Preamble: The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured Members (also referred as Insured) and CARE HEALTH INSURANCE(formerly known as Religare Health insurance Company Ltd.) (also referred as Company), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Member(s)/Claimant, the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective benefit in any Cover Period.

Policy Terms & Conditions

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 Insurance Regulatory and Development Authority ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.
The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

1. Definitions

1. **Accidental / Accident** is a sudden, unforeseen and involuntary event caused by external and visible means.
2. **Act of God Perils** means and includes lightening, storm, tempest, flood, inundation, subsidence, landslide, earthquake, cyclone, tsunami, volcano and other similar calamities;
3. **Age** means the completed age of the Insured Member as on his last birthday.
4. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
5. **Ambulance** means a road vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.
6. **Annexure** means the document attached and marked as Annexure to this Policy.
7. **Any one illness (not applicable for Travel and Personal Accident Insurance)** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
8. **Assistance Service Provider** means the service provider specified in the Policy Schedule or as appointed by the Company from time to time.
9. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the company to the extent pre-authorization approved.
10. **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy.
11. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Member as covered under the Policy.
12. **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

13. **Company (also referred as Insurer/We/Us)** means CARE HEALTH INSURANCE(formally known as Religare Health insurance Company Ltd.).

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

15. **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

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.

17. **Cover End Date** means the date specified in Annexure 'A'(Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires.

18. **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance).

19. **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences.

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

    (a) has qualified nursing staff under its employment;
    (b) has qualified Medical Practitioner/s in-charge;
    (c) has a fully equipped operation theatre of its own, where Day Care Treatment is carried out.
    (d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

21. **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is :

    (a) undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 consecutive hours because of technological advancement, and
    (b) which would have otherwise required a Hospitalization of more than 24 consecutive hours.

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

    As listed in Annexure "I"

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

23. **Dependent** means a person who is a member of the Primary Insured Member's family who is legally wedded spouse, natural or legally adopted child, dependent parents, dependent parent-in-law, dependent brothers , dependent sisters and who is named in Annexure "A" to the Policy as an Insured Member;

24. **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.

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

26. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
    (a) The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
    (b) The patient takes treatment at home on account of non-availability of room in a Hospital.

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

28. **Emergency Care (Emergency)** 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 member's health.

29. **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.

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

31. **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:
    (a) has qualified nursing staff under its employment round the clock;
    (b) 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;
    (c) has qualified Medical Practitioner(s) in charge round the clock;

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

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

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

33. **Immediate Family Member** means an Insured Member's lawful spouse, children only.

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

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

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

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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 rehabilitation for the patient or for the patient to be specially trained to cope with it;

IV. It continues indefinitely;

V. It recurs or is likely to recur.

36. **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.

37. **In-patient Care** (not applicable for Overseas Travel Insurance) means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for a covered event.

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

39. **Insured Member (Insured)** means a person whose name specifically appears under Insured in the Annexure A or the Certificate of Insurance and is a covered group member.

40. **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.

41. **ICU Charges** or (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

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

43. **Medically Dependent** means mentally or physically disabled, unable to perform 'Activities of Daily living' without the assistance or direction of another person

44. **Medical Expenses** means those expenses that an Insured Member 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 Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

45. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
For Benefits / ,effective outside India:
Medical Practitioner means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

46. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:
    (a) Is required for the medical management of the Illness or Injury suffered by the Insured Member;
    (b) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    (c) Must have been prescribed by a Medical Practitioner;
    (d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

47. **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.

48. **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.

49. **Nominee** means the person named in the Certificate of Insurance who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Member is deceased.

50. **Non-Allopathic Medical Practitioner** for the purpose of Alternative Forms of Medicine means a Medical Practitioner qualified and practicing Ayurveda or Unani or Sidha or Homeopathic forms of Medicine for treatment of Illness/Injury, and registered as per Indian Medicine Central Council Act, 1970.

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

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

53. **OPD Treatment** (Out-patient Care) 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.

54. **Physiotherapist** refers to a person who is licensed to practice as a physiotherapist where the treatment is to take place and is recognized as a physiotherapist.

