AROGYA SANJEEVANI POLICY, RELIANCE GENERAL - POLICY WORDING

SECTION-1 PREAMBLE

This Policy is a contract of insurance issued by Reliance General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

SECTION-2 OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

SECTION-3 DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

3.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 Age means age of the Insured person on last birthday as on date of commencement of the Policy.

3.3 Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4 AYUSH Treatment refers to hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

a) Central or State Government AYUSH Hospital or

b) Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/Central Council for Homeopathy; or

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

i. Having at least 5 in-patients beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

iv. Maintaining daily records of the patient and making the accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

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

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

3.8 Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

3.9 Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

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

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

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

3.11 Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. Aco-payment does not reduce the Sum Insured.

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

3.13 Day Care Centre means any institution established or day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

i. Has qualified nursing staff under its employment;

ii. Has qualified medical practitioner (s) in charge;

iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out

iv. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

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

i. Undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and

ii. Which would have otherwise required a hospitalisation of more than twenty four hours.

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

3.15. Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.16. Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact.

3.17. Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

3.18. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. Legally wedded spouse.

ii. Parents and Parents-in-law.

iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

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

3.20. Hospital means any institution established for inpatient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

iii. Has qualified medical practitioner (s) in charge round the clock;

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

v. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.21. Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'Inpatient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.22. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

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

ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics

a) It needs ongoing or long-term monitoring through consultations, examinations, checkups, and/or tests

b) It needs ongoing or long-term control or relief of symptoms

c) It requires rehabilitation for the patient or for the patient to be special trained to cope with it

d) It continues indefinitely

e) It recurs or is likely to recur

3.23 Injury means accidental physical bodily harmexcluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

3.24 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.

3.25 Insured Person means person(s) named in the schedule of the Policy.

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

3.27 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which

shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

3.28 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.29 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.

3.30 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 the licence.

3.31 Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. Is required for the medical management of illness or injury suffered by the insured;

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.

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

3.33 Network Provider means hospitals enlisted by insurer, TPAor jointly by an insurer and TPAto provide medical services to an insured by a cashless facility.

3.34 Non- Network Provider means any hospital that is not part of the network.

3.35 Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.36 Out-Patient (OPD) Treatment means treatment 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.

3.37 Pre-existing disease (PED) means any condition, ailment, injury or disease:

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

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

3.38 Pre-hospitalisation Medical Expenses means medical expenses incurred during the period of 30 days preceding the hospitalisation of the Insured Person, provided that:

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

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

3.39 Post-hospitalisation Medical Expenses means medical expenses incurred during the period of 60days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

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

3.40 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

3.41 Policy Period means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.42 Policy Schedule means the Policy Schedule attached to and forming part of Policy.

3.43 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve month period, till the policy period, as mentioned in the schedule.

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

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

3.46 Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.47 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.48 Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the predefined limit.

3.49 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims

made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

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

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

SECTION-4 COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1 Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital /Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.

ii. Intensive Care Unit (ICU) /Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.

iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital.

iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1. Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits

ii. Dental treatment necessitated due to disease or injury

iii. Plastic surgery necessitated due to disease or injury

iv. All the day care treatments

v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. In case of admission to a room/ICU/ICCU at rates exceeding the afore said limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2 AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3 Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

4.4 Pre-Hospitalization

The Company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

4.5 Post Hospitalization

The Company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

4.6 The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) K.

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.7 The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List- III and List-IV of Annexure-Arespectively.

SECTION-5 CUMULATIVE BONUS

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

iii. CB shall be available only if the Policy is renewed/premium paid within the Grace Period.

