Preamble: The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured/Insured Persons (also referred as You) and Religare Health insurance Company Ltd. (also referred as We/Us), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The 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. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

All the Policy documents are as per the format prescribed, guided & approved by the Indian Insurance Regulator, honorable "Insurance Regulatory and Development Authority of India" which is constituted as per IRDA Act, 1999. The Policy construction is driven by IRDA Regulations and Protection of Policy Holder's Interests, 2002.

POLICY TERMS AND CONDITIONS

1. Definitions

For the purposes of interpretation and understanding of this Policy, the Company has defined below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built in to the Policy are to be construed in accordance with the applicable provisions contained in the Policy.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

1.1. **Accident/Accidental** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.2. **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.

1.3. **Age** means the completed age of the Insured Person as on his last birthday.

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

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

1.6. **Annexure** means a document attached and marked as an Annexure to this Policy.

1.7. **Any One Illness** means a continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital/nursing home where the treatment may have been taken.

1.8. **Assistance Service Provider** means the service provider specified in the Policy Certificate appointed by the Company from time to time.

1.9. **Break in Policy** occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

1.10. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved.

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

- **i.** It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests;
- **ii.** It needs ongoing or long-term control or relief of symptoms;
- **iii.** It requires the Insured Person's rehabilitation or for the Insured Person to be specially trained to cope with it;
- **iv.** It continues indefinitely;
- **v.** It comes back or is likely to come back.

1.12. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.

1.13. **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

1.14. **Company** (also referred as We/Us) means Religare Health Insurance Company Limited.

1.15. **Condition Precedent** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

1.16. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. **Internal Congenital Anomaly**
Congenital anomaly which is not in the visible and accessible parts of the body

ii. **External Congenital Anomaly**
Congenital anomaly which is in the visible and accessible parts of the body

1.17. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same Insured to share the cost of an indemnity claim on a ratable proportion of sum insured. This clause shall not apply to any benefit offered on Fixed Benefit basis.

1.18. **Co-Payment** is 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.

1.19. **Cumulative Bonus** shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

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

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

1.21. **Day Care Treatment** refers to medical treatment and/or a surgical procedure which is:

i. undertaken under general or local anesthesia in a Hospital/Day Care Center in less than 24 hours because of technological advancement, and
ii. which would have otherwise required Hospitalization of more than 24 hours.

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

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

1.23. **Dental Treatment** is carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

1.24. **Disclosure to Information Norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

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

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

1.26. **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.

1.27. **Emergency Care (Emergency)** means management for a severe 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.

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

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

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

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

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

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

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

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.31. **Hospitalization** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

1.32. **Indemnity/Indemnify** means compensating the Policy Holder/Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

1.33. **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

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

1.35. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

1.36. **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Certificate and with respect to whom the premium has been received by the Company.

1.37. **Intensive Care Unit (ICU)** 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.

1.38. **Maternity expenses** shall include—

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

1.39. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

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

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

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

i. Is required for the medical management of the Illness or Injury suffered by the Insured Person;
ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. Must have been prescribed by a Medical Practitioner;
iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.43. **Network Provider** means the Hospitals or health care providers enlisted by the insurer or by a TPA and insurer together to provide medical services to an Insured on payment by a Cashless Facility.

1.44. **Newborn baby** means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

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

1.46. **Notification of Claim** is the process of notifying a Claim to the insurer or TPA by specifying the timelines as well as the address/telephone number to which it should be notified.

1.47. **OPD Treatment** is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

1.48. **Preventive Care** means any kind of treatment taken as a pro-active care measure without actual requirement or symptoms of a disease or illness.

1.49. **Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Certificate and Optional Cover (if applicable) which form part of the Policy and shall be read together.

1.50. **Policy Certificate** means the certificate attached to and forming part of this Policy.

1.51. **Policyholder** (also referred as You) means the person named in the Policy Certificate as the Policyholder.

1.52. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Certificate.

1.53. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Certificate.

1.54. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Certificate.

1.55. **Policy Year** means a period of 12 consecutive months commencing from the Policy Period Start Date or any anniversary thereof.

1.56. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

1.57. **Post-hospitalization Medical Expenses** means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

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

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company

1.58. **Pre-existing Disease** means any condition, ailment or Injury or related condition(s) for which the Insured Person had signs or symptoms, and/or were diagnosed, and/or received Medical Advice/treatment within 48 months prior to the first Policy issued by the insurer.

1.59. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that :

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

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

1.60. **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.

1.61. **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.

1.62. **Rehabilitation** means assisting an Insured Person who, following a Medical Condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring.

1.63. **Renewal** defines 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 all waiting periods.

1.64. **Room Rent** means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated Medical Expenses.

1.65. **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.

1.66. **Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

1.67. **Subrogation** shall mean the right of the insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.

1.68. **Sum Insured** means the amount specified in the Policy Certificate, for which premium is paid by the Policyholder.

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

1.70. **Third Party Administrator or TPA** means any person who is licensed under the IRDA (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.

1.71. **Total Sum Insured** is the sum total of Sum Insured and the Sum Insured accrued as No Claims Bonus and / or No Claims Bonus Super (Optional Cover) and/or Automatic Recharge and / or Unlimited Automatic Recharge (Optional Cover) and/or Additional Sum Insured for Accidental Hospitalization (Optional Cover). It represents the Company's maximum, total and cumulative liability for in respect of the Insured Person for any and all Claims incurred during the Policy Year. If the Policy Period is more than 12 months, then it is clarified that the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

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

1.73. **Variable Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category or ICU Charges applicable in a Hospital:

(a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;
(b) Intensive Care Unit charges;
(c) Fees charged by surgeon, anesthetist, Medical Practitioner;
(d) Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization.

<u>The following definitions are redefined which supersedes those respective definitions mentioned above, for Benefits and Optional Covers effective out of India:</u>

1.74. **Medical Practitioner** means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

1.75. **Qualified Nurse** means a person who holds a valid registration issued by the Nursing Council/Statutory Regulatory Authority for Medical Education in that Country and thereby entitled to render Nursing Care within the scope and jurisdiction of license.

1.76. **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice, is treatment experimental or unproven.

2. Benefits

General Conditions applicable to all Benefits and Optional Covers:

(a) Benefits / Optional Covers (if opted) shall be available to the Insured Person, only if the particular Benefit / Optional Cover is specifically mentioned in the Policy Certificate.

(b) Admissibility of a Claim under Benefit 1 (Hospitalization Expenses) is a pre-condition to the admission of a Claim under Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses), Benefit 3 (Daily Allowance), Benefit 4 (Ambulance Cover), Benefit 5 (Organ Donor Cover), Benefit 7 (Automatic Recharge), Benefit 14 (Care Anywhere), Benefit 15 (Maternity cover), Optional Cover 3 (Unlimited Automatic Recharge), Optional Cover 7 (Smart Select), Optional Cover 9 (Daily Allowance+), Optional Cover 11 (Additional Sum Insured for Accidental Hospitalization) and Optional Cover 15 (Air Ambulance Cover). The event giving rise to a Claim under Benefit 1 shall be within the Policy Period for the Claim of such Benefit to be accepted.

(c) The maximum, total and cumulative liability of the Company in respect of an Insured Person for any and all Claims arising under this Policy during the Policy Year shall not exceed the Total Sum Insured for that Insured Person.

I. On Floater Basis, the Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of all Insured Persons, shall not exceed the Total Sum Insured.

II. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured, No Claims Bonus (Benefit 10), No Claims Bonus Super (Optional Cover 4) and Additional Sum Insured for Accidental Hospitalization (Optional Cover 11). (NOTE: This clause is not applicable to Optional Cover 10: Personal Accident).

III. All Claims shall be payable subject to the terms, conditions, exclusions, sub-limits and wait periods of the Policy and subject to availability of the Total Sum Insured.

IV. The Company's liability shall be restricted to the payment of the balance amount subject to the available Total Sum Insured.

(d) Any Claim paid for Benefits namely Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (Daily Allowance), Benefit 4 (Ambulance Cover), Benefit 5 (Organ Donor Cover), Benefit 6 (Domiciliary Hospitalization), Benefit 9 (Alternative Treatments), Benefit 11 (Global coverage (excluding U.S.A.)), Benefit 13 (Vaccination Cover), Benefit 14 (Care Anywhere), Benefit 15 (Maternity cover) and Optional Covers namely Optional Cover 1 (Global Coverage – Total), Optional Cover 2 (Travel Plus), Optional Cover 6 ('Everyday Care' except Health Care Services), Optional Cover 7 (Smart Select), Optional Cover 8 (OPD Care), Optional Cover 9 (Daily Allowance+), Optional Cover 14 (Extension of Global Coverage), and Optional Cover 15 (Air Ambulance Cover), shall reduce the Total Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.

(e) Any Benefit or Optional cover specified to be payable under Cashless facility, would follow the procedures and settlement clauses mentioned as per Clause 6.2 (a).

(f) Any Benefit or Optional cover specified to be payable under Reimbursement facility, would follow the procedures and settlement clauses mentioned as per Clause 6.2 (b).