55. **Policy** means these Policy Terms & Conditions, ,(if any), the Proposal Form, Policy Schedule, Endorsements, Member List and Annexures which form part of the policy contract and shall be read together.

56. **Policy Schedule** is a Schedule attached to and forming part of this Policy.

57. **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

58. **Policyholder** (also referred as You) means the person or the entity who is the Group Administrator and named in the Policy Schedule as the Policyholder.

59. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.

60. **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.

61. **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

62. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Member is discharged from the Hospital provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required and
    ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.

63. **Pre-existing Diseases** means any condition, ailment, injury or disease:
    a.) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer **or**
    b.) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
    c.) A condition for which any symptoms and or signs if presented and have resulted within three months of the issuance of the policy in a diagnostic illness or medical condition.

64. **Pre-hospitalization Medical Expenses** Means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Member, provided that :
    i. Such Medical Expenses are incurred for the same condition for which the Insured Member's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

65. **Prescription** Refers to out-patient drugs (excluding supplements, vitamins and traditional medicine) and dressings as prescribed by a medical practitioner for the treatment of a medical condition covered by your member's plan. For avoidance of doubt, prescription will not include vitamins nor supplements nor over the counter medication even if they are prescribed by a medical practitioner.

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

67. **Primary Insured Member** means employee or a member of group who satisfies and continues to satisfy the eligibility criteria specified in the Certificate of Insurance and who is named in Annexure "A" to the Policy as an Insured Member.

68. **Qualified Nurse** (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

69. **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) 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.

70. **Rehabilitation** means assisting an Insured Member 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.

71. **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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

72. **Room Rent** means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.

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

74. **Scheduled Airline** means any civilian aircraft operated by a civilian scheduled air carrier holding a certificate, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered flights operated by such carrier.

75. **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of the policy.

76. **Specialized Practitioner** refers to a or practitioner who specializes in at least one of the following acupuncture, osteopathy, chiropractic or Chinese traditional medicine and is qualified and registered in the country where the out-patient treatment is to take place.

77. **Service Provider** means any person, organization, institution that has been empanelled with the Company to provide Services specified under the benefits.

78. **Subrogation** means the right of the Insurer to assume the rights of the Insured Member to recover expenses paid out under the Policy that may be recovered from any other source.

79. **Sum Insured** (Base Coverage Amount) means the amount specified against each Benefit for Member in the Policy Schedule which represents Our maximum liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Period.

80. **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.

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

82. **Twin Sharing Room** means a Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital.

83. **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.

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

(a) Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Member availed medical treatment;

(b) Intensive Care Unit charges;

(c) Fees charged by surgeon, anesthetist, Medical Practitioner;

(d) Investigation expenses incurred towards diagnosis of ailment requiring Hospitalization. Expenses related to the Hospitalization will be considered in proportion to the room rent stated in the Policy.

2. Scope Of Cover

General Conditions Applicable To All The Benefits:

1. The applicability of any Benefit is subject to the Policyholder having opted and such applicability is specified in the Policy Schedule.
2. All Claims shall be payable subject to the terms, conditions, wait periods and exclusions of the Policy and subject to availability of the Coverage amount against each and every Benefit.
3. Any Benefit mentioned in the Policy Schedule can be availed either under Cashless or Reimbursement basis or both, which will be specified in the Policy Schedule.
4. All the limits and sub-limits mentioned here above are subject to modification based on the customized Plan offered to group
5. The wait periods opted for Pre-Existing Diseases (PED), Named Ailments and Maternity for any Benefit and should be applicable to other Benefit and its ,(wherever applicable). In case different wait periods are selected, then maximum wait period will be applied.
6. The maximum, total and cumulative liability of the Company towards an Insured Member, for any and all Claims arising under this Policy during the Cover Year, on occurrence of an insured event in relation to that Insured Member, shall not exceed the Coverage Amount of that Insured Member which is specified against every Benefit, mentioned in the Policy Schedule.

