Policy Terms and Conditions

1. Definitions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, Regulations notified by the Authority and Circulars and Guidelines issued by the Authority shall carry the meanings explained therein. The judicial pronouncements of the highest courts in India will have the effect on the definitions and the language used in this product. The terms and conditions, coverage's and exclusions, benefits, various procedures and concepts which have been built in to the product also carry the specified meaning assigned to them in the said language.

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

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

1.2 **Acute Condition** means 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 **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.

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

1.6 **Annexure** means a document attached and marked as 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 **Break in Policy** occurs at the end of the existing Policy Period, when the premium due for renewal on a given Policy is not paid or before the premium Renewal Date or within 30 days thereof.

1.9 **Cashless Facility** means a facility extended by the Company 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 Company to the extent pre-authorization approved.

1.10 **Chronic Condition** means 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 Your rehabilitation or for You to be specially trained to cope with it

iv) It continues indefinitely

v) It comes back or is likely to come back

1.11 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of Medical Expenses or Benefits in respect of the Insured Person.

1.12 **Company** means Religare Health Insurance Company Limited.

1.13 **Condition Precedent** shall mean a policy term or condition upon which the Company's liability under the policy is conditional upon.

1.14 **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** means Congenital anomaly which is not in the visible and accessible parts of the body.

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

1.15 **Contribution** is essentially the right of the Company 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.

1.16 **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.

1.17 **Cumulative Bonus (No Claims Bonus)** shall mean any increase in the Sum Insured granted by the Company without an associated increase in premium.

1.18 **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 theater of its own where Surgical Procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the Company's authorized personnel

1.19 **Day Care Treatment** means medical treatment and/or a Surgical Procedure which is listed in Annexure - A and 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.

1.20 **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent sources of income.

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

1.22 **Disclosure to Information Norm** means 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.

1.23 **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.

1.24 **Emergency** means a medical condition arising out of any Illness or Injury contracted by the Insured Person and declared and certified by the Medical Practitioner, attending to the Insured Person, that immediate treatment is required to save the life of the Insured Person.

1.25 **Emergency Care** 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.

1.26 **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.

1.27 **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 Company's authorized personnel.

1.28 **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.

1.29 **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.

1.30 **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.

1.31 **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.

1.32 **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.

1.33 **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.

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

1.35 **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.

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

1.37 **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.

1.38 **Network Provider** means the Hospitals or health care providers enlisted by the Company to provide medical services to an Insured on payment by a Cashless Facility.

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

1.40 **Notification of Claim (Intimation)** means the process of notifying a Claim to the Company by specifying the timelines as well as the address/telephone number to which it should be notified.

1.41 **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.

1.42 **Policy** means these Policy Terms & Conditions, the Proposal Form, Policy Certificate, Add-on Benefits (if applicable) and Annexures which form part of the policy contract and shall be read together.

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

1.44 **Policyholder** means the person named in the Policy Certificate as the Policyholder.

1.45 **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.

If the Policy Period is more than 12 months, the Sum Insured shall apply on Policy Year basis.

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

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

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

1.49 **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.

1.50 **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 In-patient Hospitalization claim for such Hospitalization is admissible by the Company.

1.51 **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 Company.

1.52 **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.

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

1.54 **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.

1.55 **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.

1.56 **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.

1.57 **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.

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

1.59 **Sum Insured** means the amount specified against each Insured Person in the Policy Certificate which represents the Company's maximum, total and cumulative liability for that Insured Person for any and all Claims incurred in respect of that Insured Person during the Policy Year.

1.60 **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.

1.61 **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.

1.62 **Variable Medical Expense** means those Medical Expenses which vary in accordance with the Room Rent or room category or ICU charges in a Hospital.

2. Benefits

General Conditions applicable to all Benefits:

a. Any Benefit shall be available only if the same is specifically mentioned in the Policy Certificate.

b. Admissibility of a Claim under Benefit 1 is a pre-condition to the admission of a Claim for Benefit 2 to Benefit 5 and the event giving rise to the Claim under the Benefit 1 shall be within the Policy Period for the Claim for such Benefit to be accepted.

c. The maximum, total and cumulative liability of the Company for an Insured Person for any and all Claims incurred under this Policy during the Policy Year in relation to any Insured Person shall not exceed the Sum Insured for that Insured Person. All Claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

d. Any Claim under Benefit 1, Benefit 6, Benefit 7 and Benefit 8 shall always be subject to Clause 5.5.

e. Any Claim paid for Benefit 1 to Benefit 9 shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all future claims for that Policy Year.

2.1 Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an Illness or suffers an Injury during the Policy Period and while the Policy is in force that requires:

a. In-patient Care : The Insured Person's Hospitalization, then the Company will indemnify the Medical Expenses incurred on Hospitalization, provided that the Hospitalization was on the written advice of a Medical Practitioner.

b. Day Care Treatment : The Insured Person to undergo Day Care Treatment at a Day Care Centre or Hospital, then the Company will indemnify the Medical Expenses incurred on that Day Care Treatment, provided that the treatment was taken on the written advice of a Medical Practitioner.

c. Conditions for Medical Expenses (Applicable only if specifically mentioned in the Policy Certificate)

i) Room, boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category) :

I. If the Insured Person is admitted in a room where the Room Rent incurred or the Room Category is different than the one specified in the Policy Certificate, then the Policyholder shall bear the ratable proportion of the total Variable Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent actually incurred and the room rent limit or the Room Rent of the entitled room category to the room rent actually incurred.

II. Room Rent = 1% of Benefit 1 Sum Insured per day. Any amount accrued as No Claims Bonus under Clause 2.8 shall not form part of Sum Insured.

III. Room Category = Single Private Room. Any amount accrued as No Claims Bonus under Clause 2.8 shall not form part of Sum Insured.

For the purpose of this Clause only, Single Private Room means a Hospital room where a single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. Such room shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

ii) Intensive Care Unit Charges (ICU Charges) :

I. If the Insured Person is admitted in an ICU where the ICU charges incurred are higher than the ICU limit specified below then the Policyholder shall bear the ratable proportion of the Variable Medical Expenses in the proportion of the difference between the ICU Charges actually incurred and ICU Charges limit to the ICU Charges actually incurred.

II. ICU Charges = 2% of Benefit 1 Sum Insured per day. Any amount accrued as No Claims Bonus under Clause 2.8 shall not form part of Sum Insured.

iii) Fees charged by a surgeon, anesthetist and Medical Practitioner (Doctor / Surgeon Fees)

i) Upto 25% of Benefit 1 Sum Insured per Claim. Any amount accrued as No Claims Bonus under Clause 2.8 shall not form part of Sum Insured.

Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.2 Benefit 2 : Pre-hospitalization and Post-hospitalization

a. The Company will indemnify the Medical Expenses incurred for the Insured Person:

i) during a period of 30 days immediately prior to the date of the Insured Person's admission to the Hospital; and

ii) during a period of 60 days immediately following the date of the Insured Person's discharge from Hospital,

Provided that, the Medical Expenses relate to the same Illness/Injury for which the Company has accepted the Insured Person's Claim.

b. If the provisions of Clause 5.6(d) of the Policy Terms & Conditions has been invoked, then:

i) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for that Any One Illness; and

ii) 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 that Any One Illness.

c. Any Claim under this Benefit can be made under Clause 5.2(b).

2.3 Benefit 3 : Ambulance Cover

a. The Company will indemnify up to the amount specified against this Benefit in the Policy Certificate, for the reasonable expenses necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation to the nearest Hospital in case of an Emergency provided that the necessity of the Ambulance transportation is certified by the treating Medical Practitioner.

b. Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.4 Benefit 4 : Daily Allowance

a. The Company will pay the amount specified against this Benefit in the Policy Certificate for each continuous and completed period of 24 hours of Hospitalization of the Insured Person, provided that:

i) The Hospitalization is only for In-patient Care; and

ii) The Company will not be liable to make payment under this Benefit for more than 5 consecutive days of Hospitalization for Any One Illness.

b. Any Claim under this Benefit can be made under Clause 5.2(b).

2.5 Benefit 5 : Organ Donor Cover

a. The Company will indemnify 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 conducted on the Insured Person during the Policy Year, provided that:

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 organ donated is for the Insured Person's use.

iii) The Company will not be liable to pay the Medical Expenses incurred by the donor's for Benefit 2 or any other Medical Expenses in respect of the donor consequent to the harvesting.

b. Clause 4.3(a)(xviii) is superseded to the extent covered under this Benefit.

c. Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.6 Benefit 6 : Recharge of Sum Insured

a. If a Claim is payable under the Policy, then the Company agrees to automatically make the re-instatement of up to the Sum Insured for that Policy Year only provided that:

i) The Recharge shall be utilized only after the Sum Insured and No Claims Bonus have been completely exhausted in that Policy Year.

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

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

iv) The Recharge shall not be considered while calculating the No ClaimsBonus.

v) The total amount of Recharge shall not exceed the Sum Insured for that Policy Year.

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 of:

I. The Sum Insured

II. No Claims Bonus

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

I. The Sum Insured

II. No Claims Bonus

III. Recharge of Sum Insured

x) The balance of the Recharge shall be available during the Policy Year till it is exhausted completely.

xi) 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.

b. For additional understanding on the terms of this Benefit please refer to Exhibit - I in Annexure B.

c. Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.7 Benefit 7 : Care Anywhere

a. Company will indemnify up to the amount specified against this Benefit in the Policy Certificate for the Medical Expenses incurred outside India, in respect of the Insured Person during the Policy Year, provided that:

i) The Medical Expenses incurred are in respect of the major Illness specified below only:

I. Cancer

II. Benign Brain Tumour

III. Major Organ Transplant/Bone Marrow Transplant

IV. Heart Valve Replacement

V. Coronary Artery Bypass Graft

ii) The Medical Expenses incurred are only for In-patient Care or Day Care Treatment undertaken in any Hospital.

For the purposes of this Benefit, Hospital shall mean "Any institution established for In-patient Care and Day Care Treatment of Injury or Illness and which has been registered as a Hospital or a clinic as per law rules and/or regulations applicable for the country where the treatment is taken. The term Hospital shall not include a place of rest, a place for the aged, a place for drug-addicts or a place for alcoholics or a hotel, health spa or massage center or the like."

iii) Any payments under this Benefit shall always be made in India, in Indian Rupees and on a re-imbursement basis only. The rate of exchange as published by Reserve Bank of India (RBI) as on the date of payment to the Hospital 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 discharge, 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 4.3(a)(xxi) and Clause 5.6(a) is superseded to the extent covered under this Benefit.

b. Any Claim under this Benefit can be made under Clause 5.2(b).

2.8 Benefit 8 : No Claims Bonus

a. At the end of each Policy Year, the Company will provide 10% of the Sum Insured applicable on the last completed Policy Year, on a cumulative basis as a No Claims Bonus for each completed and continuous Policy Year, provided that no Claim has occurred in the expiring Policy Year and subject to:

i) In any Policy Year, the accrued No Claims Bonus, (including any carried forward Cumulative Bonuses if the portability provisions in Clause 4.2 have been applied), shall not exceed 50% of the total of 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 (c).

iii) For a Floater policy, the No Claims Bonus, shall be available only 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 No Claims Bonus is provisional and is subject to revision if a Claim is made in respect of the expiring Policy Year.

v) 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.

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

vii) If the Insured Persons in the expiring policy are covered on individual basis and thus have accumulated the No Claims Bonus for each member 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.

viii) 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 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.

ix) This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 6.1.

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

xi) 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.

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

b. Any Claim under this Benefit can be made under Clause 5.2(a) & (b).

2.9 Benefit 9 : Domiciliary Hospitalization

a. The Company will indemnify for the Medical Expenses incurred during Policy Year for Domiciliary Hospitalization of the Insured Person up to the amount specified against this Benefit in the Policy Certificate, provided that:

i) The condition of the Insured Person is such that the Insured Person is not in a condition to be removed to a hospital; or

ii) The Insured Person takes treatment at home on account of non-availability of room in a hospital.

b. For the purpose of this Benefit only, Domiciliary Hospitalization means medical treatment for a period exceeding 3 consecutive days, for an Illness / Injury, which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home.

c. Any Medical Expenses incurred under Benefit 2 shall not be payable under this Benefit.

d. Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit :

i) Asthma

ii) Bronchitis

iii) Chronic Nephritis and Chronic Nephritic Syndrome

iv) Diarrhoea and all types of Dysenteries including Gastro-enteritis

v) Diabetes Mellitus and Insipidus

vi) Epilepsy

vii) Hypertension

viii) Influenza, cough or cold

ix) All Psychiatric or Psychosomatic Disorders

x) Pyrexia of unknown origin

xi) Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis

xii) Arthritis, Gout and Rheumatism

e. Any Claim under this Benefit can be made under Clause 5.2 (b).