(g) The Co-payment, if and as specified in the Policy Certificate, shall be borne by the Policyholder / Insured Person on each Claim which will be applicable on Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 4 (Ambulance Cover), Benefit 5 (Organ Donor Cover), Benefit 6 (Domiciliary Hospitalization), Benefit 9 (Alternative Treatments), Benefit 11 (Global Coverage (excluding U.S.A.)), Benefit 14 (Care Anywhere), Benefit 13 (Vaccination Cover), Benefit 15 (Maternity cover), Optional Cover 1 (Global Coverage – Total), Optional Cover 11 (Additional Sum Insured for Accidental Hospitalization), Optional Cover 14 (Extension of Global Coverage) and Optional Cover 15 (Air Ambulance Cover).

I. At the time of issue of the first Policy with the Company, if Age of Insured Person or eldest Insured Person (in case of Floater) is 61 Years or above, such Insured Person or all Insured Persons (in case of Floater) shall bear a Co-payment of 20% per Claim (over & above any other co-payment, if any).

II. On attaining 61 years of Age by an existing Insured Person or eldest Insured Person (in case of Floater), the Company provides an option to Insured Person / Policyholder, only on subsequent renewal, to choose for co-payment option of 20% per claim (over & above any other co-payment, if any) which applies to such Insured Person or all Insured Persons (in case of Floater) and thereby get a discount of 20% in Premium to be paid.

III. The Co-payment shall be applicable to each and every Claim made, for each Insured Person.

(h) Deductible Option (if opted) is applicable on the Benefits namely Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 4 (Ambulance Cover), Benefit 5 (Organ Donor Cover), Benefit 6 (Domiciliary Hospitalization), Benefit 9 (Alternative Treatments), Benefit 11 (Global Coverage – excluding U.S.A.), Benefit 14 (Care Anywhere), Benefit 15 (Maternity cover), Optional Cover 1 (Global Coverage – Total), Optional Cover 11 (Additional Sum Insured for Accidental Hospitalization), Optional Cover 14 (Extension of Global Coverage) and Optional Cover 15 (Air Ambulance Cover).

(i) Hospitalization or Medical Expenses which are 'Medically Necessary' only shall be admissible under the Policy.

(j) Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis.

(k) If the Insured Person suffers a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.

(l) Coverage amount limits for Optional Cover 2 'Travel Plus', Optional Cover 6 'Everyday Care', Optional Cover 8 'OPD Care', Optional Cover 10 'Personal Accident', Optional Cover 11 'Additional Sum Insured for Accidental Hospitalization' and Optional Cover 15 'Air Ambulance Cover' are covered over and above the Sum Insured (as defined under Definition 1.68).

(m) If Insured persons belonging to the same family are covered on an Individual basis, then every Insured person can opt for different Sum Insured and different Optional Covers.

2.1 Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an Illness or suffers an Injury which requires the Insured Person to be admitted in a Hospital in India which should be Medically Necessary during the Policy Period and while the Policy is in force for:

(i) **In-patient Care:** The Company will indemnify the Policy Holder/Insured Person for Medical Expenses incurred towards Hospitalization, through Cashless or Reimbursement Facility, maximum up to the Sum Insured as specified in the Policy Certificate, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(ii) **Day Care Treatment:** The Company will indemnify the Policy Holder/Insured Person for Medical Expenses incurred on Day Care Treatment which involves a Surgical procedure, through Cashless or Reimbursement Facility, maximum up to the Sum Insured specified in the Policy Certificate, provided that the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions and period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an in-patient admission and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

(iii) **Conditions applicable for Hospitalization Expenses (Benefit 1):**

(a) **Room/Boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category):**

1) If the Insured Person is admitted in a Hospital room where the Room Category opted or *Room Rent incurred is higher than the eligible Room Category/ Room Rent* as specified in the Policy Certificate, then,

I. The Policyholder/Insured Person shall bear the ratable proportion of the total Variable Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Policy Certificate or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

II. If specifically mentioned in the Policy Certificate that the *Room Category/ Room Rent* eligibility is "Single Private Room (upgradable to next level)", it means such up-gradation will trigger only if Single Private Room is not available in the Hospital at the time of admission and Company's liability will arise only after accepting required documented proof for such Room unavailability. In case such documented proof is not furnished, then the maximum eligible Room Category would be considered as Single Private Room only.

The Policy Certificate will specify the eligibility of Room Rent or Room Category applicable for the Insured Person under the Policy. The Room Rent or Room Category available under this Policy is mentioned as follows:

2) **Single Private Room** If the Policy Certificate states 'Single Private Room' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited to stay in a Single Private Room.

3) **Single Private Room (upgradable to next level):** If the Policy Certificate states 'Single Private Room (upgradable to next level)' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited to stay in a Single Private Room or a Single Private Room of the immediate next category.

4) If the Policy Certificate states 'up to 1% of the Sum Insured per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Person payable by the Company is limited to 1% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus under (Benefit 10) or No Claims Bonus Super (Optional Cover 4), shall not form part of Sum Insured.

5) The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

(b) Intensive Care Unit Charges (ICU Charges):

1) If the Insured Person is admitted in an ICU where the ICU charges incurred are higher than the ICU Charges specified in the Policy Certificate, then the Policyholder/Insured Person shall bear the ratable proportion of the Variable Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the ICU charges actually incurred and the ICU Charges specified in the Policy Certificate to the ICU charges actually incurred.

The Policy Certificate will specify the Limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

2) If the Policy Certificate states 'up to 2% of the Sum Insured per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Person payable by the Company is limited to 2% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus (Benefit 10) or No Claims Bonus Super (Optional Cover 4) shall not form part of Sum Insured.

3) If the Policy Certificate states the eligibility of ICU Charges of the Insured Person as 'no sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization.

(c) Expenses incurred on treatment for Named Ailments / Procedures

The Company will indemnify the Insured Person for Medical Expenses incurred in respect of the below mentioned Ailments / Procedures up to the amount specified against each and every Ailment / Procedure mentioned in the Policy Certificate in a Policy Year, provided that the treatment was taken on the advice of a Medical Practitioner. (These conditions will apply only if specifically mentioned in the Policy Certificate)

i. Treatment of Cataract
ii. Treatment of Total Knee Replacement
iii. Surgery for treatment of all types of Hernia
iv. Hysterectomy
v. Surgeries for Benign Prostate Hypertrophy (BPH)
vi. Surgical treatment of stones of renal system
vii. Treatment of Cerebrovascular and Cardiovascular disorders
viii. Treatments/Surgeries for Cancer
ix. Treatment of other renal complications and Disorders
x. Treatment for breakage of bones

2.2 Benefit 2: Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses

The Company will *indemnify the Policy Holder/Insured Person for Relevant Medical Expenses incurred which are Medically Necessary*, only through Reimbursement Facility, maximum up to the Sum Insured, as specified in the Policy Certificate, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to the conditions specified below:

(i) Under Relevant Pre-hospitalization Medical Expenses, *for a period of 30 days immediately prior to the Insured Person's date of admission to the Hospital*, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Policy Start Date; and

(ii) Under Relevant Post-hospitalization Medical Expenses, *for a period of 60 days immediately after the Insured Person's date of discharge from the Hospital*.

(iii) If the provisions of Clause 6.7(d) is applicable to a Claim, then:

a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and
b) The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

2.3 Benefit 3: Daily Allowance

The Company will pay *a fixed amount* as specified against this Benefit in the Policy Certificate, for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, subject to the conditions specified below:

(i) The Company shall not be liable to make payment under this Benefit for more than 5 consecutive days of Hospitalization for each period of Hospitalization arising from Any One Illness or Accident; and

(ii) This Benefit is valid for In-patient Care Hospitalization of the Insured Person only.

2.4 Benefit 4: Ambulance Cover

The Company will *indemnify the Insured Person*, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Certificate, for the Reasonable and Customary Charges necessarily *incurred on availing Ambulance services* offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation , provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

(i) Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or

(ii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.

2.5 Benefit 5: Organ Donor Cover

The Company will *indemnify the Insured Person*, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Certificate, for the Medical Expenses *incurred in respect of the donor, for any organ transplant surgery* during the Policy Year, subject to the conditions specified below:

(i) The Organ donor is an eligible donor in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

(ii) The Insured Person is the recipient of the Organ so donated by the Organ Donor.

(iii) The Company will not be liable to pay the Medical Expenses incurred by the Insured Person towards Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses (Benefit 2) or any other Medical Expenses in respect of the donor consequent to the harvesting.

(iv) Clause 4.2 (19) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.6 Benefit 6 : Domiciliary Hospitalization

The Company will *indemnify the Insured Person,* only through Reimbursement Facility, up to the amount specified against this Benefit in the Policy Certificate, for the Medical Expenses *incurred towards Domiciliary Hospitalization*, i.e., Coverage extended when Medically Necessary treatment is taken at home (as explained in Definition 1.25), subject to the conditions specified below:

(i) The Domiciliary Hospitalization continues for a period exceeding 3 consecutive days.

(ii) The Medical Expenses are incurred during the Policy Year.

