Policy Terms and Conditions

1. Definitions

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

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

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

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

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

1.4 Annexure means a document attached and marked as Annexure to this Policy.

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

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

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

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

1.9 Company means Religare Health Insurance Company Limited.

1.10 Condition Precedent shall mean a policy term or condition upon which the Company’s liability under the policy is conditional upon.

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

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

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

1.12 Contribution is essentially the right of the Company to call upon other insurers, liable to the same Insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured.

1.13 Co-payment shall mean a cost-sharing requirement under a health insurance policy that provides that the Policyholder/Insured Person will bear a specified percentage of the admissible Claim amount. A Co-payment does not reduce the Sum Insured.

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

1.15 Day Care Centre means any institution established for Day Care Treatment of Illness and/or Injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under -

   i) has qualified nursing staff under its employment;

   ii) has qualified Medical Practitioner/s in charge;

   iii) has a fully equipped operation theater of its own where Surgical Procedures are carried out;

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

1.16 Day Care Treatment means medical treatment and/or a Surgical Procedure which is listed in Annexure - A and which is:

   i) undertaken under general or local anesthesia in a Hospital/Day Care Center in less than 24 hours because of technological advancement, and

   ii) which would have otherwise required Hospitalization of more than 24 hours.

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

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

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

1.19 Deductible is a cost-sharing requirement under this Policy that provides that the Company will not be liable for a
specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Company. A deductible does not reduce the Sum Insured. The Claim should be admissible under Benefit 1, Benefit 2, Benefit 3 and Benefit 5 of this Policy.

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

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

1.22 Emergency Care means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

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

1.24 Hospital means any institution established for In-Patient Care and Day Care Treatment of Illness and/or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
   i) has qualified nursing staff under its employment round the clock;
   ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
   iii) has qualified Medical Practitioner(s) in-charge round the clock;
   iv) has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
   v) maintains daily records of patients and makes these accessible to the Company’s authorized personnel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.39 Policyholder means the person named in the Policy Certificate as the Policyholder.

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

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

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

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

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

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

1.45 Post-hospitalization Medical Expenses means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:
   a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
   b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.

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

1.47 Pre-hospitalization Medical Expenses means Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that:
   a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
   b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.

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

1.49 Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.

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

1.51 Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of all waiting periods.

1.52 Room Rent means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

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

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

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

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

1.57 Variable Medical Expense means those Medical Expenses which vary in accordance with the Room Rent or room category or ICU charges 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 (ICU) charges
   c. Fees charged by surgeon, anesthetist, Medical Practitioner

2. Scope of Cover

General Conditions applicable to all Benefits:

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

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

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

d. Any Claim under the Policy except for Benefit 4 shall always be subject to Clause 6.5.

e. Any Claim paid except for Benefit 4 shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all future Claims for that Policy Year.

2.1 Benefit 1: Hospitalization Expenses

a. If an Insured Person is diagnosed with an Illness or suffers an Injury during the Policy Period and while the Policy is in force that requires:
i) The Insured Person's Hospitalization as In-patient Care, then the Company will indemnify the Medical Expenses incurred on Hospitalization, provided that the Hospitalization was on the written advice of a Medical Practitioner; or

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

b. Conditions for Medical Expenses

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

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

c. Any Claim under this Benefit can be made under Clause 6.2(a) & (b).

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

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

i) As Pre-Hospitalization Medical Expenses during a period of 30 days immediately prior to the date of the Insured Person's admission to the Hospital; and

ii) As Post-Hospitalization Medical Expenses during a period of 60 days immediately following the date of the Insured Person's discharge from Hospital,

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

b. If the provisions of Clause 6.6(e) of the Policy Terms & Conditions has been invoked, then:

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

ii) The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to that Any One Illness.

c. Any Claim under this Benefit can be made under Clause 6.2(b).

2.3 Benefit 3 : Organ Donor Cover

a. The Company will indemnify up to the amount specified against this Benefit in the Policy Certificate for the Medical Expenses incurred in respect of the donor for any organ transplant surgery conducted on the Insured Person during the Policy Year, provided that:

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

ii) The organ donated is for the Insured Person's use.