7. Under this Product, the Company will provide Policy Schedule to Policyholder and access of Certificate of Insurance will be provided to each Insured Member, therefore the references to the 'Policy Schedule' shall include references to the 'Certificate of Insurance'.

1. Benefit 1 : Hospitalization Expenses

If an Insured Member is diagnosed with an Illness or suffers an Injury which requires the Insured Member to be admitted in a Hospital due to Medically Necessary conditions, subject to the Coverage opted, during the Cover Year, and while the Policy in force for:

(a) **In-patient Care (Hospitalization)**

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards In-patient Care Hospitalization of the Insured Member, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in written, by a Medical Practitioner, where Insured is covered for hospital charges incurred for eligible treatment given between admission and discharge of hospital.

(b) **Day Care Treatment**

The Company will indemnify the Medical Expenses incurred which are Reasonable and Customary Charges that are Medically Necessary towards Day Care Treatment of the Insured Member, up to the Coverage Amount specified in the Certificate of Insurance provided that:

a) the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions; and
b) the period of treatment of the Insured Member in Hospital/Day Care Centre does not exceed 24 hours; and
c) the Day Care Treatment was taken on the advice of a Medical Practitioner

(c) **Road Ambulance Cover**

The company will indemnify for the reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider as specified in the Certificate of Insurance, for the Insured Member's necessary transportation provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

(i) Such Transportation is from the place of occurrence of Medical Emergency of the Insured Member, to the nearest Hospital; and/or
(ii) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Member, following an Emergency.

(d) **Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses**

The Company will indemnify the Insured Member for Relevant Medical Expenses incurred which are Medically Necessary, only through Reimbursement Facility, maximum up to the Coverage Amount, as specified in the Certificate of Insurance, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Member's Claim under Hospitalization Expenses and subject to the conditions specified below:

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

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

(iii) The number of consultations covered by this benefit is limited to once per day.

(iv) This benefit does not cover follow-up consultation or treatment after the Insured Member is discharged from an in-patient rehabilitation facility.

(v) If the provisions of Clause 6.6(f) is applicable to a Claim, then:

a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and

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

(f) **Conditions applicable for Hospitalization Expenses :**

(a) <u>Room/Boarding and nursing expenses as charged by the Hospital where the Insured Member availed medical treatment (Room Rent / Room Category):</u>

If the Insured Member is admitted in a Hospital room where the Room Category opted or *Room Rent incurred is higher than the eligible Room Category/ Room Rent* as specified in the Certificate of Insurance, then,

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

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

1) If the Certificate of Insurance states 'up to 1% of the Coverage Amount per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Member payable by the Company is limited to 1% of the Coverage Amount per day of Hospitalization.

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

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

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

1) If the Certificate of Insurance states 'up to 2% of the Coverage Amount per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Member payable by the Company is limited to 2% of the Coverage Amount per day of Hospitalization.

3. Exclusions

1. Wait Periods applicable under this Policy for Benefit under Hospitalization Expenses

a. **Initial wait period**

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

b. **Specific Wait Period for Named Ailments**

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

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

(iii) 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.

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

(v) 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.

(vi) List of specific diseases/procedures:

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

c. **Wait Period for Pre-existing Diseases**:

(i) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.
(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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

d. The Wait Periods as defined in Clauses 5.1(a), 5.1(b) and 5.1(c) shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

2. Permanent Exclusions:

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

Any Claim in respect of any Insured Member 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.

1) Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II).

2) Any pre-existing injury / illness or disability and any complications thereof and its associated medical conditions unless we had agreed otherwise in writing;

3) Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
Note: Refer Annexure – III of the Policy Terms & Conditions for list of excluded hospitals.