(iii) The Medical Expenses are Reasonable and Customary Charges which are necessarily incurred.

(iv) Any Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses (Benefit 2) shall not be payable under this Benefit.

(v) Any Medical Expenses incurred for the treatment in relation to any of the following diseases *shall not be payable* under this Benefit :

1. Asthma;
2. Bronchitis;
3. Chronic Nephritis and Chronic Nephritic Syndrome;
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
5. Diabetes Mellitus and Diabetes Insipidus;
6. Epilepsy;
7. Hypertension;
8. Influenza, cough or cold;
9. All Psychiatric or Psychosomatic Disorders;
10. Pyrexia of unknown origin for less than 10 days;
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
12. Arthritis, Gout and Rheumatism.

2.7 Benefit 7 : Automatic Recharge

If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Sum Insured once in a policy year which is valid for that Policy Year only, subject to the conditions specified below:

(i) The Recharge shall be utilized only after the Sum Insured, No Claims Bonus (Benefit – 10), No Claims Bonus Super (Optional Cover – 4) and Additional Sum Insured for Accidental Hospitalization (Optional Cover – 11) has been completely exhausted in that Policy Year.

(ii) A Claim will be admissible under the Recharge only if the Claim is admissible under Benefit 1 (Hospitalization Expenses).

(iii) The Recharge is applicable only for Benefit 1 (Hospitalization Expenses).

(iv) The Recharge shall be available only for all future Claims which are not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Person during that Policy Year.

(v) No Claims Bonus (Benefit – 10) and No Claims Bonus Super (Optional Cover – 4) shall not be considered while calculating 'Automatic Recharge'.

(vi) Any unutilized Recharge cannot be carried forward to any subsequent Policy Year.

(vii) If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis.

(viii) For any single Claim during a Policy Year the maximum Claim amount payable shall be sum total of:

a) Sum Insured
b) No Claims Bonus (Benefit – 10)
c) No Claims Bonus Super (Optional Cover – 4)
d) Additional Sum Insured for Accidental Hospitalization (Optional Cover – 11)

(ix) During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum total of:

a) Sum Insured
b) No Claims Bonus (Benefit – 10)
c) No Claims Bonus Super (Optional Cover – 4)
d) Additional Sum Insured for Accidental Hospitalization (Optional Cover – 11)
e) Automatic Recharge (Benefit – 7)

(x) In case of portability, the credit for Sum Insured would be available only to the extent of sum insured of the expiring policy, including the Recharge.

2.8 Benefit 8 : Second Opinion

In the event that the Insured Person is diagnosed with any Major Illness / Injury during the Policy Year, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner within India.

(i) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the conditions specified below:

a) This Benefit can be availed only once by an Insured Person during the Policy Year for each Major Illness / Injury.

b) The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.
c) This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
d) The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.
e) The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.
f) The Policyholder or Insured Person shall hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.
g) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.
h) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

(ii) For the purposes of this Benefit only:

a) Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder's or Insured Person's express request in relation to a Major Illness / Injury which the Insured Person has been diagnosed with during the Policy Year.
b) Major Illness / Injury means one of the following only:
    1. Benign Brain Tumor
    2. Cancer
    3. End Stage Lung Failure
    4. Myocardial Infarction
    5. Coronary Artery Bypass Graft
    6. Heart Valve Replacement
    7. Coma
    8. End Stage Renal Failure
    9. Stroke
    10. Major Organ Transplant
    11. Paralysis
    12. Motor Neuron Disorder
    13. Multiple Sclerosis
    14. Major Burns
    15. Total Blindness

2.9 Benefit 9: Alternative Treatments

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount specified in the Policy Certificate, towards Medical Expenses incurred with respect to the Insured Person's medical treatment undergone at any Government hospital or in any Institute recognized by Government and / or accredited by Quality Council of India / National Accreditation Board on Health or any other suitable institutions, through any of the alternative treatments namely Ayurveda, Sidha, Unani and Homeopathy, subject to the conditions specified below:

(i) A Claim will be admissible under this Benefit only if the Claim is admissible under 'In-patient Care' of Benefit 1 (Hospitalization Expenses).

(ii) Such Hospital should directly be run by a local/state/central Government body, which administers treatment related to Ayurveda or Unani or Sidha or Homeopathy; and

(iii) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such Alternative Treatments; and

(iv) Such treatment taken is within the jurisdiction of India; and

(v) Clause 4.2 (20) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

2.10 Benefit 10: No Claims Bonus

At the end of each Policy Year, the Company will enhance the Sum Insured by 10% flat, on a cumulative basis, as a No Claims Bonus for each completed and continuous Policy Year, provided that no Claim has been paid by the Company in the expiring Policy Year, and subject to the conditions specified below:

(i) In any Policy Year, the accrued No Claims Bonus, shall not exceed 50% of the Sum Insured available in the renewed Policy.

(ii) The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 2.1(iii).

(iii) For a Floater policy, the No Claims Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Person during the expiring Policy Year. The No Claims Bonus which is accrued during the claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year.

(iv) The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later.

(v) The No Claims Bonus shall be applicable on an annual basis subject to continuation of the Policy.

(vi) If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the No Claims Bonus for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Persons.

(vii) If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 (two) or more Floater / Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.

(viii) This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 7.1 (Disclosure to Information Norm).

(ix) In the event of a Claim occurring during any Policy Year, the accrued No Claims Bonus will be reduced by 10% of the Sum Insured at the commencement of next Policy Year, but in no case shall the Total Sum Insured be reduced than the Sum Insured.

(x) In case Sum Insured under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Sum Insured.

(xi) In case Sum Insured under the Policy is increased at the time of renewal, the No Claims Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year.

(xii) The Recharge amount ('Automatic Recharge' & 'Unlimited Automatic Recharge') shall not be considered while calculating 'No Claims Bonus'.

(xiii) Along with the Benefits (Base Covers) under the Policy, accrued **'No Claims Bonus' can be utilized for** Optional Cover 1 (Global Coverage – Total), Optional Cover 9 (Daily Allowance+) and Optional Cover 14 (Extension of Global Coverage), if opted for.

(xiv) In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with 2 or 3 year policy tenure).

2.11 Benefit 11: Global Coverage (excluding U.S.A.)

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility, for Hospitalization Expenses incurred outside India and anywhere across the world excluding United States of America, up to the amount specified against this Benefit in the Policy Certificate, subject to the conditions specified below:

(i) A mandatory Co-Payment of 10% per Claim is applicable, which will be in addition to any other co-payment (if any) applicable in the Policy.

(ii) The Benefit is available for 45 continuous days from the date of travel in a Single Trip and 90 days on a cumulative basis as a whole, in a Policy Year.

(iii) The Medical expenses payable shall be limited to Benefit 15 (Maternity Cover) and Inpatient Care & Day Care Treatment under Benefit 1 (Hospitalization Expenses) only; 'Pre-Hospitalization' and 'Post-Hospitalization' expenses are not covered under the purview of this cover.

(iv) The payment of any Claim under this Benefit will be based on the rate of exchange as on the Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Loss, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

Note:

a) Clause 6.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

b) Exclusions applicable to this Benefit have been mentioned under Permanent Exclusions, Clause 4.2.

2.12 Benefit 12: Annual Health Check-up

(i) On the Policyholder's / Insured Person's request, through Cashless Facility, the Company will arrange for the Insured Person's Annual Health Check-up for the list of medical tests specified below at its Network Provider in India, subject to the conditions specified below:

a) This Benefit shall be available only once during a Policy Year per Insured Person; and
b) This benefit does not reduce the Sum Insured.

(ii) Medical Tests covered in the Annual Health Check-up, applicable for Sum Insured up to 60 Lakh Rupees for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

Set No.	List of Medical Tests covered as a part of Annual Health Check-up	Plan
1	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	Care 2, Care 3 & Care 8
2	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	Care 4 & Care 9
3	Complete Blood Count with ESR, Urine Routine, Blood Group, Fasting Blood Sugar, Lipid Profile, TMT, Kidney Function Test	Care 5 & Care 6

(iii) Medical Tests covered in the Annual Health Check-up, applicable for Care 7, for Insured Persons who are of Age 18 years or above on the Policy Period Start Date, are as follows :-

Infection Markers Complete Blood Count(CBC) ESR ABO Group & Rh Type Urine Routine Stool Routine	**Lipid Profile** Cholesterol LDL HDL Triglycerides VLDL
Liver Function Test S Bilirubin (Total/Direct) SGPT SGOT GGT Alkaline Phosphatase Total Protein Albumin : Globulin	**Kidney Function Test** Creatinine Blood Urea Nitrogen Uric Acid
Lung Function Markers Lung Function Test	**Diabetes Markers** Hba1c
Cardiac Markers Treadmill Test ECG	**Imaging Tests** X-Ray – Chest Ultrasound Abdomen

(iv) Medical Tests covered in the Annual Health Check-up, applicable for Insured Persons who are of Age below 18 years on the Policy Period Start Date for all Plans except Care 1, are as follows :-

List of Medical Tests covered as a part of Annual Health Check-up
Physical Examination (Height, Weight and Body Mass Index (BMI)), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic)

2.13 Benefit 13: Vaccination Cover:

The Company will indemnify the Insured Person up to the amount specified against this Benefit in the Policy Certificate, through Cashless or Reimbursement Facility, towards Vaccination expenses for the Insured Person(s) up to 18 years of Age, as prescribed in the National Immunization Schedule (NIS) for protection against Diphtheria, Pertussis, Tetanus, Polio, Measles, Hepatitis B and Tuberculosis, which fall under category of Vaccine preventable diseases as per the Grid provided below.