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

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

c. Any Claim under this Benefit can be made under Clause 6.2(a) & (b).

2.4 Benefit 4 : Health Check-up

a. On the Insured Person's request, the Company shall arrange for the Insured Person's Health Check-up at its Network Provider or any other Service Providers empanelled with the Company to provide the services, in India:

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

ii) This Benefit shall only be available once every Policy Year.

b. Clause 6.5 of this Policy shall not be applicable for any Claim settlement under this Benefit.

c. Any Claim under this Benefit can be made under Clause 6.2(a).

2.5 Benefit 5 : Enhance Anywhere

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

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

I. Cancer

II. Benign Brain Tumour

III. Major Organ Transplant/Bone Marrow Transplant
IV. Heart Valve Replacement
V. Coronary Artery Bypass Graft

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

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

iii) Any payments under this Benefit shall always be made in India, in Indian Rupees and on a reimbursement basis only. The rate of exchange as published by Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of foreign currency amounts into Indian Rupees for payment of any Claim under this Benefit. Where on the date of discharge, RBI rates are not published, the rates next published by RBI shall be considered for conversion.

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

v) Clause 4.3(a)(xxi) and Clause 6.6(a) is superseded to the extent covered under this Benefit.

b. Any Claim under this Benefit can be made under Clause 6.2(b).

3. Special Conditions

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

3.1 Special Condition 1: Floater Cover
a. The Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of all Insured Persons, shall not exceed the Sum Insured.

b. Definition 1.54 is deleted entirely and replaced with the following:

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

3.2 Special Condition 2: Co-payment
a. The Policyholder shall bear 20% of the Final Claim Amount assessed by the Company in accordance with Clause 6.5 in accordance with the table below and the Company's liability shall be restricted to the balance amount payable:

<table>
<thead>
<tr>
<th>Cover Type</th>
<th>Entry Age* of Insured Person or Eldest Insured Person (in case of Floater)</th>
<th>Applicable To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>&gt;=61 years</td>
<td>Individual Insured Person</td>
</tr>
<tr>
<td>Floater</td>
<td>&gt;=61 years</td>
<td>All Insured Person's</td>
</tr>
</tbody>
</table>

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

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

4. Exclusions

4.1. Waiting Period
a. 30-Day waiting period

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

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

b. Specific waiting period

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

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

II. Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastroidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders;
IV. Cataract;
V. Dilatation and Curettage;
VI. Fissure / Fistula in anus, Hemorrhoids/Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers;
VII. Surgery of Genito urinary system unless necessitated by malignancy;
VIII. All types of Hernia, Hydrocele;
IX. Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy;
X. Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant;
XI. Kidney Stone / Ureteric Stone / Lithotripsy/ Gall Bladder Stone;
XII. Myomectomy for fibroids;
XIII. Varicose veins and varicose ulcers

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

c. Pre-existing Disease: Any claims for Medical Expenses incurred for diagnosis or treatment of any Pre-existing Disease shall not be admissible until the completion of 48 months of continuous coverage since the inception of the first Policy with the Company.

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

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

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

4.2. The Company shall provide an option to the Policyholder to renew the Policy without an applicable Deductible, on the expiry of 4 continuous years of coverage under this Policy, subject to the following:

i) The Policyholder shall pay in full in advance the premium specified for exercising this option.

ii) This option shall be permitted to be exercised provided that the Company receives written notice from the Policyholder for exercising this option at least 15 days prior to the expiry of this Policy.

iii) The waiting periods as defined in Clause 4.1(b) and 4.1(c) of this Policy Terms and Conditions shall be further applicable for a period of 12 months to the amount of the Deductible.

iv) If the Sum Insured selected while exercising this option exceeds the Sum Insured of this Policy, the credit for waiting periods as defined in Clause 4.1(a), 4.1(b) and 4.1(c) of this Policy Terms and Conditions shall be applicable afresh to the incremental Sum Insured.

v) The Policyholder shall be permitted to exercise this option only if all the Insured Persons under this Policy opt for a Sum Insured which is at least equal to or higher than the sum of the Sum Insured and Deductible under this Policy.

vi) This option shall be applicable only for those Insured Persons who have completed 4 continuous years under this Policy.

vii) Exercise of this option shall be permitted only at the time of renewal of this Policy.