4) 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;

5) Maternity: Code Excl18

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

6) Any treatment directly related to surrogacy whether the member is acting as surrogate, or is the intended parent;

7) Any treatment begun or for which the need has arisen during the first ninety (90) days after birth, for any child conceived by artificial means or any form of assisted conception or if the child is born via surrogacy;

8) Birth control, Sterility and Infertility: Code- Excl17

Expenses related to Birth Control, 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;

9) 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;

10) Charges incurred in connection with routine eye examinations and ear examinations, dentures, crowns, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment;

11) Refractive Error: (Code- Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

12) Unproven Treatments: Code- Excl16
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

13) Expenses incurred on advanced treatment methods other than as mentioned in clause 2.1 (h)

14) Any expenses incurred on providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment of any kind, like wheelchairs, walkers, crutches, ambulatory devices, unless allowed under the Policy, cost of Cochlear implants;

15) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital;

16) Treatment of any external Congenital Anomaly or Illness or defects or anomalies including their associated medical conditions or chronic medical conditions or vegetative state cover (on the basis of declaration by the treating doctor) or treatment relating to external birth defects;

We define vegetative state as a condition of profound non-responsiveness with no sign of awareness or consciousness or a functioning mind, even if the Insured can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;

17) Treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage on the basis of declaration by the treating doctor. It is stated that treatment up to 90 days for permanent neurological damage will be covered under this Policy;

18) Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability

19) Obesity/ Weight Control(Code- Excl06)
Expenses related to the surgical treatment of obesity that does not fulfill 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

20) Cosmetic or plastic Surgery: Code- Excl08
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner;

21) Change-of-Gender treatments: Code- Excl07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex;

22) Out-patient treatment;

23) Treatment received outside India;

24) Domiciliary hospitalization or treatment;

25) Investigation & Evaluation(Code- Excl04)
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded;

26) Rest Cure, rehabilitation and respite care- Code- Excl05
a) 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;

27) An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;

28) An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

29) Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor or activity;

30) Professional fees charged by a member of the Insured Member's immediate family or by a person normally resident in the household of the Insured or under his employment;

31) Training for or participating in professional sport of any kind or any sport for which the insured receives a salary or monetary reimbursement, including grants or sponsorship;

32) The Insured Member serving in any branch of the military, navy, air force or any branch of armed forces or

any paramilitary forces;

33) Radioactive contamination whether arising directly or indirectly ionizing radiation, toxic, explosive or other hazardous properties of nuclear material;

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

35) All preventive care, Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics;

36) 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);

37) All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery;

38) Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine;

39) 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;

40) Breach of law: Code- Excl10
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent;

41) 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, Areca nut intoxicating drugs and alcohol or hallucinogens;

42) Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness or any administration costs or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;

43) Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies;

44) Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or any room upgrades, menu items not included as standard or visitors meals;

45) 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;

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 is also excluded.

46) Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner;

47) Continuous ambulatory peritoneal dialysis. Coverage for 'Continuous ambulatory peritoneal dialysis' is available on OPD basis and as part of Pre-Post hospitalization expenses;

48) Charges for items not listed in the policy schedule applicable to the member or considered as not medically necessary or which may be considered as elective;

49) Alopecia wigs and/or toupee and all hair or hair fall treatment and products including any investigations; all forms of acne;

50) Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions;

51) Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule including the associated medical conditions shown on the endorsement;

52)Cryopreservation or harvesting or storage of stem cells as a preventive measure against possible disease/illness/injury, or implantation or re-implantation of living cells or living tissue whether autologous or provided by a donor;

53) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12

54) Any other weight management services, treatment and supplies unless requires hospitalization and surgery ;

55) 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)

56) Hormone Replacement Therapy;

57) Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor

racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving;

58) The evacuation would involve moving Insured Member from a remote location where there is no or limited access;

59) Dental, Orthodontics, Periodontics, Endodontics or any preventative dentistry no matter who gives the treatment;

60) Charges for residential stays in Hospital which are not medically necessary or are incurred for social or domestic reasons or for reasons which are not directly connected with treatment or where the Hospital has effectively become the place of domicile or permanent abode;

61) Any charges made by the medical practitioner, hospital, laboratory or any such medical services which are not reasonable and customary;

62) Genetic tests undertaken to establish whether or not the Insured may be genetically disposed to the development of a medical condition in the future unless requires for current medical treatment;

63) Insured Person suffering from or has been diagnosed with or has been treated for Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/ Thalassemia Major/G6PD deficiency prior to the first Policy Start Date, then costs of treatment related to or arising from the disorder whether directly or indirectly will be treated as a Pre-existing Disease and will not be covered within first 48 months from the date of first issuance of the Policy