S. No	Vaccine& its presentation	Protection against	S. No	Vaccine& its presentation	Protection against
1	BCG (Bacillus Calmette Guerin)- Lyophilized vaccine	Tuberculosis	**5**	Measles - Lyophilized vaccine	Measles
2	OPV (Oral Polio Vaccine)- Liquid vaccine	Poliomyelitis	**6**	TT (Tetanus Toxoid) – Liquid vaccine	Tetanus
3	Hepatitis B – Liquid Vaccine	Hepatitis B	**7**	JE vaccination Lyophilized vaccine	Japanese Encephalitis (Brain fever)
4	DPT (Diphtheria, Pertussis and Tetanus Toxoid) – Liquid vaccine	Diphtheria, Pertussis and Tetanus	**8**	Hib (given as pentavalent containing Hib + DPT + Hep B) – Liquid vaccine	Hib Pneumonia and Hib meningitis

2.14 Benefit 14: Care Anywhere

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, for the Medical Expenses incurred towards the Insured Person's Major Illness / Injury treatment undertaken outside India, during the Policy Year, up to the Sum Insured specified in the Policy Certificate, subject to the conditions specified below:

(i) The Medical Expenses incurred towards the major Illness / injury treatment which are covered as a part of this Benefit are:

1. Benign Brain Tumor
2. Cancer
3. Coma
4. Coronary Artery Bypass Graft
5. End Stage Lung Disease
6. End Stage Renal Failure
7. Heart Valve Replacement
8. Major Burns
9. Major Organ Transplant
10. Myocardial Infarction
11. Stroke
12. Total Blindness

(ii) The Medical Expenses incurred are only for 'In-patient Care' or 'Day Care Treatment' undertaken in any Hospital; 'Pre-Hospitalization' and 'Post-Hospitalization' expenses are not covered under the purview of this cover.

(iii) The rate of exchange as published by Reserve Bank of India (RBI) as on the Date of Loss shall be used for conversion of foreign currency amounts into Indian Rupees for payment of any Claim under this Benefit. Where on the Date of Loss, RBI rates are not published, the rates next published by RBI shall be considered for conversion.

(iv) The Company shall be liable to make payment under this Benefit only if prior written notice of at least 7 days is given to the Company.

(v) Clause 6.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

2.15 Benefit 15: Maternity Cover

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility, for the Medical Expenses associated with Hospitalization of an Insured Person for the delivery of a child, up to amount specified against this Benefit in the Policy Certificate, subject to the conditions specified below:

(a) Claims will not be admissible for any expenses incurred for diagnosis / treatment related to any Maternity Expenses until 24 months since the inception of the first Policy with the company.
(b) This Benefit is available only under Floater cover type for all Insured Persons of age 18 years or above.
(c) Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit.
For this purpose 'week' shall constitute any consecutive 7 days.
(d) Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Benefit 1 (Hospitalization Expenses).
(e) The Company shall be liable to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy, as per MTP Act, 1971(amended) and other applicable laws and rules.
(f) Clause 4.2 (4) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3. OPTIONAL COVERS:

The Policy provides the following Optional Covers which can be opted either at the inception of the policy or at the time of renewal. The Policy Certificate will specify the Optional Covers that are in force for the Insured Persons.

3.1 Optional Cover 1: Global Coverage – Total

"Global Coverage – Total" is an extension to Benefit 11 (Global Coverage (excluding U.S.A.)) and hence all the provisions stated under Clause 2.11, holds good for Clause 3.1 as well, except that the geographical scope of coverage through Optional Cover 1 is extended to United States of America also.

3.2 Optional Cover 2: Travel Plus

The Benefits under this Optional Cover are valid outside India, which will be available for 45 continuous days from the date of travel in a Single Trip and 90 days on a cumulative basis as a whole, in a Policy Year.

This Optional Cover includes six varied Benefits namely "Worldwide In-Patient Cover (for Emergency)", "Worldwide OPD Cover", "Loss of Passport", "Loss of Checked-in Baggage", "Repatriation of Mortal Remains" and "Medical Evacuation" which are explained below.

3.2.1 Worldwide In-Patient Cover (for Emergency)

If an Insured Person suffers an Injury or is diagnosed with an Illness as an Emergency condition that requires the Insured Person to take an In-patient Treatment which should be Medically Necessary, then the Insured Person can avail a 'Single Private Room' during the Hospitalization and the Company shall indemnify such relevant & reasonable Medical Expenses incurred by Insured Person, through Cashless or Reimbursement Facility, up to the Sum Insured as specified in the Policy Certificate or Rs. 20 Lakhs (whichever is lesser), subject to the conditions specified below:

(i) The In-patient Hospitalization is on the written advice of a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary; 'Day Care Treatment', 'Pre-Hospitalization' and 'Post-Hospitalization' expenses are not covered under the purview of this cover.

(ii) The treatment for the Illness or Injury commences during the Policy Period and immediately after the diagnosis of the Illness or occurrence of the Injury;

(iii) The amount assessed by the Company on each admitted Claim for the Insured Person under this Benefit shall be reduced by the Deductible of Rs. 5,000. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible on that Claim is exhausted.

(iv) 'Single Private Room' mentioned here above, should comply with Clause 2.1 (iii) (a) (1) & 2.1 (iii) (a) (2).

3.2.2 Worldwide OPD Cover

(i) If an Insured Person while on a foreign land suffers an Injury or is diagnosed with an Illness, that requires the Insured Person to take an Out-patient Treatment, then the Company shall indemnify such Medical Expenses, through Reimbursement Facility, up to the Sum Insured as specified in the Policy Certificate or Rs. 20 Lakhs (whichever is lesser).

(ii) The amount assessed by the Company on each admitted Claim for the Insured Person under this Benefit shall be reduced by the Deductible of Rs. 5,000. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible on that Claim is exhausted.

3.2.3 Loss of Passport

(i) If an Insured Person loses his / her original passport, then the Company will indemnify the Insured Person up to 1% of the Sum Insured specified in the Policy Certificate or Rs. 20,000 (whichever is lesser), towards obtaining a duplicate or new passport.

(ii) The amount assessed by the Company on each admitted Claim for the Insured Person under this Benefit shall be reduced by the Deductible of Rs. 2,500. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible on that Claim is exhausted.

(iii) **Additional Documents to be submitted for any Claim under this Benefit :**

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

a) Copy of the police report
b) Details of the attempts made to trace the passport;
c) Statement of claim for the expenses incurred;
d) Original receipt for payment of charges to the authorities for obtaining a new or duplicate passport.

3.2.4 Loss of Checked-in Baggage

If the entire Checked-In Baggage is lost whilst in the custody of the Common Carrier, the Company will indemnify to the extent of cost incurred by the Insured Person towards replacement of the entire baggage and its contents as per market value, up to 1% of the Sum Insured specified in the Policy Certificate or Rs. 20,000 (whichever is lesser), subject to the conditions specified below:

(i) Coverage under this Benefit shall commence only after the Checked-In Baggage is entrusted to the Common Carrier and a receipt obtained and coverage under this Benefit shall terminate automatically on the Common Carrier reaching the Place of Destination specified in the ticket of the Insured Person during the Policy Period;

(ii) If more than one (1) piece of Checked-in Baggage has been checked-in under the same ticket of the Insured Person and all the pieces of Checked-in Baggage are not lost, then the Company's liability shall be restricted to 0.5% of the Sum Insured specified in the Policy Certificate or Rs. 10,000 (whichever is lesser);

(iii) If the lost/undelivered Checked-In Baggage is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit in full irrespective of whether delivery of the baggage is taken or not;

(iv) If a portion of the lost/undelivered Checked-In Baggage is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit attributable to the portion of Checked-in Baggage traced in full irrespective of whether delivery of the baggage is taken;

(v) The liability of the Company shall be determined based on the market value of the Contents of the Checked-In Baggage as on the scheduled/expected date of delivery at the destination port;

(vi) In case the market value of any single item of the Contents (excluding Valuables) of a Checked-In Baggage exceeds Rs.5,000/-, the Company's liability shall be limited to Rs.5,000/- only;

(vii) **Additional Documents to be submitted for any Claim under this Benefit:**

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

a) Property irregularity report issued by the appropriate authority.
b) Voucher of the Common Carrier for the compensation paid for the non-delivery / short delivery of the Checked-In Baggage.
c) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the non-delivery / short delivery of the Checked-In Baggage.

