8: COVERAGE DETAILS

Built-in Covers		
Cover	**Brief Description**	**Limits**
1. Medical Expenses	This cover indemnifies the insured for any medical expenses incurred on Inpatient Treatment. Pre-Hospitalization and Post- Hospitalization is also covered for the insured for that instance inpatient treatment This shall also cover Day Care Treatment - i.e. indemnify the insured for the medical expenses incurred under Day care procedure as advised by Medical Practitioner.	Sum Insured is limited to the selected combination of aggregate deductible and Sum Insured
2. Domiciliary Hospital-ization	This cover indemnifies the Insured Person for the medical expenses incurred for treatment under Domiciliary hospitalization	Within the Sum Insured subject to Aggregate Deductible
3. Maternity Cover	This cover will indemnify the Insured Person for the Medical Expenses related to pregnancy, childbirth, pre and post natal hospitalisation or medically recommended and lawful termination of pregnancy	Limited to 1,00,000 subject to Aggregate Deductible; available with Aggregate Deductible of Rs 2 lakhs and above
4. Organ Donor	This cover will indemnify the Insured Person for the Medical Expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery performed on insured	Within the Sum Insured subject to Aggregate Deductible
5. AYUSH Treatment	This cover will indemnify the Insured Person for the Medical Expenses incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa Riga and Homeopathy	Within the Sum Insured subject to Aggregate Deductible
6. Ambulance Cover	The cover indemnifies the Insured Person for expenses on availing Ambulance services offered by a Hospital or by an Ambulance service provider on Inpatient hospitalization	3500 per hospitalization
7. Modern Treatment Methods	This cover indemnifies the insured for the medical expenses incurred on treatment of listed Modern Treatment Methods	Limited to 50% of the selected Sum Insured subject to aggregate deductible
Optional Covers (Personal Accident)**		
8. Accidental Death	This Cover compensates the Insured Person / Nominee/Legal Heir / Assignee for the Death of an Insured Person caused by an Accidental injury	Personal Accident Sum Insured: Option from Rs. 1 lakh up to Rs. 25 lakhs, in Multiples of 1 lakh.
9. Permanent Total Disability	This Cover compensates the Insured Person / Nominee / Legal Heir / Assignee for the Permanent Total Disability caused by an Accidental injury	
10.Permanent Partial Disability	This Cover compensates the Insured Person for the Permanent Partial Disability caused by an Accident	
11.Burns and Broken Bones	This Cover compensates the Insured Person for the medical expenses incurred for Burns and Broken bones caused by an Accident	Broken Bones: Option (I): Rs. 2.5 lakhs Option (ii): Rs. 1.5 lakhs Option (iii): Rs. 1 lakh Sum Insured for Burns shall be the same as the Personal Accident Sum Insured

* For opting any other optional covers, it is mandatory to opt for Accidental Death cover.

** Payment for Permanent Partial Disability, Burns and Broken Bones as per pre-defined benefit table.

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

S. 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.	LEGGINGS
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, ORTHO KIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

S. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS

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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.	PULSE OXYMETER CHARGES

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

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

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

S. 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

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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.	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.	40. REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
41.	OPERATION OF CATARACT
42.	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
43.	ANTERIOR CHAMBER PARACENTESIS/CYCLODIATHERMY/ CYCLOCRYOTHERAPY/GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
44.	ENUCLEATION OF EYE WITHOUT IMPLANT
45.	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
46.	LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
5.	**OPERATIONS ON THE SKIN & SUBCUTANEOUS TISSUES**
47.	INCISION OF A PILONIDAL SINUS
48.	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
49.	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
50.	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
51.	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
52.	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
53.	FREE SKIN TRANSPLANTATION, DONOR SITE
54.	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
55.	REVISION OF SKIN PLASTY
56.	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES.
57.	CHEMOSURGERY TO THE SKIN.
58.	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
59.	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
6.	**OPERATIONS ON THE TONGUE**