64) Ear or body piercing and tattoing or treatment needed as a result of any of these;

65) Any charges for treatment incurred during a period for which the premium is not paid;

66) Any claim or part of a claim in which the member has to pay a deductible or co-insurance (where applicable). In such a claim, we will only pay the balance of the claim after we have deducted the excess (or deductible or co-insurance) amount;

67) All bank or credit or foreign exchange charges when the claims payment is made in a currency other than the policy currency upon the member's request;

68) Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound);

69) Any other conditions at the discretion of Underwriter

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

4. Claims Intimation, Assessment and Management

1. Upon 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 Insured Member 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 Insured Member (or Nominee or legal heir if the Insured Member is deceased), shall notify the Company either at Company call Centre or in writing immediately and in any event within the timeframe (if any) specified in the Benefit under which the Claim is made.

(ii) Claim must be filed within 15 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization benefits.

Note: 6.1 (a) (i) and 6.1 (a) (ii) are precedent to admission of liability under the policy.

(iii) If the Insured Member is to undergo planned Hospitalization, the Insured Member shall give written intimation to the Company of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.

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

I Policy Number ;
II Name of Primary Insured Member;
III Name and unique identification number of the Insured Member in respect of whom the Claim is being made;
IV Nature of Illness or Injury and the Benefit under which the Claim is being made;
V Date and place of Injury or Death and/or date and place of admission to Hospital (as applicable);
VI Name and address of the attending Medical Practitioner and Hospital;
VII Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
VIII Any other information / document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected.

(v) A Claim has to be notified to the Company within 24 hours or before discharge (whichever is earlier) for Emergency Hospitalization.

2. Claims Procedure

(a) **Cashless :**

Cashless facility is available only at Network Hospitals of the Company or Assistance Service Provider. The Insured Members can avail cashless facility at the time of admission into a Network Hospital, by presenting the health card, provided by the Company under this Policy,

along with a valid photo identification document (like: Voter ID card / Driving License / Passport / PAN Card / any other identification documentation as approved by the Company).

(b) In addition to the above, in order to avail cashless facility, the following procedure must be followed:

(i) Pre-authorization: the Insured Member must call the Company or Assistance Service Provider call centre (xxx-xxxxxxxxx) and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours prior before the commencement of a 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 or Assistance Service Provider will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Member's Hospitalization.

(iii) If the request for availing cashless facility is authorized by the Company or Assistance Service Provider, then payment for the Medical Expenses incurred in respect of the Insured Member 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 within Deductible (if applicable) or any other costs and expenses not authorized under the cashless facility shall be made directly by the Insured Member to the Network Hospital. All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member and all other information and documentation specified at Clause 6.4 shall be submitted to the Network Hospital immediately and in any event before the Insured Member's discharge from Hospital.

(iv) In case Policyholder/Insured Member cannot avail the cashless facility, payment for the treatment will have to be made by the Insured Member to the Network Hospital, 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.

(c) The list of updated Network Hospitals is available with the Company or Assistance Service Provider and is subject to amendment or modification of the Network Hospitals and/or the extent of cashless facilities available at particular Network Hospitals from time to time.

(d) Before availing the cashless facility, Policyholder or the Insured Member is required to check the applicable list of Network Providers for the area where he intends to avail the cashless facility through the call center number as provided in the Certificate of Insurance.

(e) Health card issued by the Company shall not be used

(i) On termination or cancellation of this Policy

(ii) After Cover End Date

(iii) On death of Insured Member

(f) **Re-imbursement :**

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.1 and Clause 6.4 shall be submitted to the Company at Insured Member's own expense, immediately and in any event within 30 days of Insured Member's discharge from Hospital.

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

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

(iv) For Claim settlement under reimbursement, the Company will pay the Insured Member. In the event of death of the Insured Member, the Company will pay the nominee (as named in the Certificate of Insurance) and in case of no nominee, to the legal heirs or legal representatives of the Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.