(viii) **Additional Exclusions applicable to any Claim under this Benefit:**

Any Claim in respect of the Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

1. Any partial loss or damage of any items contained in the Checked-In Baggage.
2. Any loss arising from any delay, detention, confiscation by customs officials or other public authorities.
3. Any loss due to damage to the Checked-In Baggage.
4. Any loss of the Checked-In Baggage sent in advance or shipped separately.
5. Valuables (Valuables shall mean and include photographic, audio, video, painting, computer and any other electronic equipment, telecommunications and electrical equipment, telescopes, binoculars, antiques, watches, jewelry and gems, furs and articles made of precious stones and metals).

3.2.5 Repatriation of Mortal Remains

If death of the Insured Person happens solely and directly due to an Insurable event, the Company shall indemnify the Policyholder, through Reimbursement Facility, up to the Sum Insured as specified in the Policy Certificate or Rs. 20 Lakhs (whichever is lesser), for the costs of repatriation of the mortal remains of the Insured Person back to the Place of Residence or for a local burial or cremation at the place where death has occurred.

(a) **Additional documents to be submitted for any Claim under this Benefit :**

It is a condition precedent to the Company's liability under this Benefit that the following information and documents shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

(i) Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death;
(ii) Copy of the postmortem certificate, if conducted;
(iii) Documentary proof for expenses incurred towards disposal of the mortal remains;
(iv) In case of transportation of the body of the deceased to the Place of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.

3.2.6 Medical Evacuation

The Company shall indemnify up to the Sum Insured as specified in the Policy Certificate or Rs. 20 Lakhs (whichever is lesser), for the reasonable cost incurred towards the medical evacuation of the Insured Person in an Emergency, through an Ambulance, including Air Ambulance or any other transportation and evacuation services to the nearest Hospital, (including necessary medical care en-route forming part of the treatment) for any Illness contracted or Injury sustained by the Insured Person during the Policy Year, subject to the conditions specified below:

(i) The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's emergency Medical evacuation;

(ii) These transportation expenses are limited to transporting the Insured Person from the place of contracting or sustaining such Illness or Injury to the nearest appropriate Hospital. Any transportation from one hospital to another is not covered under this Benefit;

(iii) This benefit will be extended only through Cashless Facility, if the costs are certified and authorized by the Company or the Assistance Service Provider in advance, unless the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arrange for the emergency Medical evacuation at their own cost and expense in which case the Company will indemnify the costs incurred on the emergency Medical evacuation in accordance with the terms of this Benefit.;

(iv) Payment under this Benefit is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit 3.2.1 (Worldwide In-Patient Cover (for Emergency));

(v) **Additional Documents to be submitted for any Claim under this Benefit:**

a) It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
b) Medical reports and transportation details issued by the evacuation agency, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of evacuation.
c) Documentary proof for expenses incurred towards the Medical Evacuation.

Notes for Clause 3.2 (Travel Plus):

i. Clause 6.7(a) of Payment Terms under Claims Procedure and Management is superseded to the extent covered under this Benefit.

ii. The payment of any Claim under this Benefit will be based on the rate of exchange as on the Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Loss, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

iii. Additional Exclusions applicable to any Claim under this Benefit:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following *shall not be* admissible under this Optional cover unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

1. Medical treatment taken outside the Country of Residence if that is the sole reason or one of the reasons for the journey.
2. Any treatment which is not Medically Necessary and could reasonably be delayed until the Insured Person's return to the Country of Residence.
3. Any treatment of orthopedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.
4. Degenerative or oncological (Cancer) diseases.
5. Rest or recuperation at a spa or health resort, sanatorium, convalescence home or similar institution.
6. Any expenses related to services, including Physiotherapy, provided by Chiropractitioner; and the expenses on prostheses / prosthetics (artificial limbs).
7. Traveling against the advice of a Medical Practitioner; or receiving, or is supposed to receive, medical treatment; or having received terminal prognosis for a medical condition; Or taking part or is supposed to participate in war like or peace keeping operation.

Note for Deductible under 'Worldwide In-Patient Cover (for emergency)', 'Worldwide OPD Cover' and 'Loss of Passport' of Optional Cover 'Travel Plus' – Once the claimed amount is converted into Indian Rupees, the deductible (in INR) will be applied to calculate the final pay-out to the Claimant.

3.3 Optional Cover 3: Unlimited Automatic Recharge

"Unlimited Automatic Recharge" is an extension to Benefit 7 (Automatic Recharge) and hence all the provisions stated under Clause 2.7, holds good for Clause 3.3 as well, except that the Recharge shall be available unlimited times during the Policy Year. However, in case of a single claim payout, the maximum liability of the Company shall not exceed the Sum Insured. No Claims Bonus (Benefit – 10) and No Claims Bonus Super (Optional Cover – 4) shall not be considered while calculating 'Unlimited Automatic Recharge'.

3.4 Optional Cover 4: No Claims Bonus Super

"No Claims Bonus Super" is an extension to Benefit 10 (No Claims Bonus) and hence all the provisions stated under Clause 2.10, holds good for Clause 3.4 as well, except the below clauses which have been modified for the purpose of this Optional Cover:

(i) If no Claim has been paid in the expiring Policy Year and the Policy is renewed with the Company without any break, the Insured Person would receive a flat 50% increase in the Sum Insured on a cumulative basis as a No Claims Bonus Super (which is over & above the Sum Insured accrued under Benefit 10 – No Claims Bonus), for each completed and continuous Policy Year.

(ii) In any Policy Year, the accrued No Claims Bonus Super shall not exceed 100% of the total of the Sum Insured available in the renewed Policy.

(iii) In the event of a Claim occurring during any Policy Year, the accrued No Claims Bonus Super will be reduced by 50% of the Sum Insured at the commencement of next Policy Year, but in no case shall the Total Sum Insured be reduced than the Sum Insured.

(iv) At the time of Policy renewal if the Policyholder chooses not to renew this Optional Cover, then the No Claims Bonus Super under the expiring Policy shall be forfeited.

(v) The Recharge amount ('Automatic Recharge' & 'Unlimited Automatic Recharge') shall not be considered while calculating 'No Claims Bonus Super'.

(vi) Along with the Benefits (Base Covers) under the Policy, accrued **'No Claims Bonus Super' can be utilized for** Optional Cover 1 (Global Coverage – Total), Optional Cover 9 (Daily Allowance+) and Optional Cover 14 (Extension of Global Coverage), if opted for.

(vii) In case no claim is made in a particular Policy Year, 'No Claims Bonus Super' would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with 2 or 3 year policy tenure).

3.5 Optional Cover 5: Deductible Option

If this Optional Cover is opted, then Policyholder is entitled for a discount on the Premium payable.

(i) The claim amount assessed by the Company for a particular claim shall be reduced by the Deductible as specified in the Policy Certificate in accordance with Clause 6.6 (b) (iii) and the Company shall be liable to make payment under the Policy for any Claim only when the Deductible on that Claim is exhausted.

(ii) The Deductible shall be applicable on an aggregate basis for all Claims made by the Insured Person in a Policy Year.

(iii) Illustration for applicability of Deductible in the same Policy Year:

(Amount in Rs.)

Case	Sum Insured	Deductible	Claim 1	Claim 2	Claim 3	Payable 1	Payable 2	Payable 3
1	500,000	100,000	75,000	125,000	100,000	-	100,000	100,000
2	500,000	100,000	75,000	250,000	300,000	-	225,000	275,000
3	500,000	100,000	250,000	400,000	400,000	150,000	350,000	Claim not payable as SI is exhausted

3.6 Optional Cover 6: Everyday Care

The Company will provide the following Everyday Care Services (the "Services") to the Insured Person during the Policy Year, under this Optional Cover.

(i) Out-Patient consultations:

The Insured Person may avail out-patient treatment at any of the Company's Network Service Provider which is payable up to 1% of Sum Insured as specified in the Policy Certificate. For the purpose of this Benefit, a flat Co-payment of 20% per consultation is applicable and no other co-payment mentioned as per Clause 2 (g) or elsewhere in the Policy is applicable.

(ii) Diagnostic Examinations:

The Insured Person may avail Diagnostic Examination facilities anywhere within the Company's Network Service Provider which is payable up to 1% of Sum Insured as specified in the Policy Certificate, as prescribed by a Medical Practitioner. For the purpose of this Benefit, a flat Co-payment of 20% per Diagnostic Examination is applicable and no other co-payment mentioned as per Clause 2 (g) or elsewhere in the Policy is applicable.

(iii) **Health Care Services** which include only the following:

a) **Doctor Anytime /Free Health Helpline:** The Insured Person may seek medical advice from a Medical Practitioner through the telephonic or online mode by contacting the Company on the helpline details specified on the Company's website;
b) **Health Portal:** The Insured Person may access health related information and services available through the Company's website;
c) **Health & Wellness Offers:** The Insured Person may avail discounts primarily on the OPD Consultations, Diagnostics and Pharmacy offered through our Network Service Providers (which are listed on the Company's website).

Note: For the purpose of above Clause, **Network Service Provider** means any person, organization, institution that has been empanelled with the Company to provide Services specified under this Optional Cover to the Insured Person.