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.

v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

SECTION-6 WAITING PERIOD

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

6.1. Pre-Existing Diseases (Code: Excl 01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

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

iv. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2 First Thirty Days Waiting Period (Code: Excl 03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

6.3 Specific Waiting Period (Code: Excl 02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

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

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

i. 24 months waiting period

1. Benign ENTdisorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

SECTION-7 EXCLUSIONS

The Company shall not be liable to make any payment under the

policy, in respect of any expenses incurred in connection with or in respect of:

7.1 Investigation & Evaluation (Code: Excl04)

i. Expenses related to any admission primarily for diagnostics and evaluation purposes

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

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

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7.3 Obesity/ Weight Control (Code: Excl06):

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) Greater than or equal to 40 or
   b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7.4 Change-of-Gender treatments (Code: Excl 07):

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

7.5 Cosmetic or Plastic Surgery (Code: Excl 08):

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

7.6 Hazardous or Adventure sports (Code: Excl 09):

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

7.7 Breach of law (Code: Excl 10):

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

7.8 Excluded Providers (Code: Excl 11):

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

7.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code: Excl 12):

7.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code:Excl13)

7.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code:Excl14)

7.12 Refractive Error (Code: Excl 15)

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

7.13 Unproven Treatments-Code (Code: Excl 16)

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

7.14 Sterility and Infertility (Code: Exc l7):

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

7.15 Maternity Expenses (Code - Excl 18)

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.16 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.

7.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

7.18 Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

7.19 Treatment taken outside geographical limits of India.

7.20 In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

SECTION-8 MORATORIUM PERIOD:

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

SECTION-9 CLAIMS PROCEDURE

1.1 Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.

(ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/ TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for nonmedical and inadmissible expenses.

(v) The Company/ TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

(vi) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPAfor reimbursement.

1.2 Procedure for Reimbursement of Claims

For reimbursement of claims the insured person may submit the documents to TPA(If applicable)/ Company within the prescribed time limit as specified hereunder.

SR. NO.	TYPE OF CLAIM	PRESCRIBED TIME LIMIT
1	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

9.1 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA(if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.2 Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form

ii. Photo Identity proof of the patient

iii. Medical practitioner's prescription advising admission

iv. Original bills with itemized break-up

v. Payment receipts

vi. Discharge summary including complete medical history of the patient along with other details.

vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).

ix. Sticker/Invoice of the Implants, wherever applicable.

x. MLR(Medico Legal Report copyif carried out and FIR (First information report) if registered, where ever applicable.

xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque

xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs I Lakh as per AML Guidelines

xiii. Legal heir/succession certificate, wherever applicable

xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

9.3 Co-payment

Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

9.4 Claim Settlement (provision for Penal Interest)

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

document.

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

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

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

9.5 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy,

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

9.6 Payment of claim

All claims under the policy shall be payable in Indian currency only.

SECTION-10 GENERAL TERMS AND CONDITIONS

10.1 Disclosure to information norm

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

10.2 Conditions precedent of to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

10.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and/or premium, if necessary, accordingly.

10.4 Records to be Maintained

The 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 for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

10.5 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

10.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

10.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

10.8 Multiple Policies

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

2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.

3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

10.9 Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: -

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

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

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent.

The company shall not repudiate the policy on the ground of fraud, if the insured person /beneficiary can prove that the

misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

10.10 Cancellation

a. The Company may cancel this Policy on by giving 7 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

- **In case of no claim in the policy**

In the event of cancellation by the insured the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

Calculation of Pro-Rata refund:

Return Premium=Total Policy Premium*(1-((Number of Policy days expired)/(Total Policy Days)))

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

- **In case of claim in the policy**

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

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

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

10.11 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

   However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions

10.12 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

10.13 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured

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

10.14 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

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

10.15 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person.

The Company is not bound to give notice that it is due for renewal.

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

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

iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy.

iv. Coverage is not available during the grace period, except in case where the premium is paid in instalment

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

10.16 Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as

mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.

ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

iii. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.