4.3. Permanent Exclusions:

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

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

ii) Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.

iii) Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

iv) 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.

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

vi) Experimental, investigational or unproven treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.

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

viii) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, health hydrox, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.

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

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

xi) Aesthetic treatment, cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer or burns.

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

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

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

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

xvi) Any travel or transportation expenses including Ambulance charges.

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


xx) Treatment received outside India.


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

xxiii) 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, restraint and detainment of all kinds.

xxiv) Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.

xxv) Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.

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

xxvii) Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient’s diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.
xxvii) Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the hospital under whatever head.

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

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

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

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

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

xxx) Impairment of an Insured Person’s intellectual faculties by abuse of stimulants or depressants.

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

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

xxxiii) Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions.

xxxiv) Any specific time-bound or lifetime exclusions specified in the Policy Certificate.

5. Portability

a. If the Policyholder and/or Insured Person applies to the Company for a health insurance policy, provided that the proposed Insured Person has to be covered without any break under any individual indemnity health insurance policy from any non-life insurance company registered with the IRDA or any group indemnity health insurance policy from the Company.

b. The Waiting Periods as defined in Clauses 4.1(a), 4.1(b) and 4.1(c) of this Policy shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the Eligible Cumulative Bonus under the expiring health insurance policy.

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

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

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

i) If the Insured Person was covered on a Floater basis under the expiring policy and is proposed to be covered on a Floater basis with the Company, then the Eligible Cumulative Bonus to be carried forward for credit under this Policy would also be applied on a Floater basis only.

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

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

i) The Company may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.

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

Note: Portability provisions will apply even if the Insured Person migrates to any other health insurance policy.
6. Claims Intimation, Assessment and Management

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

a. Claims Intimation
   i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Policyholder or Insured Person, shall notify the Company either at the Company's call center or in writing immediately.
   ii) If the Insured Person is to undergo planned Hospitalization, the Policyholder or Insured Person shall give written intimation to the Company of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.
   iii) It is agreed and understood that the following details are to be provided to the Company at the time of intimation of Claim:
       I. Policy Number;
       II. Name of the Policyholder;
       III. Name of the Insured Person in respect of whom the Claim is being made;
       IV. Nature of Illness or Injury;
       V. Name and address of the attending Medical Practitioner and Hospital;
       VI. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
       VII. Any other information, documents or details as requested by the Company.

6.2 Claims Procedure

a. Cashless Facility
   i) Cashless Facility is available only at Network Hospitals. The Insured Person can avail of this 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 (Voter ID card / Driving License / Passport / PAN Card or any other identification documentation as approved by the Company).
   ii) For availing Cashless Facility, the Policyholder /Insured Person shall submit a pre-authorization form to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.
   iii) In addition to the foregoing, in order to avail of the Cashless Facility, the following procedure must be followed:
       I. Pre-authorization: The Policyholder or Insured Person must call the Company's call center and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours before the commencement of planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.
       II. The Company will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which cashless facility is sought to be availed. The Company will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Person's
       III. If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility. Payment in respect of Co payments (if applicable) or any other costs and expenses not authorized under the Cashless Facility shall be made directly by the Policyholder or Insured Person to the Network Hospital. All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified in Clause 6.4 shall be submitted to the Network Hospital immediately and in any event before the Insured Person's discharge from Hospital.
   iv) It is agreed and understood that the Company may, in its sole discretion, modify or add to the list of Network Provider or modify or restrict the extent of cashless facilities that may be availed at any particular Network Provider. For an
updated list of Network Provider and the extent of cashless facilities available at each Network Provider; the Policyholder or Insured Person can refer to the list of Network Provider available on the Company's website or at the call centre.

b. Re-imbursement

The Company shall be given intimation of Hospitalization at its call center or in writing at least 48 hours before the commencement of a planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency. It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified in Clause 5.4 below shall be submitted (at the Policyholder or Insured Person's expense) to the Company immediately and in any event within 15 days of Insured Person's discharge from Hospital.