3.7 Optional Cover 7: Smart Select

If this Optional Cover is opted, then Policyholder is entitled for a discount of 15% on the Premium payable, subject to following conditions:

(i) If the Insured Person takes Medical Treatment in hospitals other than those listed in Annexure – IV to the Policy Terms and Conditions, then the Policyholder/Insured Person shall bear a Co-Payment of 20% on each and every Claim arising in such regard, which will be in addition to any other co-payment (if any) applicable in the Policy.
(ii) However, no such additional co-payment shall be applicable if treatment is availed in the hospitals listed in Annexure IV to the Policy Terms and Conditions.

NOTE: *For an updated list of Hospitals mentioned under Annexure – IV to the Policy Terms and Conditions, the Policyholder / Insured Person should refer to the Company's Website.*

3.8 Optional Cover 8: OPD Care

The Company will indemnify the Insured Person, only through Reimbursement Facility, for availing Out-Patient consultations, Diagnostic Examinations and Pharmacy expenses, up to the amount specified against this Optional Cover in the Policy Certificate, during the Policy Year, subject to the following condition:

- Coverage for Optional Cover 'OPD Care' is provided for entire Policy year and is available to all the Insured members in a Floater Policy type along with Individual Policy type.
- All the valid OPD claim expenses incurred by the Insured Person in a policy year will be payable / reimbursed by the Company. However, claim can be filed with the Company, only twice during that Policy year, as and when that Insured Person may deem fit.

3.9 Optional Cover 9: Daily Allowance+

The Company will pay *a fixed amount* as specified against this Benefit in the Policy Certificate, for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, subject to the conditions specified below:

(i) The Company shall not be liable to make payment under this Benefit for more than 30 days of Hospitalization during a Policy Year; and

(ii) This Benefit is valid for In-patient Care Hospitalization of the Insured Person only.

(iii) In case the Insured Person is admitted in an ICU, the Company will pay twice the *fixed amount* as specified against this Benefit in the Policy Certificate, for each continuous and completed period of 24 hours of Hospitalization in an ICU.

(iv) The Payment under this Optional Cover will be in addition to any payment made under Benefit 3 (Daily Allowance).

(v) At one point of time, an Insured Person cannot stay both in a regular Hospital room as well as in an ICU room. Hence, only either one of the rooms would be considered for pay-out as per the Insured Person's room occupancy in the Hospital.

3.10 Optional Cover 10: Personal Accident

The Insured Persons covered and the coverage amount chosen for the Proposer under this Optional Cover, are specified against this Optional Cover in the Policy Certificate.

If the Policy Certificate states that spouse and / or children of the Proposer are covered under this Optional Cover, then the coverage amount for them will be as follows:-

(i) For Spouse: 50% of the coverage amount chosen for Proposer

(ii) Per Child: 25% of the coverage amount chosen for Proposer (If opted for 'Per Child', cover should be taken for all dependent children under this Policy)

Proposer's Dependent parents are not eligible to for coverage under this Optional Cover 'Personal Accident'.

This Optional Cover includes two Benefits namely "Accidental Death" and "Permanent Total Disablement" which are explained below and are applicable to events arising worldwide:-

3.10.1 Accidental Death

If the Insured Person suffers an Injury during the Policy Period, which directly results in the Insured Person's death within 12 months from the date of Accident (including date of Accident), then the Company will pay 100% of the coverage amount of that Insured Person under this Optional Cover.

3.10.2 Permanent Total Disablement (PTD)

If the Insured Person suffers an Injury during the Policy Period, which directly results in the Insured Person's Permanent Total Disablement within 12 months from the date of Accident (including date of Accident), then the Company will pay the amount as specified in the table below :

Sr. No.	Insured Events	Amount payable = % of the coverage amount of that Insured Person under this Optional Cover
I	Total and irrecoverable loss of sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot	100%
II	Total and irrecoverable loss of (a) use of two hands or two feet; or (b) one hand and one foot; or (c) sight of one eye and use of one hand or one foot	100%
III	Total and irrecoverable loss of sight of one eye, or of the actual loss by physical separation of one entire hand or one entire foot	50%
IV	Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
V	Paraplegia or Quadriplegia or Hemiplegia	100%

Note: For the purpose of Sr. No. I to IV above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

For the purpose of this Benefit only:

(i) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(ii) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(iii) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

Insured Event means an event that is covered under the Policy and which is in accordance with the Policy Terms & Conditions.

3.10.3 Additional Exclusions applicable to any Claim under this Benefit:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible, unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

1. Any pre-existing injury or physical condition;
2. The Insured Person operating or learning to operate any aircraft or performing duties as a member of a crew on any aircraft or Scheduled Airline or any airline personnel;
3. The Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;
4. Participation in actual or attempted felony, riots, civil commotion or criminal misdemeanour;
5. The Insured Person engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports;
6. The Insured Person serving in any branch of the military, navy or air-force or any branch of armed Forces or any paramilitary forces;
7. The Insured Person working in or with mines, tunnelling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs work or ship crew

services or as jockeys or circus personnel or aerial photography or engaged in Hazardous Activities;

8. Impairment of the Insured Person's intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance.
9. Persons whilst working with in activities like racing on wheels or horseback, winter sports, canoeing involving white water rapids, any bodily contact sport.
10. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.
11. Any change of profession after inception of the Policy which results in the enhancement of the Company's risk, if not accepted and endorsed by the Company on the schedule of Policy Certificate.

3.11 Optional Cover 11: Additional Sum Insured for Accidental Hospitalization

In case any Claim is made for Emergency Care of any Injury due to an Accident during the Policy Period, the Company shall automatically provide an additional Sum Insured equal to the Sum Insured for In-patient Care for that Insured Person who is hospitalized, provided that:

(i) The 'additional Sum Insured for Accidental Hospitalization' shall be utilized only after the Sum Insured has been completely exhausted;

(ii) The total amount payable under this Optional Cover shall not exceed the sum total of the Sum Insured, No Claims Bonus, No Claims Bonus Super (if opted) and 'additional Sum Insured for Accidental Hospitalization';

(iii) The 'additional Sum Insured Accidental Hospitalization' shall be available only for such Insured Person for whom Claim for Hospitalization following the Accident has been accepted under the Policy;

(iv) The 'additional Sum Insured Accidental Hospitalization' shall be applied only once during the Policy Period.

3.12 Optional Cover 12: International Second Opinion

"International Second Opinion" is an extension to Benefit 8 (Second Opinion) and hence all the provisions stated under Clause 2.8, holds good for Clause 3.12 as well, except that the geographical scope of coverage through Optional Cover 12 is applicable to worldwide excluding India only.

3.13 Optional Cover 13: Reduction in PED Wait Period

Choosing this Optional Cover reduces the applicable wait period of 48 months for Claims related to Pre-existing diseases, to 24 months.

Hence all the provisions stated under Clause 4.1 (iii) and Definition 1.58 holds good for Clause 3.13 as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease after just 24 months of continuous coverage has elapsed, since the inception of the first Policy with the Company.

NOTE: This Optional Cover will be available only at the time of inception of the Policy and only for the Sum Insured chosen at that time.

3.14 Optional Cover 14: Extension of Global Coverage

This Optional Cover is an extension to Benefit 15 'Global Coverage (excluding USA)' and Optional Cover 1 'Global Coverage – Total' and hence all the related provisions stated under Clause 2.15 and Clause 3.1, holds good for Clause 3.14 as well, except that the duration of coverage will be extended to 90 continuous days in a single trip and maximum 180 days on a cumulative basis.

3.15 Optional Cover 15: Air Ambulance Cover

The Company will indemnify the Insured Person up to the amount specified against this Benefit in the Policy Certificate, for the Reasonable and Customary Charges necessarily *incurred on availing Air Ambulance services,* in India, offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that:

(i) The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's requirement for Air Ambulance;

(ii) The transportation expenses under this Optional Cover include transportation from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or transportation from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency;

(iii) This benefit will be extended only through Cashless Facility, if the costs are certified and authorized by the Company or the Assistance Service Provider in advance. In case the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arranges for the emergency Air Ambulance at their own expense, then the Company will reimburse such costs incurred in accordance with the terms of this Optional Cover;

(iv) Payment under this Optional Cover is subject to a Claim for the same Illness or Injury being admitted by the Company under Benefit 1;

(v) **Additional Documents to be submitted for any Claim under this Benefit:**

a) It is a condition precedent to the Company's liability under this Optional Cover that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

b) Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of air ambulance services.

c) Documentary proof for expenses incurred towards availing Air Ambulance services.

4. Exclusions

4.1. Waiting Periods:

(i) First 30-Day waiting Period

a) Claim for any Medical Expenses incurred for treatment of any Illness during the first 30 days from the Policy Period Start Date shall not be admissible, except those Medical Expenses incurred directly as a result of an Injury taking place within the Policy Period.

b) This exclusion shall not apply for subsequent Policy Years provided that there is no Break in Policy for that Insured Person and that the Policy has been renewed with the Company for that Insured Person within the Grace Period and for the same or lower Sum Insured.