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

(vi) Insured Member (or Nominee or legal heir if the Insured Member is deceased) shall (at his expense) give the documentation specified at Clause 6.4 and any additional documentation specified in the Benefit provision under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

(g) **Claims incurred outside India:** The Company's Assistance Service Provider should be intimated for availing cashless facility under the applicable Benefits.

3. Policyholder's and Insured Member's duty at the time of Claim

(a) The Insured Member shall check the updated list of Network Hospitals before submission of a pre-authorization request for cashless facility; and

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

(iii) The Insured Member will, at the Company request submit himself/herself for a medical examination by the Company's/Assistance Service Provider nominated

Medical Practitioner as often as the Company consider reasonable and necessary. The cost of such medical examination shall be borne by the Company.

(iv) The Company's /Assistance Service Provider Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and Hospitalization records and to investigate the facts and examine the Insured Member.

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

4. Claim Documents

(a) The following information and documentation shall be submitted to the Company /Assistance Service Provider in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy in respect of all Claims:

(i) Duly completed and signed Claim form, in original;
(ii) Identity proof with photo, Age proof and Address Proof;
(iii) Medical Practitioner's referral letter advising Hospitalization;
(iv) Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
(v) Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
(vi) Original bills from pharmacy / chemists;
(vii) Original pathological / diagnostic test reports and payment receipts;
(viii) Indoor case papers (if applicable);
(ix) Accident proof - First Information Report/ final police report, if applicable;
(x) Disability Certificate from Government Medical Board, Fitness Certificate, Medical Prescription
(xi) Post mortem report, if conducted;
(xii) Any other information/document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected

(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 Member's name.

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

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

5. Claim Assessment

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

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

(i) If a room/ ICU accommodation has been opted for where the rent or category is higher than the eligible limit for that Insured Member under the Policy, then, the Insured Member shall bear the ratable proportion of the Variable Medical Expenses (including surcharge or taxes thereon) in the proportion of the room rent actually incurred less room rent limit and divided by room rent actually incurred.

(ii) If any sub-limits on Medical Expenses are applicable as specified in the Certificate of Insurance, the Company's liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.

(iii) Co-payments, Deductibles and Franchise Deductibles, if any, shall be applicable on the amount payable by the Company after applying Clause 6.5.(b)(i), (ii).

(c) The Claim amount assessed in Clause 6.5(b) above would be deducted from the Coverage Amount of respective Benefit.

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

6. Payment Terms

(a) This Policy covers only medical treatment taken entirely within India and within area of cover as shown in the Certificate of Insurance.

(b) Only for reimbursement cases, payments under this Policy shall be made in Indian Rupees and within India. For all admissible reimbursement Claims and benefit (fixed pay-out) Claims, the exchange rate on the date of loss shall be applied.

(c) If the Assistance Service Provider or the Company requests that bills or vouchers in a local language or vernacular be accompanied by an appropriate translation into English then the costs of such translation must be borne by the Policyholder or the Insured Member.

(d) The Claim amount assessed for any Benefit would be deducted from the Coverage Amount and for the unexpired Cover Year, balance Coverage Amount shall be available.

(e) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member, once the Coverage Amount for that Insured Member is exhausted.

(f) If the Insured Member 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.

(g) Under cashless facility, the payment of Claims shall be made to the Network Hospital and the Company discharge would be complete and final.

(h) For the Reimbursement Claims, the Company will pay to the Primary Insured Member unless specified otherwise in the Certificate of Insurance. In the event of death of the Primary Insured Member, unless specified otherwise in the Certificate of Insurance, the

Company will pay the nominee (as named in Annexure A to the Policy) and in case of no nominee to the legal heir of the Primary Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.

(i) **The Company shall settle or reject any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Member an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Member, the Company shall make payment within 7 days from the date of receipt of such acceptance. However, if a claim warrants an investigation in the opinion of the Company, then the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case there is delay in the payment beyond the stipulated timelines from the date of receipt of last necessary document to the date of payment of claim, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India at the beginning of financial year, unless the extent regulation requires payment based on some other prescribed interest rate.