60.	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
61.	PARTIAL GLOSSECTOMY
62.	GLOSSECTOMY
63.	RECONSTRUCTION OF THE TONGUE
64.	OTHER OPERATIONS ON THE TONGUE
7.	**OPERATIONS ON THE SALIVARY GLANDS & SALIVARY DUCTS**
65.	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
66.	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
67.	RESECTION OF A SALIVARY GLAND
68.	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
69.	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
8.	**OTHER OPERATIONS ON THE MOUTH & FACE**
70.	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
71.	INCISION OF THE HARD AND SOFT PALATE
72.	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
73.	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
74.	PALATOPLASTY
75.	OTHER OPERATIONS IN THE MOUTH
9.	**OPERATIONS ON THE TONSILS & ADENOIDS**
76.	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
77.	TONSILLECTOMY WITHOUT ADENOIDECTOMY
78.	TONSILLECTOMY WITH ADENOIDECTOMY
79.	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
80.	OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
81.	TRAUMA SURGERY AND ORTHOPAEDICS
82.	INCISION ON BONE, SEPTIC AND ASEPTIC
83.	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
84.	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
85.	REDUCTION OF DISLOCATION UNDER GA
86.	ARTHROSCOPIC KNEE ASPIRATION
87.	ADENOIDECTOMY
10.	**OPERATIONS ON THE BREAST**
88.	INCISION OF THE BREAST ABSCESS
89.	OPERATIONS ON THE NIPPLE
90.	EXCISION OF SINGLE BREAST LUMP
11.	**OPERATIONS ON THE DIGESTIVE TRACT,KIDNEY AND BLADDER**
91.	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
92.	SURGICAL TREATMENT OF ANAL FISTULAS
93.	SURGICAL TREATMENT OF HEMORRHOIDS
94.	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
95.	OTHER OPERATIONS ON THE ANUS
96.	ULTRASOUND GUIDED ASPIRATIONS
97.	SCLEROTHERAPY, ETC.
98.	LAPAROTOMY FOR GRADING LYMPHOMA WITH SPLENECTOMY/LIVER/LYMPH NODE BIOPSY
99.	THERAPEUTIC LAPAROSCOPY WITH LASER
100.	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/ EXPLORATION COMMON BILE DUCT
101.	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY / REMOVAL OF FOREIGN BODY/ DIATHERMY OF BLEEDING LESIONS
102.	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
103.	EXCISION OF RENAL CYST
104.	DRAINAGE OF PYONEPHROSIS/PERINEPHRIC ABSCESS
105.	APPENDICECTOMY WITH/WITHOUT DRAINAGE
12.	**OPERATIONS ON THE FEMALE SEXUAL ORGANS**
106.	INCISION OF THE OVARY
107.	INSUFFLATIONS OF THE FALLOPIAN TUBES
108.	OTHER OPERATIONS ON THE FALLOPIAN TUBE
109.	DILATATION OF THE CERVICAL CANAL
110.	CONISATION OF THE UTERINE CERVIX
112.	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/ DIATHERMY/CRYOSURGERY/
113.	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
114.	OTHER OPERATIONS ON THE UTERINE CERVIX
115.	INCISION OF THE UTERUS (HYSTERECTOMY)
116.	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
117.	INCISION OF VAGINA
118.	INCISION OF VULVA
119.	CULDOTOMY
120.	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
121.	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
13.	**OPERATIONS ON THE PROSTATE & SEMINAL VESICLES**
122.	INCISION OF THE PROSTATE

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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.	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

The list above is indicative. The Company reserves the right to modify the list from time to time. However any deletion in the list of surgeries would be after IRDA approval.

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OMBUDSMAN OFFICE			
Office of the Ombudsman	**Address**	**Contact Details**	**Areas of Jurisdiction**
AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 001.	Tel.: 079 - 27546150/27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078.	Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	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@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009.	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneshwar@cioins.co.in	Orissa
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DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@cioins.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar Over Bridge, S.S. Road, Guwahati – 781001 (ASSAM).	Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, LIC OF INDIA, 10th Floor, 'Jeevan Prakash', Divisional Office, M. G. Road, Ernakulam, Kochi – 682011.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry.
KOLKATA	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@cioins.co.in	West Bengal, UT of Andaman & Nicobar Islands, Sikkim

LUCKNOW	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@cioins.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, Ambedkar Nagar, Sultanpur, Maharajgang, Sant Kabir Nagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharath Nagar.
MUMBAI	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@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist: Gautam Buddh Nagar, U.P. - 201301.	Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	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, Gautam Budha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006.	Tel.: 0612 - 2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	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@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on IRDAI website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.reliancegeneral.co.in

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