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

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

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

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

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

iii) Notification of Claim and submission or provision of all information and documents shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy.

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

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

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

6.4 Claim Documents

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

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

ii) Medical Practitioner's referral letter advising Hospitalization;

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

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

v) Original bills from pharmacy/chemists;

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

vii) Indoor case papers;

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

ix) Post mortem report, if conducted;

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

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

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

6.5 Claim Assessment

a. All Claims under this Policy shall be assessed by the Company in the following progressive order:

i) If a room category opted for is higher than the Single Private Room, then, the Variable Medical Expenses payable shall be pro-rated as per the applicable limits.

ii) The Deductible shall be applied to the aggregate of all Claims that are either paid or payable (and not excluded), under this Policy.
The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible.

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

iv) The balance amount, if any, shall be the Claim payable.

6.6 Payment Terms

a. This Policy covers only medical treatment taken entirely within India (Except for Benefit 5). All payments under this Policy shall be made in Indian Rupees and within India.

b. Payment under this Policy shall be made only to the extent that such Medical Expenses are not paid under any other insurance policy, if any.

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

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

e. The Company shall settle any Claim within 30 days of receipt of all the necessary documents/information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of Claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

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

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

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

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

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

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

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

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

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

7.6 No constructive Notice
Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

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

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

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

b. In case the Claim amount exceeds the Sum Insured, then Policyholder shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under:
   i) If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim.

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

7.10 Policy Disputes
Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law. The disputes on quantum on payment of losses or any other dispute explained in the paragraph shall be preferred to be dealt and resolved under the alternative dispute resolutions system including Arbitration and Conciliation Act of India.

7.11 Free Look Period
a. The Policyholder may, within 15 days from the receipt...
of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination (as per the below mentioned grid) and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

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

7.12 Renewal Notice

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

b. The Company may, in its sole discretion, revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the IRDA rules and regulations as applicable from time to time. The premium payable on renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.

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

d. The Company reserves the right to carry out underwriting in relation to any request for change in the Sum Insured or Deductible at the time of renewal of the Policy.

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

d. In case of demise of the Policyholder,

i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder.

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

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

   II. A person over Age 18 who satisfies the Company’s criteria to become a Policyholder.

f. No claims based loading shall be applicable to this policy.

7.13 Cancellation/Termination

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

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

c. Refund % to be applied on premium received

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

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

7.15 Communication

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

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

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

7.16 Alterations in the Policy

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

7.17 Overriding effect of Policy Certificate

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

7.18 Electronic Transactions

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

7.19 Grievances

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

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

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

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

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

Head - Customer Service,
Religare Health Insurance Company Limited,
Unit No. 604 - 607, 6th Floor, Tower C,
Unitech Cyber Park, Sector-39,
Gurugram-122001 (Haryana)