(j) The Claim shall be paid only for the Cover Year in which the Insured event which gives rise to a Claim under this Policy occurs.

(k) The Company may change the Assistance Service Provider or utilize the service of any other assistance service provider by giving written notification to the Policyholder.

5. General Terms and Conditions

1 Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, misdescription or non-disclosure of any material particulars or any material information having been withheld in the Proposal Form or accompanying document or if a Claim is fraudulently made or any fraudulent means or devices are used by Policyholder, the Insured Member 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 on cancellation of the Policy.

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 Policyholder or the Insured Member, shall be a condition precedent to the Company's liability under this Policy.

3 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense or any material information that the Insured Member and/or Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company in order to accept the risk of insurance and if so on what terms. The Insured Member/Policyholder must exercise the duty of disclosure to Company before Renewal, extension, variation, endorsement. The Company may, in its discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

4 Records to be maintained

Policyholder and the Insured Members shall keep an accurate record containing all relevant medical records and shall allow the Company or the Company representatives to inspect such records. Policyholder or the Insured Member shall furnish such information as the Company may require under this Policy at any time during the Cover 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.

5 No constructive Notice

Any knowledge or information of any circumstance or condition in relation to Policyholder, the Insured Members which is in the Company possession and 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 or absolve the Policyholder or Insured from their duty of disclosure.

6 Complete Discharge

Payment made by the Company to Policyholder / to the Insured Member or their legal representatives / 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 construed as an effectual discharge in favor of the Company.

7 Multiple Policies

a. In case any Insured Member is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Member shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the Coverage Amount of such Policy.
b. In case the Claim amount under a single policy exceeds the Coverage Amount, then Policyholder/Insured Member shall have the right to choose the companies with whom the Claim is to be settled. Further, policyholder/Insured Member shall have the right to choose the companies from whom he/she wants to claim the balance amount. Insured shall only be indemnified the hospitalization costs in accordance with terms & conditions of chosen Policy.
c. Policyholder/Insured Members shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted.

8 Free Look Period

i. The Policyholder/Insured Member 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.
ii. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.
iii. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

9 **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.

10 Renewal Notice

a. The Coverage will automatically terminate on the Cover End Date. All renewal applications and requisite premium shall be given to the company on or before the Cover End Date provided the policy is in force and in any event before the expiry of the Grace Period. The Policyholder shall give the company written notice along with the renewal application of any material changes to the risk insured under the Policy. If no such written notice is received by the company along with the renewal application, it shall be deemed that there is no material change to the risk.

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

b. The company will ordinarily not refuse to renew the Policy except on grounds of fraud, moral hazard or misrepresentation or non-co-operation by the Insured. This policy can be renewed subject to Master Policy renewability based on agreed terms

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

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

e. This product may be withdrawn / modified by the company after due approval from the IRDAI. In case this product is withdrawn / modified by the company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI subject to Underwriting. The company shall duly intimate Policyholder atleast three months prior to the date of such withdrawal / modification of this product and the options available to Insured Member at the time of renewal of this policy.

f. No loading based on individual claim experience shall be applicable on renewal premium payable

11 Cancellation / Termination

a. The Company may at any time, cancel this Policy on grounds of 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 Policyholder/Insured member or any one acting on Policyholder/Insured member

behalf. The Company shall have no liability to make payment of any claims and the premium paid shall be forfeited ab initio to the Company and no refund of premium shall be effected by the Company, by giving 15 days' notice in writing by Registered Post Acknowledgment Due/recorded delivery to Policyholder/Insured member last known address.

a. Policyholder/Insured member 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 that no refund shall be made for those Insured Member who has incurred Claim under the Policy.

b. Refund % to be applied on total premium received as on the date of receipt of the cancellation request

Cancellation date up to (x months) from Policy Period Start Date	1 Year
Up to 1 month	75.00%
1 month to 3 months	50.00%
3 months to 6 months	25.00%
6 months to 12 months	0.00%
12 months to 15 months	N.A.
15 months to 18 months	N.A.
18 months to 24 months	N.A.
24 months to 30 months	N.A.
30 months to 36 months	N.A.
36 months to 42 months	N.A.
42 months to 48 months	N.A.
48 months to 54 months	N.A.
Beyond 54 months	N.A.