(ii) Specific Waiting Period

Any Claim for or arising out of any of the following Illnesses or Surgical Procedures shall not be admissible during the first 24 (twenty four) consecutive months of coverage of the Insured Person by the Company from the first Policy Period Start Date:

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders(unless caused by accident), Joint Replacement Surgery(unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and Curettage
6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers

(iii) **Pre-existing Disease:** Claims will not be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-existing Disease until 48 months of continuous coverage has elapsed, since the inception of the first Policy with the Company.

(iv) If the Sum Insured is enhanced on any renewal of this Policy, the waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the incremental amount of the Sum Insured only.

(v) If the Sum Insured is reduced on any renewal of this Policy, the credit for waiting periods as defined above in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be restricted to the lowest Sum Insured under the previous Policy.

(vi) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(vii) If Coverage for Benefits (in case of change in Product Plan) or Optional Covers are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above in Clauses 4.1 (i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the newly added Benefits or Optional Covers, from the time of such renewal.

(viii) For specific Covers offered on a global basis namely Benefit 11 'Global Coverage (excluding USA)', Optional Cover 1 'Global Coverage – Total' and Optional Cover 2 'Travel Plus', first 30 day Waiting Period defined as per Clause 4.1 (i) does not apply on the foreign land, in case the Insured Person travels abroad.

4.2. Permanent Exclusions:

The following list of permanent exclusions is applicable to all the Benefits and Optional Covers.

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).
2. The Company shall not admit any Claim in respect of an Insured Person which involves treatment/consultation in any of the hospitals as listed in Annexure – III to the Policy Terms & Conditions.
3. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
4. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.
5. Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.
6. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
7. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment.
8. Unproven/Experimental or investigational treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.
9. Expenses incurred on High Intensity Focused Ultra Sound, Balloon Sinuplasty, Enhanced External Counter Pulsation Therapy and related therapies. Deep Brain Simulation, Hyperbaric Oxygen Therapy, Robotic Surgery ((whether invasive or non-invasive), Holmium Laser Enucleation of Prostate, KTP Laser surgeries, cyber knife treatment, Femto laser surgeries and such other similar therapies, bioabsorbable stents.
10. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices,

instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.

11. Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital (except for Benefit – 6: Domiciliary Hospitalization).
12. Treatment of any external Congenital Anomaly, genetic disorders or Illness or defects or anomalies or treatment relating to external birth defects.
13. Treatment of mental illness, stress or psychological disorders or Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness.
14. Cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer or burns.
15. Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.
16. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
17. All preventive care (except eligible and entitled for Benefits – 12: Annual Health Check-up), Vaccination (except eligible and entitled for Benefit – 13: Vaccination Cover), including Inoculation and Immunizations (except in case of post-bite treatment), vitamins and tonics.
18. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
19. All expenses related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery (This exclusion is only applicable for Care Plan 1).
20. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine.
21. 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.
22. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.
23. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs, alcohol or hallucinogens.
24. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.
25. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies.
26. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head.
27. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

28. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.
29. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
30. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions.
31. Stem cell implantation/surgery and storage except for allogeneic bone marrow transplantation
32. All the Hazardous Activities
33. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
34. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In-Patient Care Hospitalisation or Day Care Hospitalisation is excluded.
35. Oral Chemotherapy.
36. Any other exclusion as specified in the Policy Certificate.

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

5. Portability

In case Portability has been granted to the Policyholder and/or Insured Person under this Policy then:-

(i) The proposed Insured Person has to be covered without any break in insurance coverage under any similar indemnity health insurance policy from any non-life insurance company or Health Insurance Company registered with the Authority (IRDAI) or any similar group indemnity health insurance policy from the Company; and

(ii) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) of this Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the sum insured and the deductible under the expiring health insurance policy.

(iii) The Waiting Periods under Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the sum insured and the deductible under the terms of the expiring policy.

(iv) The Waiting Periods as defined in Clauses 4.1(i), 4.1(ii) and 4.1(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

(v) Credit for the sum insured of the expiring policy shall additionally be available as under:

a) If the Insured Person was covered on a Floater basis under the expiring policy and is proposed to be covered on a Floater basis with the Company, then the sum insured to be carried forward for credit under this Policy would also be applied on a Floater basis only.
b) In all other cases the sum insured to be carried forward for credit in this Policy would be applied on an individual basis only.

(vi) In case the Policyholder has opted to switch to any other insurer under portability and the outcome of acceptance of the portability is awaited from the new insurer on the date of renewal:

a) The Company may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.
b) In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the extended Policy Period part of Policy, as applicable. In such cases, Policyholder shall be liable to pay the premium for the balance period and continue with the Company for that Policy year.

6. Claims Procedure and Management

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by the Company. All the procedures and processes such as pre-requisite for filing an admissible Claim, Duties of a Claimant, Documents to be submitted for filing a valid Claim, Claim Settlement Facilities, Intimation of Claims by the Insured to the Company, Progressive order for Assessment of Claims by the Company, settlement of payable Claim Amount by the Company to the Insured Person/Claimant (in case of Reimbursement Facility) and/or Hospital (in case of Cashless Facility) and related terms of Payment, are explained herein.

6.1. Pre-requisite for admissibility of a Claim:

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

(i) The Condition Precedent Clause has to be fulfilled.

(ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered benefits and any other person who is not accepted by the Company as an Insured Person.

(iii) The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.

(iv) All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

6.2. Claim settlement - Facilities

(a) Cashless Facility

The Company extends Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

(i) **Submission of Pre-authorization Form:** A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

(ii) **Identification Documents:** The "Health card" provided by the Company under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to the Company for authentication purposes. Valid Photo Identification Proof documents which will be accepted by the Company are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by the Company.

(iii) **Company's Approval:** The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

(iv) **Company's Authorization:**

a) If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility.

b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.

c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request the Company for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously authorized limit. The Company will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

(v) **Event of Discharge from Hospital:** All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 6.4 and 6.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.

(vi) **Company's Rejection:** If the Company does not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

(vii) **Network Provider related:** The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on the Company's website or at the call center.

(viii) **Claim Settlement:** For Claim settlement under Cashless Facility, the payment shall be made to the Network Provider whose discharge would be complete and final.

(ix) **Claims incurred outside India:** The Company's Assistance Service Provider should be intimated for availing Cashless Facility outside India under Benefit 11 (Global coverage (excluding USA)), Benefit 14 (Care Anywhere), Optional Cover 1 (Global coverage – Total), Optional Cover 2 (Travel Plus) and Optional Cover 12 (International Second Opinion).

(b) Re-imbursement Facility

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.4 and Clause 6.5 shall be submitted to the Company at Policyholder's / Insured Person's own expense, immediately and in any event within 15 days of Insured Person's discharge from Hospital.

(ii) The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.

(iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.

(iv) For Claim settlement under reimbursement, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Certificate) and in case of no 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.

(v) 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

6.3. Duties of a Claimant/ Insured Person in the event of Claim

(a) It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

(i) The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.

(ii) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(iii) The Insured Person shall follow the directions, advice or guidance provided by a Medical Practitioner and the Company shall not be obliged to make payment that is brought about or contributed to by the Insured Person failing to follow such directions, advice or guidance.

(iv) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6 (Claims Procedure and Management) of the Policy.

(v) The Insured Person will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

(vi) The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

The Company shall be provided with complete necessary documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

6.4. Claims Intimation

Upon the occurrence of any Illness or Injury that may result in a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, all of the following shall be undertaken:

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Company shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's call center or in writing.

(ii) Claim must be filed within 15 days from the date of Loss from the hospital.
Note: 6.4 (i) and 6.4 (ii) are precedent to admission of liability under the policy.

(iii) The following details are to be disclosed to the Company at the time of intimation of Claim:

1. Policy Number;
2. Name of the Policyholder;
3. Name of the Insured Person in respect of whom the Claim is being made;
4. Nature of Illness or Injury;
5. Name and address of the attending Medical Practitioner and Hospital;
6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
7. Any other necessary information, documentation or details requested by the Company.

(iv) In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

6.5. Documents to be submitted for filing a valid Claim

(i) The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 6 in respect of all Claims:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID of Insured Person;
3. Medical Practitioner's referral letter advising Hospitalization;
4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;
5. Original bills, receipts and discharge summary from the Hospital/Medical Practitioner;
6. Original bills from pharmacy/chemists;
7. Original pathological/diagnostic test reports/radiology reports and payment receipts;
8. Operation Theatre Notes;
9. Indoor case papers;
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. Ambulance Receipt;
12. MLC/FIR report, Post Mortem Report if applicable and conducted;
13. Any other document as required by the Company to assess the Claim.

Notes:

- The Company may give a waiver to one or few of the above mentioned documents depending upon the case.

- Under Optional Cover 2: 'Travel Plus', additional documents which are required for assessing claims pertaining to 'Loss of Passport', 'Loss of Checked-in Baggage' and 'Medical Evacuation', have been mentioned under Clauses 3.2.3 (iii), 3.2.4 (vii) and 3.2.6 (v) respectively.
- Under Optional Cover 15: 'Air Ambulance Cover', additional documents which are required for assessing claims has been mentioned under Clause 3.15(v).