2.10 Benefit 10 : Health Check-up

a. On the Insured Person's request, the Company shall arrange for the Insured Person's Health Check-up in accordance with the table below at its Network Provider, provided that:

i) This Benefit shall be available only to those Insured Persons that are Age 18 or above on the Policy Period Start Date provided further that this Benefit shall not be available to any Insured Person who is covered under the Policy as the Policyholder's child.

ii) This Benefit shall only be available once in every year during the Policy Year.

Package No.	List of Medical Tests covered in Annual Health Check-up	Age	Plan
1	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine	18 years & above	Care 1
2	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, ECG, S Cholesterol, SGPT, Creatinine	18 years & above	Care 2 & Care 6
3	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, Lipid Profile, Kidney Function Test, Complete Physical Examination by Physician	18 years & above	Care 3
4	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose , Lipid Profile, Stress Test (TMT) or 2D echo, Kidney Function Test, Complete Physical Examination by Physician	18 years & above	Care 4 & Care 5

b. Any Claim under this Benefit can be made under Clause 5.2(a).

2.11 Benefit 11 : Second Opinion

a. If the Insured Person is diagnosed with any Major Illness 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.

b. 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 following:

i) This Benefit can be availed a maximum of one time by an Insured Person during the Policy Year for each Major Illness.

ii) 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.

iii) 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.

iv) 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.

v) 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.

vi) The Policyholder or Insured Person shall indemnify the Company and hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advise, 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.

vii) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.

viii) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

c. For the purposes of this Benefit only:

i) Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder or Insured Person's express request in relation to a Major Illness which the Insured Person has been diagnosed with during the Policy Year.

ii) Major Illness means one of the following only:

I. Benign Brain Tumour

II. Cancer

III. End Stage Lung Failure

IV. Heart Attack

V. Open Chest Coronary Artery Bypass Graft

VI. Heart Valve Replacement

VII. Coma

VIII. End Stage Renal Failure

IX. Stroke

X. Major Organ Transplant

XI. Paralysis

XII. Motor Neuron Disease

XIII. Multiple Sclerosis

XIV. Major Burns

XV. End Stage Liver Disease

d. Any Claim under this Benefit can be made under Clause 5.2(a).

3. Special Conditions

Special Conditions shall be applicable only if the same is specifically mentioned in the Policy Certificate.

3.1 Special Condition 1 : Floater Cover

a. 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 Sum Insured.

b. Definition 1.59 is deleted entirely and replaced with the following:

Sum Insured : The amount specified in the Policy Certificate which represents the Company's maximum, total and cumulative liability for all Insured Persons for any and all Claims incurred during the Policy Year.

3.2 Special Condition 2 : Co-payment

a. The Policyholder shall bear 20% of the Final Claim Amount assessed by the Company in accordance with Clause 5.5 in accordance with the table below and the Company's liability shall be restricted to the balance amount payable :

Cover Type	Entry Age* of Insured Person or Eldest Insured Person (in case of Floater)	Applicable To
Individual	>=61 years	Individual Insured Person
Floater	>=61 years	All Insured Person's

* Entry Age means the age of the Insured Person at the time of issue of the first Policy with the Company.

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

4. Exclusions

4.1. Waiting Period

a. 30-Day waiting period

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

ii) This exclusion shall not apply for subsequent Policy Years provided that there is no break in insurance cover for that Insured Person and that the Policy has been renewed with the Company for that Insured Person on time and for the same or lower Sum Insured.

b. Specific waiting period

i) 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:

I. Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism and Spinal Disorders, Joint Replacement Surgery;

II. 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;

III. Benign Prostatic Hypertrophy;

IV. Cataract;

V. Dilatation and Curettage;

VI. Fissure/Fistula in anus, Hemorrhoids/Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers;

VII. Surgery of Genito urinary system unless necessitated by malignancy;

VIII. All types of Hernia, Hydrocele;

IX. Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy;

X. Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant;

XI. Kidney Stone/Ureteric Stone/Lithotripsy/Gall Bladder Stone;

XII. Myomectomy for fibroids;

XIII. Varicose veins and varicose ulcers

ii) If an Insured Person is suffering from any of the above Illnesses, conditions or Pre-existing Diseases at the time of commencement of first policy with the Company, any Claim in respect of that Illness, condition or Pre-existing Disease shall not be covered until the completion of 48 months of continuous insurance coverage with the Company from the first Policy Period Start Date.

c. Pre-existing Disease: Claims will not be admissible for any Medical Expenses incurred as Hospitalization Expenses for 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.

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

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

f. The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

4.2 Portability

a. If the Policyholder and/or Insured Person applies to the Company for a health insurance policy, provided that

i) The proposed Insured Person has to be covered without any break under any similar individual indemnity health insurance policy from any non-life insurance company registered with the IRDA or any similar group indemnity health insurance policy from the Company; and

ii) The Sum Insured opted for with the Company should be equal to or higher than the Sum Insured of the expiring health policy, then

The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) 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 Eligible Cumulative Bonus under the expiring health insurance policy.

The Waiting Periods under Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the total of sum insured and Eligible Cumulative Bonus under the terms of the expiring policy.

b. The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

c. Credit for the sum insured and the Eligible Cumulative Bonus of the expiring policy shall additionally be available as under:

i) 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 Eligible Cumulative Bonus to be carried forward for credit under this Policy would also be applied on a Floater basis only.

ii) In all other cases the Eligible Cumulative Bonus to be carried forward for credit in this Policy would be applied on an individual basis only.

For the purpose of this provision the "Eligible Cumulative Bonus" shall mean the additional sum insured and cumulative bonus which the Insured Person would have been eligible for, had the same policy been renewed with the same insurance company.

d. 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:

i) 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.

ii) In case any Claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the Policy Period of 12 full calendar months. The Company's liability for the payment of the Claim shall commence only once such premium is received. Alternately, the Company may deduct the premium payable by the Policyholder and pay the balance Claim amount, if any and issue Policy for the balance Policy Period.

Note: Portability provisions will apply even if the Insured Person migrates to any other health insurance policy.

4.3 Permanent Exclusions

a. 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:

i) Any condition or treatment as specified in Annexure - C

ii) 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.

iii) 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.

iv) 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.

v) 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.

vi) Charges incurred in connection with cost of routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

vii) 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.