10.17 Possibility of Revision of Terms of the Policy Including the Premium Rates

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

10.18 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy. The insured shall be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

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

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

10.19 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/ immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India

10.20 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start a fresh only for the enhanced portion of the sum insured

10.21 Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document

10.22 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/ Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

SECTION-11 REDRESSAL OF GRIEVNACES

Grievance-In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link https://reliancegeneral.co.in
E-mail: rgicl.services@relianceada.com
Telephone: (022) 4890 3009 (Paid)
Post/Courier: Any branch office, the correspondence address, during normal business hours.
Write to us at: Winway Building 2nd and 3rd Floor, 11/12 Block No - 4, Old No - 67, South Tukoganj, Indore (M.P) - 452001.
For further details on Grievance redressal procedure please refer below link: https: / / reliance general.co.in/ Insurance/About -Us/ GrievanceRedressal.aspx
IRDAI Integrated Grievance Management System https://igms.irda.gov.in/

Insurance Ombudsman- The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure B

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation

You can reach us through any of the following methods for any service related issue and assistance:

Claims Servicing	
Name	R Care
Correspondence Address:	Reliance General Insurance. No. 1-89/ 3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081.
Contact No.:	(022) 4890 3009 (Paid)/(022) 4111 2600
E-mail :	rgicl.rcarehealth@relianceada.com
Fax No. :	(022) 4890 3009

1. TABLE OF BENEFITS

Claims Servicing	
Name	Arogya Sanieevani Policy, Reliance General
Product Type	Individual / Floater
Category of Cover	Indemnity
Sum insured	₹50,000/- (Fifty Thousand) to ₹10,00,000/- (Ten Lakhs) (in the multiples of fifty thousand) On Individual basis - SI shall apply to each individual family member On Floater basis - SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. Legally wedded spouse. ii. Parents and Parents-in-law Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
Name	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care
Pre-Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctors fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital/ Nursing Home up to 2% of the sum insured subject to maximum of ₹5000/- per day. 2. Intensive Care Unit (ICU) charges Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/ Nursing Home up to 5% of the sum insured subject to maximum of ₹10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or ₹40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years.
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims

ANNEXURE-A- ATTACHED TO POLICY WORDINGS

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

Sl. No.	Item
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)

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26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPY ES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZE R KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HINGED)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE Tablets
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT,RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

Sl. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET/WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS / VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES

35.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND / NAME TAG
37.	PULSEOXYMETER CHARGES

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

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

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

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

Annexure-B

OMBUDSMAN OFFICE			
Office of the Ombudsman	**Address**	**Contact Details**	**Areas of Jurisdiction**
AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 001.	Tel.: 079 - 27546150/27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078.	Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.: 0755 - 2769201, 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh

BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009.	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneshwar@cioins.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@cioins.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar Over Bridge, S.S. Road, Guwahati – 781001 (ASSAM).	Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, LIC OF INDIA, 10th Floor, 'Jeevan Prakash', Divisional Office, M. G. Road, Ernakulam, Kochi – 682011.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072.	Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, UT of Andaman & Nicobar Islands, Sikkim
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkar Nagar, Sultanpur, Maharajgang, Sant Kabir Nagar, Azamgarh, Kushinagar,

			Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharath Nagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist: Gautam Buddh Nagar, U.P. - 201301.	Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Budha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006.	Tel.: 0612 - 2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020 - 41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Arogya Sanjeevani Policy, Reliance General. UIN No.: RELHLIP21001V012021.

RELIANCE GENERAL INSURANCE COMPANY LIMITED

PRE-AUTHORISATION FORM

REQUEST FOR CASHLESS HOSPITALISATION HEALTH INSURANCE POLICY

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)				
a) Name of TPA / Insurance Company:				
b) Toll free phone number:				
c) Toll free FAX:				
TO BE FILLED BY THE INSURED/PATIENT				
a) Name of Patient:				
b) Gender:	☐ Male ☐ Female	c) Age:	Years Y Y	Months M M
d) Date of birth::	D D / M M / Y Y Y Y			
e) Contact number:				
f) Contact number of attending relative:				
g) Insured card ID Number:				
h) Policy number / Name of Corporate:				
i) Employee ID:				
j) Currently do you have any other Mediclaim/Health insurance:	☐ Yes ☐ No			
If yes, company name:				
Give details:				
l) Do you have a family physician:	☐ Yes ☐ No			
If yes, name of the family physician:				
Contact number, if any:				
(Please complete declaration on Page 3 of this form)				
TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL				
a) Name of the treating doctor:				
b) Contact number of the treating doctor:				
c) Nature of illness/disease with presenting complaints:				
d) Relevant clinical findings:				
e) Duration of the present ailment:	_____ days			
i) Date of first consultation:	D D / M M / Y Y Y Y			
ii) Past history of present ailment if any:				
iii) ICD 10 code:				
f) Provisional diagnosis:				
g) Proposed line of treatment:	☐ Medical management	☐ Surgical management	☐ Intensive care	
	☐ Investigation	☐ Non-allopathic treatment		
h) If investigation and/or medical management, provide details:				