c. In case of demise of the Primary Insured Member,
   i. Where the Policy covers only the Primary Insured Member, this Policy shall stand null and void from the date and time of demise of the Primary Insured Member.
   ii. Where the Policy covers other Insured Members, this Policy shall continue till the end of Cover Period for the other Insured Members. If the other Insured Members wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a Primary Insured Member provided that:
      I. Written notice in this regard is given to the Company before the Cover End Date; and
      II. A Person who satisfies the Company's criteria to become a Primary Insured Member. The criteria being:
         (a) He / She should become a member of the Group against whom the Master policy is issued.

(b) He / She should satisfy the age limit criteria as mentioned in the product.

d. **Cancellation in case of premium installment is opted** -

If Policyholder cancels the Policy after the Free look period or demise of Insured where he/she is the only insured in the Policy, then the Company will refund 50% of the installment premium for the unexpired installment period, provided no Claim has been made under the Policy

12 **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 or the Insured Member proves to the Company satisfaction that the delay in reporting of the Claim was for reasons beyond the Insured Member's control.

13 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Schedule/ Certificate of Insurance.
b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule/ Certificate of Insurance. 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.

14 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.

15 Out of all the details of the various benefits provided in the Policy Terms and Conditions, only the details pertaining to benefits chosen by policyholder as per Policy Schedule shall be considered relevant

16 Electronic Transactions

The Policyholder and Insured Member agrees 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 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. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions

17 Continuity Benefits

The company will grant continuity of benefits which were available to the Insured Members under a group insurance policy in the immediately preceding Cover Period provided that:

i. The company shall be liable to provide continuity of only those benefits (for e.g: Initial wait period, wait period of Specific Diseases etc)which are applicable under the Policy;
ii. The Insured Members to whom continuity benefits will be provided should be covered under the group insurance policy;
iii. Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by the company and the credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by the company. Application for this Policy is made within 45 days before, but not earlier than 60 days from the expiry of that group insurance policy
iv. Insured Member can apply only at the time of renewal of the group Policy.

18 Obligation in respect to minor

If an Insured Member is less than 18 years of age, the Primary Insured Member shall be responsible for ensuring compliance with all terms and conditions of this Policy on behalf of that Insured Member.

19 Nominee

The Primary Insured Member can at the inception or at any time before the expiry of the Policy, make the nomination for the purpose of payment of Claims.

Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement to the Policy is made by the Company.

In case of any Insured Member other than the Primary Insured Member under the Policy, for the purpose of payment of Claims in the event of death, the default nominee would be the Primary Insured Member.

20 Proximate Clause

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

21 Sanctions and Compliance with Laws

This insurance does not apply to the extent that trade or economic sanctions or other similar laws or regulations prohibit the coverage provided by this insurance.

22 Grievances

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

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

Website: www.careinsurance.com
Email: customerfirst@careinsurance.com
Contact No.: 1860-500-4488, 1800-102-4488
Courier: Any of Our Branch Office or corporate office

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

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

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

Head – Customer Services,
CARE HEALTH INSURANCE(formally known as Religare Health insurance Company Ltd.),Unit No. 604-607. 6th Floor, Tower C,Unitech Cyber Park, Sector-39,Gurgaon– 122001 (Haryana)

(c) If the Policyholder / Insured Member is not satisfied with the Company's redressal of the Policyholder's / Insured Member's grievance through one of the above methods,

the Policyholder / Insured Member may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsmen offices are mentioned below:

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 E-mail : bimalokpal.ahmedabad@ecoi.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	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@ecoi.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.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@ecoi.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, 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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,	Delhi

	Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory 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@ecoi.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe – a part 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@ecoi.co.in	West Bengal, 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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur,

		Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Office of the 'Executive Council of Insurers'
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),

Mumbai – 400 054.
Tel : 022-26106889/671/980
Fax : 022-26106949
Email- inscoun@ecoi.co.in