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

ix) 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.

x) Treatment of any Congenital Anomaly or Illness or defects or anomalies or treatment relating to birth defects.

xi) Treatment of mental illness, stress or psychological disorders.

xii) Aesthetic treatment, 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.

xiii) Any treatment/surgery for change of sex or gender reassignments including any complication arising from these treatments.

xiv) Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

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

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

xvii) All expenses related to donor treatment, including surgery to remove organs from the donor, in case of transplant surgery.

xviii) Non-allopathic treatment.

xix) Any OPD Treatment.

xx) Treatment received outside India.

xxi) Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/ Day Care Treatment is required.

xxii) 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.

xxiii) 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.

xxiv) 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 tobacco, intoxicating drugs and alcohol or hallucinogens.

xxv) Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

xxvi) Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

xxvii) Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the hospital under whatever head.

xxviii) 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:

I. 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.

II. 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.

III. 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.

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 shall also be excluded.

xxix) Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.

xxx) Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

xxxi) 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.

xxxii) Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Certificate.

5. Claims Intimation, Assessment and Management

5.1 Upon the occurrence of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the Company's liability under the Policy, the Policyholder or Insured Person shall undertake all of the following:

a. Claims Intimation

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 Policyholder or Insured Person, shall notify the Company either at the Company's call center or in writing immediately.

ii) If the Insured Person is to undergo planned Hospitalization, the Policyholder or Insured Person shall give written intimation to the Company of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.

iii) It is agreed and understood that the following details are to be provided to the Company at the time of intimation of Claim:

I. Policy Number;

II. Name of the Policyholder;

III. Name of the Insured Person in respect of whom the Claim is being made;

IV. Nature of Illness or Injury;

V. Name and address of the attending Medical Practitioner and Hospital;

VI. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;

VII. Any other information, documentation or details requested by the Company.

5.2 Claims Procedure

a. Cashless

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

ii) In addition to the foregoing, in order to avail of the cashless facility, the following procedure must be followed:

I. Pre-authorization: The Policyholder or Insured Person must call the Company's call center and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours before the commencement of planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

II. The Company will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which cashless facility is sought to be availed. The Company will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Person's Hospitalization.

III. 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. Payment in respect of co-payments (if applicable) or any other costs and expenses not authorized under the cashless facility shall be made directly by the Policyholder or Insured Person to the Network Provider. 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 at Clause 5.4 shall be submitted to the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.

IV. If the Company does not authorize the cashless facility due to insufficient Sum Insured or if insufficient information is provided to the Company to determine the admissibility of the Claim, payment for the treatment will have to be made by the Policyholder or Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company and the same will be considered by the Company subject to the Policy.

iii) It is agreed and understood that the Company may, in its sole discretion, modify or add to the list of Network Provider or modify or restrict the extent of cashless facilities that may be availed at any particular Network Provider. For an updated list of Network Provider and the extent of cashless facilities available at each Network Provider, the Policyholder or Insured Person can refer to the list of Network Provider available on the Company's website or at the call centre.

b. Re-imbursement

The Company shall be given intimation of Hospitalization at its call center or in writing at least 48 hours before the commencement of a planned Hospitalization

or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency. It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified in Clause 5.4 below shall be submitted (at the Policyholder or Insured Person's expense) to the Company immediately and in any event within 15 days of Insured Person's discharge from Hospital.

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

a. The Policyholder or Insured Person shall check the updated list of Network Provider before submission of a pre-authorisation request for cashless facility; and

b. It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

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

ii) 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.

iii) 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 time frames specified in Clause 5 of the Policy.

iv) The Insured Person will, at the request of the Company, submit himself 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.

v) 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.

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

5.4 Claim Documents

a. The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 5 in respect of all Claims:

i) Duly completed and signed Claim form, in original;

ii) Medical Practitioner's referral letter advising Hospitalization;

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

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

v) Original bills from pharmacy/chemists;

vi) Original pathological/diagnostic test reports/radiology reports and payment receipts;

vii) Indoor case papers;

viii) First Information Report, final police report, if applicable;

ix) Post mortem report, if conducted;

x) Any other document as required by the Company to assess the Claim

b. Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider the Company will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.

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

d. The Company shall condone delay on merit for delayed Claims where delay is proved to be for reasons beyond the control of the Policyholder or the Insured Person.

5.5 Claim Assessment

a. 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 6.9 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 rent or category is higher than the eligible limit as applicable in accordance with Clause 2.1(c)(i) & (ii) for that Insured Person under the Policy, then, the Variable Medical Expenses payable shall be pro-rated as per the applicable limits.

iii) If any sub-limits on Medical Expenses are applicable in accordance with Clause 2.1(c)(iii), the Company's liability to make payment shall be limited to such extent as applicable.

iv) Co-payment, if any, shall be applicable on the amount payable by the Company after applying Clause 5.5(a)(i), (ii) and (iii).

b. The Claim amount assessed in Clause 5.5(a) above would be deducted from the following amounts in the following progressive order:

i) Sum Insured;

ii) No Claims Bonus;

iii) Recharge of Sum Insured (if applicable).

5.6 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 Sum Insured of the Insured Person shall be reduced by the amount payable or paid under the Policy Terms and Conditions and only the balance amount shall be available as the Sum Insured for the unexpired Policy Year.

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

d. 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 an offer of settlement of Claim and upon acceptance of such offer by the Policyholder 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 time lines, 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.

e. If the Policyholder or 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.

f. For cashless Claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

g. For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Certificate) and in case of no nominee at its discretion to the legal heirs of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

6. General Terms and Conditions

6.1 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 to the Company.

6.2 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.

6.3 Reasonable Care

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

6.4 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. The Company may, in its discretion, adjust the scope of cover and/ or the premium paid or payable, accordingly.

6.5 Records to be maintained

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

6.6 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.

6.7 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.

6.8 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 civil or criminal 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 effecting 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.

6.9 Contribution

a. In case any Insured is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to 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.

c. This clause shall not apply to any Benefit offered on a fixed benefit basis.

6.10 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. The disputes on quantum on payment of losses or any other dispute explained in the paragraph shall be preferred to be dealt and resolved under the alternative dispute resolutions system including Arbitration and Conciliation Act of India.

6.11 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. 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 (as per the below mentioned grid) 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.

Age/Sum Insured	Sum Insured upto 5 Lac	Sum Insured 7 Lac & 10 Lac	Sum Insured above 10 Lac
6 years to 18 years	Nil	Nil	₹2,200
19 years to 45 years	Nil	₹825	₹2,200
46 years & above	₹825	₹2,200	₹2,200

b. It is agreed and understood that this clause cannot be exercised on any renewal of this Policy.