i) Route of drug administration:			
i) If surgical, name of surgery:			
i) ICD 10 PCS Code:			
j) If other treatments, provide details:			
k) How did injury occur?			
l) In case of accident:			
i) Is it RTA:	☐ Yes ☐ No	ii) Date of injury:	D D / M M / Y Y Y Y
iii) Reported to police:	☐ Yes ☐ No	iv) FIR number:	
v) Injury/disease caused due to substance abuse/alcohol consumption:		☐ Yes ☐ No	
vi) Test conducted to establish this:	☐ Yes ☐ No (If Yes, attach reports)		
m) In case of maternity:	☐ G ☐ P ☐ L ☐ A	i) Date of delivery:	D D / M M / Y Y Y Y

DETAILS OF PATIENT ADMITTED

a. Date of admission:	D D / M M / Y Y Y Y	
b. Time:	HH : MM	
c. Is this an emergency/a planned hospitalization event?:	☐ Emergency ☐ Planned	
d. Expected no. of days' stay in hospital:	___ ___ ___ days	
e. Room type:		
f. Per day room rent + nursing and service charges + patient's diet:		₹. _____
g. Expected cost for investigation and diagnostics:		₹. _____
h. ICU charges:		₹. _____
i. OT charges:		₹. _____
j. Professional fees Surgeon + Anaesthetist fees + Consultation charges:		₹. _____
k. Medicines + Consumables + Cost of implants (if applicable please specify, other hospital expenses):		₹. _____
l. All inclusive package charges if any applicable:		₹. _____
m. Sum total expected cost of hospitalization:		₹. _____

MANDATORY: PAST HISTORY OF ANY CHRONIC ILLNESS IF YES, SINCE (MONTH / YEAR)

☐ Diabetes	MM/YYYY
☐ Heart disease	MM/YYYY
☐ Hypertension	MM/YYYY
☐ Hyperlipidemias	MM/YYYY
☐ Osteoarthritis	MM/YYYY
☐ Asthma/COPD/Bronchitis	MM/YYYY
☐ Cancer	MM/YYYY
☐ Alcohol or drug abuse	MM/YYYY
☐ Any HIV or STD/Related ailments	MM/YYYY
☐ Any other ailment give details:	

DECLARATION (Please read very carefully)

We confirm having read, understood and agreed to the Declarations on page 3 of this form:

a. Name of the treating doctor:

b. Qualification:

c. Registration number with state code: ☐ ☐ ☐ ☐ ☐ ☐

Hospital seal (Must include Hospital ID) Patient/Insured name and signature

DECLARATION BY THE PATIENT/REPRESENTATIVE:

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer after the discharge. I agree to sign on the final bill & the discharge summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the Insurer not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the Insurer.
5. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
6. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer.

Patient's/Insured's name: _____

Contact number: Patient's/Insured's signature

HOSPITAL DECLARATION:

1. We have no objection to any authorized Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Insurance Company, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital seal

_____

Doctor's signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM:

1. Detailed discharge summary and all bills from the hospital
2. Cash memos from the hospitals/chemists supported by proper prescription.
3. Receipts and pathological test reports from pathologists, supported by note from the attending medical practitioner/surgeon recommending such pathological tests.
4. Surgeon's certificate stating nature of operation performed and surgeon's bill and receipt.
5. Certificates from attending medical practitioner/surgeon that the patient is fully cured.