If the Policyholder / Insured Person is not satisfied with the Company's redressal of the Policyholder's / Insured Person's grievance through one of the above methods, the Policyholder / Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are on the next page:
<table>
<thead>
<tr>
<th>Office of the Ombudsman</th>
<th>Contact Details</th>
<th>Jurisdiction of Office (Union Territory, District)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHMEDABAD</td>
<td>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 <a href="mailto:ahmedabad@ecoi.co.in">ahmedabad@ecoi.co.in</a></td>
<td>Gujarat, Dadra &amp; Nagar Haveli, Daman and Diu</td>
</tr>
<tr>
<td>BENGALURU</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, BENGALURU - 560 078. Tel.: 080-2222049 / 2222048 Email: bimalokpal <a href="mailto:bengaluru@ecoi.co.in">bengaluru@ecoi.co.in</a></td>
<td>Karnataka</td>
</tr>
<tr>
<td>BHOPAL</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P.)-462 003. Tel.: 0755-2769201 / 9202 , Fax : 0755-2769203 E-mail : bimalokpal <a href="mailto:bhopal@ecoi.co.in">bhopal@ecoi.co.in</a></td>
<td>Madhya Pradesh &amp; Chhattisgarh</td>
</tr>
<tr>
<td>BHUBANESHWAR</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.: 0674 - 2596461 / 2596455, Fax : 0674-2596429 E-mail: bimalokpal <a href="mailto:bhubaneswar@ecoi.co.in">bhubaneswar@ecoi.co.in</a></td>
<td>Orissa</td>
</tr>
<tr>
<td>CHANDIGARH</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.: 0172 - 2706196 / 2706468, Fax : 0172-2708274 E-mail: bimalokpal <a href="mailto:chandigarh@ecoi.co.in">chandigarh@ecoi.co.in</a></td>
<td>Punjab, Haryana, Himachal Pradesh, Jammu &amp; Kashmir, Chandigarh</td>
</tr>
<tr>
<td>CHENNAI</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akbar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI-600 018. Tel.: 044-24333668 / 24335284, Fax : 044-24333664 E-mail : bimalokpal <a href="mailto:chennai@ecoi.co.in">chennai@ecoi.co.in</a></td>
<td>Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)</td>
</tr>
<tr>
<td>DELHI</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.: 011 - 23232481 / 23213504 E-mail : bimalokpal <a href="mailto:delhi@ecoi.co.in">delhi@ecoi.co.in</a></td>
<td>Delhi</td>
</tr>
<tr>
<td>GUWAHATI</td>
<td>Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.: 0361 - 2632204 / 2602205 E-mail : bimalokpal <a href="mailto:guwahati@ecoi.co.in">guwahati@ecoi.co.in</a></td>
<td>Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura</td>
</tr>
<tr>
<td>HYDERABAD</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel.: 040 - 67504123 / 23312122 E-mail : bimalokpal <a href="mailto:hyderabad@ecoi.co.in">hyderabad@ecoi.co.in</a></td>
<td>Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry</td>
</tr>
<tr>
<td>Office of the Ombudsman</td>
<td>Contact Details</td>
<td>Jurisdiction of Office (Union Territory, District)</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>JAIPUR</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhaiwani Singh Marg, Jaipur - 302 005. Tel.: 0141-2740363 Email: <a href="mailto:Bimalokpal.jaipur@ecoi.co.in">Bimalokpal.jaipur@ecoi.co.in</a></td>
<td>Rajasthan</td>
</tr>
<tr>
<td>ERNAKULAM</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Pulinan Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel.: 0484-2358759/2359338, Fax : 0484-2359336 E-mail: <a href="mailto:bimalokpal.ernakulam@ecoi.co.in">bimalokpal.ernakulam@ecoi.co.in</a></td>
<td>Kerala, Lakshadweep, Mahe – a part of Pondicherry</td>
</tr>
<tr>
<td>KOLKATA</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindustan Bldg. Annex., Kolkata – 700 072. Tel.: 033-22124339/22124340, Fax : 033-22124341 E-mail: <a href="mailto:bimalokpal.kolkata@ecoi.co.in">bimalokpal.kolkata@ecoi.co.in</a></td>
<td>West Bengal, Andaman &amp; Nicobar Islands, Sikkim</td>
</tr>
<tr>
<td>LUCKNOW</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazratganj, LUCKNOW-226 001. Tel.: 0522 - 2231330 / 2231331, Fax : 0522-2231310 E-mail: <a href="mailto:bimalokpal.lucknow@ecoi.co.in">bimalokpal.lucknow@ecoi.co.in</a></td>
<td>Districts of Uttar Pradesh: Lalgur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gaziapur, Jalaln, Kanpur, Lucknow, Unnao, Sitapur, Lucknow, Mirzapur, Bahraich, Barabanki, Rae bareli, Sevast, Gorakhpur, Faizabad, Amethi, Kaushambi, Bulandshahr, Ilahi, Ambedkar, Sultanpur, Allahabad, Mahuari, Santkabirnagar, Azamgarh, Koshinagar, Gorkhpur, Deoria, Maun, Ghazipur, Chandauli, Ballia, Saharanpur</td>
</tr>
<tr>
<td>MUMBAI</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annex, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: <a href="mailto:bimalokpal.mumbai@ecoi.co.in">bimalokpal.mumbai@ecoi.co.in</a></td>
<td>Goa, Mumbai Metropolitan Region excluding Navi Mumbai &amp; Thane</td>
</tr>
<tr>
<td>NOIDA</td>
<td>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: <a href="mailto:bimalokpal.noida@ecoi.co.in">bimalokpal.noida@ecoi.co.in</a></td>
<td>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bhat, Bareilly, Bijnor, Badar, Bulandshahar, Etah, Kasij, Mainpur, Mathura, Meerut, Moradabad, Muzzafarnagar, Oraiyya, Pilibhit, Etawah, Faridabad, Firozabad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahabad, Harpur, Shamli, Rampur, Kasganj, Saribhil, Amroha, Hapur, Kanshiram Nagar, Saharanpur</td>
</tr>
<tr>
<td>Office of the Ombudsman</td>
<td>Contact Details</td>
<td>Jurisdiction of Office (Union Territory, District)</td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
<td>PATNA</td>
<td>Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: <a href="mailto:bimalokpal.patna@ecoi.co.in">bimalokpal.patna@ecoi.co.in</a></td>
<td>Bihar, Jharkhand</td>
</tr>
<tr>
<td>PUNE</td>
<td>Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: <a href="mailto:bimalokpal.pune@ecoi.co.in">bimalokpal.pune@ecoi.co.in</a></td>
<td>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</td>
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</tbody>
</table>