6.12 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 Company may, in its sole discretion, revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the IRDA rules and regulations as applicable from time to time. 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 such as Waiting Periods and coverage of Pre-existing Diseases. 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. The provisions of Section 64VB of the Insurance Act shall be applicable.

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. If the Policy Certificate specifies that the Policy has been issued on an auto renewal basis, the conditions specified above shall apply only on the expiry of the entire auto renewal period as specified in the Policy Certificate.

f. The Company reserves the right to carry out underwriting in relation to any request for increase of the Sum Insured at the time of renewal of the Policy.

g. This product may be withdrawn by the Company after due approval from the IRDA. In case this product is withdrawn by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDA. The Company shall duly intimate the Policyholder regarding withdrawal of this product and the options available to the Policyholder at the time of Renewal of this policy.

6.13 Cancellation/Termination

a. The Company may at any time, cancel this Policy on grounds as specified in Clause 6.1, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.

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.

c. Refund % to be applied on premium received

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

d. 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.

   ii) Where the Policy covers other Insured Members, this Policy shall continue till the end of Policy Period. 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 over Age 18 who satisfies the Company's criteria to become a Policyholder.

6.14 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.

6.15 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 to its address 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.

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

6.16 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.

6.17 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.

6.18 Electronic Transactions

The Policyholder and 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.

6.19 Grievances

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

b. If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

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

or write to:

The Grievance Cell
Head of Customer Services
Religare Health Insurance Company Limited
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, U.P. - 201301
E-mail : resolve1@religarehealthinsurance.com

Post/Courier : Any branch office or the correspondence address, during normal business hours

c. If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may contact the Company at:

Director - Services
Religare Health Insurance Company Limited
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, U.P. - 201301
E-mail : resolve2@religarehealthinsurance.com

d. If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned on the next page-

Office of the Ombudsmen	Name of the Ombudsmen	Contact Details	Area of Jurisdiction
AHMEDABAD	Shri P. Ramamoorthy	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, AHMEDABAD - 380 014. Tel : 079-27546840, Fax : 079-27546142 E-mail : ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		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 : 0755-2569201, Fax : 0755-2769203 E-mail : bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR - 751 009. Tel : 0674-2596455, Fax : 0674-2596429 E-mail : ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri. Manik 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, Fax : 0172-2708274 E-mail : ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI		Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel : 044-24333668/5284, Fax : 044-24333664 E-mail : chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI - 110 002. Tel : 011-23239633, Fax : 011-23230858 E-mail : iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Shri D. C. Choudhury	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 : ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD - 500 004. Tel : 040-65504123, Fax : 040-23376599 E-mail : insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam - a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranathan	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM - 682 015. Tel : 0484-2358759, Fax : 0484-2359336 E-mail : iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, KOLKATA - 700 072. Tel : 033-22124346/(40), Fax : 033-22124341 E-mail : iombsbpa@bsnl.in	West Bengal, Bihar, Jharkhand and UT of Andeman & Nicobar Islands, Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW - 226 001. Tel : 0522-2231331, Fax : 0522-2231310 E-mail : insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI		Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI - 400 054. Tel : 022-26106928, Fax : 022-26106052 E-mail : ombudsmanmumbai@gmail.com	Maharashtra, Goa

The details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council : www.generalinsurancecouncil.org.in, 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 -

Shri M.V.V. Chalam, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI - 400 021
Tel : 022-26106245
Fax : 022-26106949
E-mail : inscoun@gmail.com

The Secretary
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI - 400 021.
Tel : 022 26106980
Fax : 022-26106949

Annexure A - List of Day Care Treatments

1. Microsurgical operations on the middle ear

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

2. Other operations on the middle & internal ear

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

3. Operations on the nose & the nasal sinuses

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

4. Operations on the eyes

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

5. Operations on the skin & subcutaneous tissues

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

6. Operations on the tongue

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

7. Operations on the salivary glands & salivary ducts

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

8. Other operations on the mouth & face

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

9. Operations on tonsils and adnoids

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

10. Operations on the breast

86. Incision of the breast abscess
87. Operations on the nipple

88. Excision of single breast lump

11. Operations on the digestive tract, Kidney and Bladder

89. Incision and excision of tissue in the perianal region
90. Surgical treatment of anal fistulas
91. Surgical treatment of hemorrhoids
92. Division of the anal sphincter (sphincterotomy)
93. Other operations on the anus
94. Ultrasound guided aspirations
95. Sclerotherapy, etc.
96. Laparotomy for grading Lymphoma with Splenectomy/Liver/Lymph Node Biopsy
97. Therapeutic Laparoscopy with Laser
98. Cholecystectomy and Choledocho-Jejunostomy/Duodenostomy/Gastrostomy/Exploration Common Bile Duct
99. Esophagoscopy, gastroscopy, duodenoscopy with polypectomy/removal of foreign body/diathermy of bleeding lesions
100. Lithotripsy/Nephrolithotomy for renal calculus
101. Excision of renal cyst
102. Drainage of Pyonephrosis/Perinephric Abscess
103. Appendicectomy with/without Drainage

12. Operations on the female sexual organs

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

13. Operations on the prostate & seminal vesicles

119. Incision of the prostate
120. Transurethral excision and destruction of prostate tissue
121. Transurethral and percutaneous destruction of prostate tissue
122. Open surgical excision and destruction of prostate tissue
123. Radical prostatovesiculectomy
124. Other excision and destruction of prostate tissue
125. Operations on the seminal vesicles
126. Incision and excision of periprostatic tissue
127. Other operations on the prostate

14. Operations on the scrotum & tunica vaginalis testis

128. Incision of the scrotum and tunica vaginalis testis
129. Operation on a testicular hydrocele
130. Excision and destruction of diseased scrotal tissue
131. Other operations on the scrotum and tunica vaginalis testis

15. Operations on the testes

132. Incision of the testes
133. Excision and destruction of diseased tissue of the testes
134. Unilateral orchidectomy
135. Bilateral orchidectomy
136. Orchidopexy
137. Abdominal exploration in cryptorchidism
138. Surgical repositioning of an abdominal testis
139. Reconstruction of the testis
140. Implantation, exchange and removal of a testicular prosthesis
141. Other operations on the testis

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

142. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
143. Excision in the area of the epididymis
144. Epididymectomy

17. Operations on the penis

145. Operations on the foreskin
146. Local excision and destruction of diseased tissue of the penis
147. Amputation of the penis
148. Other operations on the penis