(ii) The Company will accept bills/invoices which are made in the Insured Person's name only.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

6.6. Claim Assessment

(a) The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

(b) All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

(i) If the provisions of the Contribution Clause in Clause 7.9 are applicable, the Company's liability to make payment under that Claims shall first be apportioned accordingly.

(ii) If a Room/ICU accommodation has been opted for where the Room Rent or Room Category or ICU Charges is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Certificate, then the Variable Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Clause 2.1(iii) (a) & (b).

(iii) The Deductible (if applicable) shall be applied to the aggregate of all Claims that are either paid or payable under this Policy. The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible where the Claim amount is within the Deductible, the Company will not apply the Contribution Clause. Similarly, if 'Deductible per claim' is applicable, the Company's liability to make payment shall commence only once the 'Deductible per claim' limit is exceeded and the Company will not apply the Contribution Clause.

(iv) Co-payment shall be applicable on the amount payable by the Company as specified in the Policy Certificate.

(c) The Claim amount assessed in Clause 6.6 (b) above would be deducted from the following amounts in the following progressive order:

(i) Sum Insured;
(ii) Additional Sum Insured for Accidental Hospitalization (if applicable);
(iii) No Claims Bonus (if applicable);
(iv) No Claims Bonus Super (if applicable);
(v) Automatic Recharge (if applicable);
(vi) Unlimited Automatic Recharge (if applicable).

(d) All claims incurred in India are dealt by the Company directly.

6.7. Payment Terms

(a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.

(b) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.

(c) **The Company shall settle any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

(d) **If the Policyholder / Insured Person suffers a relapse within 45 days** of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

(e) **If any Claim is made which extends in to two Policy Periods**, then such Claim shall be paid taking into consideration the available Sum Insured in these Policy Periods including the deductible for each Policy Period. Such eligible Claim amount will be paid to the Policyholder / Insured Person after deducting the extent of premium to be received for the renewal/due date of premium of the policy, if not received earlier.

(f) The Premium for the policy will remain the same for the policy period mentioned in the Policy Certificate.

7. General Terms and Conditions

7.1. Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder or the Insured Person or any one acting on his/their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited ab initio to the Company.

7.2. Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy.

7.3. Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense, as per Annexure – V. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

7.4. Reasonable Care

Insured Persons shall take all reasonable steps to safeguard against any Illness or Injury that may give rise to a Claim.

7.5. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

7.6. Complete discharge

Payment made by the Company to the Policyholder or Insured Person or the nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

7.7. Proximate Clause

The Company covers the Policyholder / Insured Person only to the extent of Proximity cause which means active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

7.8. Subrogation

The Policyholder and Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any rights and remedies or obtaining relief or indemnity from any other party to which the Company is or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of affecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on a fixed benefit basis.

7.9. Contribution

(a) In case any Insured Person is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Person shall have the right to settle the Claim with any of the Companies, provided that the Claim amount payable is up to the Sum insured of such Policy.

(b) In case the Claim amount exceeds the Sum Insured, then Policyholder shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under:

(i) If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim.

(ii) This clause shall not apply to any Benefit offered on a fixed benefit basis.

7.10. Policy Disputes

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

7.11. Free Look Period

(a) The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.

(b) If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.

(c) Provision for free look period is not applicable and available at the time of renewal of the Policy.

7.12. Renewal Terms

(a) This Policy will automatically terminate on the Policy Period End Date. All renewal applications should reach the Company on or before the Policy Period End Date.

(b) The premium payable on renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.

(c) For the purpose of this provision, Grace Period means a period of 30 days immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period.

(d) The Company will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.

(e) The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.

(f) This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.

(g) The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.

(h) Renewal shall be offered lifelong. The Insured Person shall be given an option to port this Policy into any other health insurance product of the Company and credit shall be given for number of years of continuous coverage under this Policy for the standard waiting periods.

(i) No loading based on individual claim experience shall be applicable on renewal premium payable.

7.13. Cancellation / Termination

(a) The Company may at any time, cancel this Policy on grounds as specified in Clause 7.1 by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address and the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited and no refund of premium shall be effected by the Company.

(b) The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy.

Refund % to be applied on premium received

Cancellation date from Policy Period Start Date	Policy Tenure – 1 Year	Policy Tenure – 2 Years	Policy Tenure – 3 Years
Up to 1 month	75.00%	87.50%	91.50%
1 month to 3 months	50.00%	75.00%	88.50%
3 months to 6 months	25.00%	62.50%	75.00%
6 months to 12 months	0.00%	50.00%	66.50%
12 months to 15 months	N.A.	25.00%	50.00%
15 months to 18 months	N.A.	12.50%	41.50%
18 months to 24 months	N.A.	0.00%	33.00%
24 months to 30 months	N.A.	N.A.	8.00%
Beyond 30 months	N.A.	N.A.	0.0%

(c) In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at the short period scales.

(ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

I. Written notice in this regard is given to the Company before the Policy Period End Date; and

II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

7.14. Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

7.15. Communication

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

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

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

7.16. Alterations in the Policy

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

7.17. Overriding effect of Policy Certificate

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

7.18. Electronic Transactions

The Policyholder and/or Insured Person agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

7.19. Grievances

The Company has developed proper procedures and effective mechanism to address of complaints by the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued by the Authority (IRDAI) from time to time in this regard.

(a) If the Policyholder / Insured Person has a grievance that the Policyholder / Insured Person wishes the Company to redress, the Policyholder / Insured Person may contact the Company with the details of the grievance through:

Website: www.religarehealthinsurance.com
Email: customerfirst@religarehealthinsurance.com
Contact No.:1800-200-4488
Fax: 1800-200-6677

Courier: Any of Company's Branch Office or corporate office

The Policyholder/Insured Person may also approach the grievance cell at any of the Company's branches with the details of his/her grievance during the Company's working hours from Monday to Friday.

Exclusively for Senior Citizens, the Company has a separate extension on the Customer Service Toll Free Number. This separate customer service channel prioritizes and routes any kind of request / grievance raised by Senior Citizens through various fast track internal escalations leading to lesser Turn-Around-Time (TAT) for request / grievance addressal.

(b) If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may contact the Company's Head of Customer Service at:

Head – Customer Services,
Religare Health Insurance Company Limited,
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, U.P. – 201301.

(c) If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsmen offices are mentioned below:

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, 5, Navyug Colony, Nr. C.U. Shah College, Ashram Road, AHMEDABAD-380 014. Tel : 079-27545441/27546139 , Fax : 079-27546142 E-mail : bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Shri. M. Parshad	Insurance Ombudsman, Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, BENGALURU - 560 025. Tel No: 080-22222049/22222048 Email: bimalokpal.bengaluru @gbic.co.in	Karnataka
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P.)-462 023. Tel : 0755-2769201/9202 , Fax : 0755-2769203 E-mail : bimalokpal.bhopal@gbic.co.in	Madhya Pradesh & Chhattisgarh
Office of the Ombudsman	**Name of the Ombudsman**	**Contact Details**	**Jurisdiction of Office (Union Territory, District)**

BHUBANESHWAR	Shri B.N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel : 0674-2596455/2596003 , Fax : 0674-2596429 E-mail: bimalokpal.bhubaneswar@gbic.co.	Orissa
CHANDIGARH	Shri Manik B. Sonawane	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel : 0172-2706468/2705861, Fax : 0172-2708274 E-mail: bimalokpal.chandigarh@gbic.co.	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Shri Virander Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI-600 018. Tel : 044-24333668 /24335284, Fax : 044-24333664 E-mail : bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Smt. Sandhya Baliga	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel : 011-23237539/23232481 , Fax : 011-23230858 E-mail : bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI		Insurance Ombudsman, Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel : 0361-2132204/5, Fax : 0361-2732937 E-mail : bimalokpal.guwahati@gbic.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G.Rajeswara Rao	Insurance Ombudsman, 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 E-mail : bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
JAIPUR	Shri. Ashok K. Jain	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel : 0141-2740363 Email : bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM	Shri P.K. Vijay Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759/2359338, Fax : 0484-2359336 E-mail : bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Shri K.B. Saha	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindustan Bldg. Annexe, 4, C.R.Avenue, Kolkata – 700 072. Tel : 033-22124339/22124340, Fax : 033-22124341 E-mail : bimalokpal.kolkata@gbic.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
LUCKNOW	Shri N.P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331/2231330, Fax : 0522-2231310 E-mail : bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Shri A.K. Dasgupta	Insurance Ombudsman, 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@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
NOIDA		Office of the Insurance Ombudsman, Email: bimalokpal.noida@gbic.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, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA		Office of the Insurance Ombudsman, Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand
PUNE	Shri. A. K. Sahoo	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel: 020-32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.religarehealthinsurance.com or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council –

Office of the 'Governing Body of Insurance Council'
Secretary General / Secretary,
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
Mumbai – 400 054.
Tel : 022-26106245/889/671
Fax : 022-26106949
Email- inscoun@gbic.co.in