18. Operations on the urinary system

149. Cystoscopical removal of stones
150. Catheterisation of Bladder

19. Other Operations

151. Lithotripsy
152. Coronary angiography
153. Biopsy of Temporal Artery for Various Lesions
154. External Arterio-venous Shunt
155. Haemodialysis
156. Radiotherapy for Cancer
157. Cancer Chemotherapy
158. Endoscopic polypectomy

20. Operations of bones and joints

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

Annexure B - Exhibit 1: Illustration for Recharge of Sum Insured

For Policy Period 1st Jan. 2012 to 31st Dec. 2012

Details	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Sum Insured at Policy Year Start Date (01-Jan-2012)	3,00,000	3,00,000	3,00,000	3,00,000
No Claims Bonus	-	-	90,000	90,000
			Assuming that policy has 3 claim free years	
Total Eligible Sum Insured for Claim	3,00,000	3,00,000	3,90,000	3,90,000
Claim 1 on 01-May-2012 :				
Claim made for (Rs.)	2,00,000	2,00,000	3,50,000	4,50,000
Claim Amount Eligible	2,00,000	2,00,000	3,50,000	3,90,000
Sum Insured utilized for Claim	2,00,000	2,00,000	3,00,000	3,00,000
No Claims Bonus available	No	No	Yes	Yes
No Claim Bonus amount to be utilized for Claim	N.A.	N.A.	50,000	90,000
Total Claim Payable	2,00,000	2,00,000	3,50,000	3,90,000
Balance Sum Insured available for the balance policy period	1,00,000	1,00,000	-	-
Balance No Claim Bonus available for the balance policy period	-	-	40,000	-
Recharge Sum Insured available for the balance policy period	3,00,000	3,00,000	3,00,000	3,00,000
Claim 2 on 01-Sep-2012				
Claim made for (Rs.)	2,00,000	4,00,000	3,50,000	3,50,000
Claim Amount Eligible	2,00,000	3,00,000	3,40,000	3,00,000
Sum Insured utilized for Claim	1,00,000	1,00,000	-	-
No Claims Bonus available	No	No	Yes	No
No Claim Bonus amount to be utilized for Claim	N.A.	N.A.	40,000	N.A.
Recharge available	Yes	Yes	Yes	Yes
Recharge Sum Insured utilized	1,00,000	2,00,000	3,00,000	3,00,000
Total Claim Payable	2,00,000	3,00,000	3,40,000	3,00,000
Balance Sum Insured available for the balance policy period	-	-	-	-
Recharge Sum Insured available for the balance policy period	2,00,000	1,00,000	-	-

Note : It is assumed that Claim Event 1 and Claim Event 2 are not related events

Annexure C : List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy

S. No.	List of expenses generally excluded ("Non-medical")in hospital indemnity policy - toiletries/cosmetics/personal comfort or convenience items	S. No.	List of expenses generally excluded ("Non-medical")in hospital indemnity policy - toiletries/cosmetics/personal comfort or convenience items
1	Hair removal cream	55	Hand holder
2	Baby charges (unless specified/indicated)	56	Hansaplast/Adhesive bandages
3	Baby food	57	Lactogen/Infant food
4	Baby utilites charges	58	Slings
5	Baby set	Items specifically excluded in the policies	
6	Baby bottles	59	Weight control programs/supplies/services
7	Brush	60	Cost of spectacles/contact lenses/hearing aids, etc.
8	Cosy towel	61	Dental treatment expenses that do not require hospitalisation
9	Hand wash	62	Hormone replacement therapy
10	Moisturizer paste brush	63	Home visit charges
11	Powder	64	Infertility/subfertility/assisted conception procedure
12	Razor	65	Obesity (including morbid obesity) treatment
13	Shoe cover	66	Psychiatric & psychosomatic disorders
14	Beauty services	67	Corrective surgery for refractive error
15	Belts/braces	68	Treatment of sexually transmitted diseases
16	Buds	69	Donor screening charges
17	Barber charges	70	Admission/registration charges
18	Caps	71	Hospitalisation for evaluation/diagnostic purpose
19	Cold pack/Hot pack	72	Expenses for investigation/treatment irrelevant to the disease for which admitted or diagnosed
20	Carry bags		
21	Cradle charges	73	Any expenses when the patient is diagnosed with retro virus + or suffering from/HIV/AIDS etc is detected/directly or indirectly
22	Comb		
23	Disposables razors charges (for site preparations)	74	Stem cell implantation/surgery and storage
24	Eau-de-cologne/Room fresheners	List of expenses generally excluded ("Non-medical")in hospital indemnity policy - items which form part of hospital services where separate consumables are not payable but the service is	
25	Eye pad		
26	Eye shield		
27	Email/Internet charges	75	Ward and Theatre booking charges
28	Food charges (other than patient's diet provided by Hospital)	76	Arthroscopy & Endoscopy instruments
29	Foot cover	77	Microscope cover
30	Gown	78	Surgical blades, Harmonic scalpel, shaver
31	Leggings	79	Surgical drill
32	Laundry charges	80	Eye kit
33	Mineral water	81	Eye drape
34	Oil charges	82	X-ray film
35	Sanitary pad	83	Sputum cup
36	Slippers	84	Boyles apparatus charges
37	Telephone charges	85	Blood grouping and cross matching of donors samples
38	Tissue paper	86	Savlon
39	Tooth paste	87	Band aids, bandages, sterile injections, needles, syringes
40	Tooth brush	88	Cotton
41	Guest services	89	Cotton bandage
42	Bed Pan	90	Micropore/Surgical tape
43	Bed under pad charges	91	Blade
44	Camera cover	92	Apron
45	Cliniplast	93	Torniquet
46	Crepe bandage	94	Orthobundle, Gynaec bundle
47	Curapore	95	Urine container
48	Diaper of any type	Elements of room charge	
49	DVD, CD charges	96	Luxury tax
50	Eyelet collar	97	HVAC
51	Face mask	98	House keeping charges
52	Flexi mask	99	Service charges where nursing charge also charged
53	Gause soft	100	Television & Air conditioner charges
54	Gauze	101	Surcharges

102	Attendant charges	153	Ambulance equipment
103	Im Iv Injection charges	154	Microsheild
104	Clean sheet	155	Abdominal binder
105	Extra diet of patient (other than that which forms part of bed charge)	Items payable if supported by a prescription	
106	Blanket/Warmer blanket	156	Betadine\Hydrogen peroxide\Spirit\Disinfectants etc.
Administrative or Non-medical charges		157	Private nurses charges- Special nursing charges
107	Admission kit	158	Nutrition planning charges - Dietician charges - Diet charges
108	Birth certificate	159	Sugar free tablets
109	Blood reservation charges and Ante-natal booking charges	160	Creams, powders, lotions (toileteries are not payable, only prescribed medical pharmaceuticals payable)
110	Certificate charges		
111	Courier charges	161	Digestion gels
112	Conveyance charges	162	Ecg electrodes
113	Diabetic chart charges	163	Gloves
114	Documentation charges/Administrative expenses	164	HIV kit
115	Discharge Procedure charges	165	Listerine/Antiseptic mouthwash
116	Daily chart charges	166	Lozenges
117	Entrance pass/Visitors pass charges	167	Mouth paint
118	Expenses related to prescription on discharge	168	Nebulisation kit
119	File opening charges	169	Novarapid
120	Incidental expenses/Misc. charges (not explained)	170	Volini gel/Analgesic gel
121	Medical certificate	171	Zytee gel
122	Maintenance charges	172	Vaccination charges
123	Medical records	Part of hospital's own costs and not payable	
124	Preparation charges	173	AHD
125	Photocopies charges	174	Alcohol swabes
126	Patient identification band/Name tag	175	Scrub solution/Sterillium others
127	Washing charges	176	Vaccine charges for baby
128	Medicine box	177	Aesthetic treatment/Surgery
129	Mortuary charges	178	TPA charges
130	Medico legal case charges (MLC charges)	179	Visco belt charges
External durable devices		180	Any kit with no details mentioned, Delivery kit, Orthokit, Recovery kit, etc.
131	Walking aids charges	181	Examination gloves
132	BIPAP machine	182	Kidney tray
133	Commode	183	Mask
134	CPAP/CAPD equipments	184	Ounce glass
135	Infusion pump - cost	185	Outstation consultant's/Surgeon's fees
136	Oxygen cylinder (for usage outside the hospital)	186	Oxygen mask
137	Pulseoxymeter charges	187	Paper gloves
138	Spacer	188	Pelvic traction belt
139	Spirometre	189	Referral doctor's fees
140	SpO2 Probe	190	Accu check (glucometery/strips)
141	Nebulizer Kit	191	Pan can
142	Steam Inhaler	192	Sofnet
143	Arm sling	193	Trolley cover
144	Thermometer	194	Urometer, Urine jug
145	Cervical collar	195	Ambulance
146	Splint	196	Tegaderm/Vasofix safety
147	Diabetic foot wear	197	Urine bag
148	Knee braces (long/short/hinged)	198	Softovac
149	Knee immobilizer/Shoulder immobilizer	199	Stockings
150	Lumbo sacral belt		
151	Nimbus bed or water or air bed charges		
152	Ambulance collar		

Claim Process

At Religare, the principal purpose for our existence is to ensure that our customers enjoy hassle-free access to best-in-class healthcare delivery facilities, and we live this objective through our seamless claim process.

Please refer to the following steps in the claim procedure to ensure smooth processing of the same:

Cashless Treatment at Network Hospitals

Step 1 : Claim Intimation

- In case of unplanned hospitalization, call and inform us within 24 hours of your admission. However, if your hospitalization is planned, kindly intimate us 48 hours prior to your admission.
- You can intimate us by calling on 1800-200-4488 or writing to us at customerfirst@religarehealthinsurance.com

Step 2 : Initiating the process for Pre-Authorization

- A Pre-Authorization form will be available at the hospital's Insurance/TPA desk, or you can alternatively download the same from our website www.religarehealthinsurance.com
- The completed Pre-Authorization form has to be faxed to us at 1800-200-6677 or can also be sent at any of our other coordinates. This may be done by you or the respective hospital.

Step 3 : Processing a request for Pre-Authorization

- If your request for Pre-Authorization is approved, you and the hospital will be duly informed by us.
- In case of any information deficiency or further information requirement, you and the hospital will be regularly intimated by us to ensure resolution of the same at the earliest.
- If your request for Pre-Authorization is not approved, it in no way means that your claim is/will be rejected. It only indicates that we are not able to process your request basis the requisite information available with us at this point of time. In such cases, you may claim for reimbursement of your expenses after discharge from the hospital.

Reimbursement of treatment expenses incurred at Network/NonNetwork Hospitals

Step 1 : Claim Intimation

- In case of unplanned hospitalization, call and inform us within 24 hours of your admission. However, if your hospitalization is planned, kindly intimate us 48 hours prior to your admission.

  The following information is to be provided during the claim intimation-
  - Policy Holder's Name
  - Claimant's Name & Customer ID
  - Hospital details
  - Diagnosis and Treatment details
  - Approximate claim amount
  - Date of admission
- We will provide a reference ID for all future communication pertaining to the claim request.

Step 2 : Initiating the Claim process

- The Claim form can be downloaded from our website www.religarehealthinsurance.com
- The completed claim form has to be sent to us along with the following documents –
  - Duly completed and signed Claim form, in original;
  - Medical Practitioner's referral letter advising Hospitalization;
  - Medical Practitioner's prescription advising drugs/diagnostic tests/ consultation;
  - Original bills, receipts and discharge card from the Hospital/Medical Practitioner;
  - Original bills from pharmacy/chemists;
  - Original pathological/diagnostic test reports/radiology reports and payment receipts;
  - Indoor case papers;
  - First Information Report, final police report, if applicable;
  - Post mortem report, if conducted;
  - Any other document as required by the Company to assess the Claim
- The claim form and additional documents are to be sent to us at the following address:

  Religare Health Insurance Company Limited
  GYS Global, Plot No. A3, A4, A5, Sector - 125,
  Noida, U.P. - 201 301

Step 3 : Claim Processing and Reimbursement

- If your request for reimbursement of expenses is approved, you will be duly intimated by us.
- In case of any information deficiency or further information requirements, you will be communicated instantly to ensure resolution of the same at the earliest
- If your request for claims is declined, you will be communicated the same along with valid reason(s) for rejection. However, if the insured/insured's representative has further documents to enhance/substantiate his case for claim, the same can also be sent to us; and if found rational, the case will be reopened for review of the documents and response, if any.

We will ensure that you are updated at all important stages of your claim process. To help us serve you better, please ensure the following-

- The Pre-Authorization/Claim form is filled completely, sincerely and truly and all the required documents are submitted along with the form and in original, wherever specified
- Retain a copy of the duly filled forms
- Please quote the Member ID/Reference number for all communication related to the above

Add-on Benefits

1. The Add-on Benefits shall be available only if the same is specifically mentioned in the Policy Certificate.

2. The Add-on Benefits are subject to the terms and conditions stated below and the Policy Terms & Conditions.

3. Add-on Benefit 1: Everyday Care

3.1 Definition :
For the purpose of this Add-on Benefit :

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

b. Everyday Care Services :
The Company will provide the following Everyday Care Services (the "Services") under this Add-on Benefit to the Insured Person during the Policy Period:

i) Health Care Services which include only the following :

I. Doctor Anytime/Free Health Helpline : The Insured Person may seek medical advice from a Medical Practitioner through the telephonic or on online mode by contacting the Company on the helpline details specified on the Company's website;

II. Health Portal: The Insured Person may access health related information and services available through the Company's website;

III. Health & Wellness Offers : The Insured Person may avail discounts on the health and wellness products and services listed on the Company's website through the Network Service Provider.

ii) Doctor consultations:

I. The Insured Person may consult a Medical Practitioner within the Company's Network, on payment of ₹100 per consultation.

II. Maximum 4 consultations in a Policy Year are permissible for the same Illness or Injury.

c. Service Provider means any person, organization, institution that has been empanelled with the Company to provide Services specified under this Add-on Benefit to the Insured Person.

d. Clause 4.3(a)(xx) of the Policy Terms & Conditions is superseded only to the extent expressly specified in this Add-on Benefit.

3.2 Claim Process applicable to this Add-on Benefit.

a. If the Service is being availed in person, the Insured Person shall present his unique identification number along with a valid identification document (Voter ID card/driving license/passport/PAN card/any other identity proof as approved by the Company) to the Service Provider and pay ₹100 per consultation (in case of Doctor Consultation as specified under Clause 3.1 (b)(ii)) prior to availing such Services.

The Service Provider will provide the Services only after validation and authorization of the unique identification number by the Company.

b. If the Services are availed over the telephone or through online mode, the Insured Person will be required to provide the details as sought by the Company/ Service Provider in order to establish authenticity and validity prior to availing such Services.

c. If the Services are availed through the discount/redeemable voucher provided by the Company, the Insured Person shall present the discount/redeemable voucher along with a valid identification document (Voter ID card/ driving license/ passport/PAN card/ any other identity proof as approved by the Company) to the Service Provider prior to availing such Services.

3.3 General Terms & Conditions

a. If the Policyholder opts for this Add-on Benefit during the Policy Period, the expiry of this Add-on Benefit would coincide with the Policy Period End Date.

b. It is agreed and understood that the Company may, at its sole discretion, modify the list of Service Providers, Medical Practitioners or Health & Wellness Offers..

c. The rate of discount and the name of Service Provider offering the Services can be obtained either through Company's website or from the Company's call centre. Before availing the Services, the Policyholder or Insured Person may check the updated details of the available Service Providers and the applicable discounts/services from the Company's website or call centre.

d. The list of Services and discounts offered may vary with location and may be time barred and/or may change depending upon availability of Service Providers and discounts/Services available at such locations.

e. The Insured Person is free to choose whether to obtain the Services and, if obtained under this Add-on Benefit, then whether or not to act on the advice/information received and/or use the Services obtained.

f. These Services are for additional information purposes only and do not and should not be deemed to substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

g. The Company does not make any representation as to the adequacy or accuracy of the Services, the Insured Person's or any other person's reliance on the same or the use to which the Services are put. 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 Service Provider or for any consequences of actions taken or not taken in reliance thereon.

h. The Insured Person understands and agrees that although the confidentiality of the information provided by him shall be maintained however the calls made by him shall be recorded for the purposes of quality and for maintaining the record of their health information.

3.4 Cancellation

a. The Policyholder may give 15 days' notice in writing, to the Company, for the cancellation of this Add-on Benefit, in which case the Company shall from the date of receipt of the notice, cancel this Add-on Benefit and refund the premium for the unexpired period at the short period scales, as mentioned below, provided that the Insured Person has not utilized any of the Everyday Care Services specified in Clause 3.1 (b) of this Add-on Benefit.

b. Refund % to be applied on annual premium rates

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

c. If any of the Everyday Care Services specified in Clause 3.1 (b) of this Add-on Benefit has been utilized and the Policyholder chooses to cancel this Add-on Benefit then Company shall not be liable to refund any premium paid in respect to this Add-on Benefit.

4. Add-on Benefit 2 : No Claim Bonus Super

4.1 If no Claim has occurred in the expiring Policy Year and the Policy is renewed with the Company without any break, the Company will provide 50% of the Sum Insured of the expiring Policy on a cumulative basis as a No Claims Bonus Super for each completed and continuous Policy Year.

4.2 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.

4.3 General Terms and Conditions:

a. The No Claims Bonus Super shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 2.1 (c) of the Policy Terms and Conditions.

b. For a Floater policy, the No Claims Bonus Super, shall be also be available only 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 Super which is accrued during the Claim-free Policy Period will only be available to those Insured Persons who were insured in such Claim-free Policy Period and continue to be insured in the subsequent Policy Period.

c. The accrued No Claims Bonus Super as notified in the renewal notice shall be provisional and is subject to revision if a Claim is made under the expiring Policy Year.

d. The accrued No Claims Bonus Super will be forfeited if the Policy is not continued/renewed on or before Policy Period End Date and in any event not later than the expiry of the Grace Period.

e. The No Claims Bonus Super shall be applicable on an annual basis subject to continuation of the Policy.

f. This clause does not alter the Company's right to decline renewal or cancellation of the Policy.

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

h. At the time of Policy renewal if the Policyholder chooses not to renew this Add-on Benefit, then the No Claims Bonus Super under the expiring Policy shall be forfeited.

i. Any Claim under this Add-on Benefit shall always be subject to Clause 5.5 of the Policy Terms and Conditions.

j. 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.

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

4.4 Cancellation

a. The Policyholder may give 15 days' notice in writing, to the Company, for the cancellation of this Add-on Benefit, in which case the Company shall from the date of receipt of the notice, cancel this Add-on Benefit and refund the premium for the unexpired period at the short period scales, as mentioned below provided no Claim has been made under Clause 2 of the Policy Terms and Conditions:

b. Refund % to be applied on annual premium rates

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

c. If any Claim is made under Benefit 1, Benefit 6 or Benefit 7 of the Policy Terms and Conditions and the Policyholder chooses to cancel this Add-on Benefit then Company shall not be liable to refund any premium paid in respect of this Add-on Benefit.