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’
Secretary General/Secretary,
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
Annexure A - List of Day Care Treatments

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

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

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

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

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

6. Operations on the tongue
   59. Incision, excision and destruction of diseased tissue of the tongue
   60. Partial glossectomy
61. Transoral incision and drainage of a pharyngeal abscess
62. Excision of single breast lump
63. Incision and excision of tissue in the perianal region
64. Surgical treatment of anal fistulas
65. Surgical treatment of hemorrhoids
66. Division of the anal sphincter (sphincterotomy)
67. Other operations on the anus
68. Ultrasound guided aspirations
69. Laparotomy for grading Lymphoma with Splenectomy/Liver/Lymph Node Biopsy
70. Therapeutic Laparoscopy with Laser
71. Cholecystectomy and Choledocho-Jejunostomy/ Duodenostomy/Gastrectomy/Exploration Common Bile Duct
72. Esophagoscopy, gastroscopy, duodenoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions
73. Lithotripsy/Nephrolithotomy for renal calculus
74. Excision of renal cyst
75. Drainage of Pyonephrosis/Perinephric Abscess
76. Appendicectomy with/without Drainage
77. Incision of the ovary
78. Insufflations of the Fallopian tubes
79. Other operations on the Fallopian tube
80. Dilatation of the cervical canal
81. Conisation of the uterine cervix
82. Therapeutic curettage with Colposcopy/ Biopsy/ Diathermy/Cryosurgery/
83. Laser Therapy of Cervix for Various lesions of Uterus
84. Other operations on the uterine cervix
85. Incision of the uterus (hysterectomy)
86. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
87. Incision of vagina
88. Incision of vulva
89. Excision of Bartholin’s glands (cyst)
90. Salpingo-Oophorectomy via Laparotomy
91. Incision of the prostate
92. Transurethral excision and destruction of prostate tissue
93. Transurethral and percutaneous destruction of prostate tissue
94. Glossectomy
95. Reconstruction of the tongue
96. Other operations on the tongue
97. Operations on the salivary glands & salivary ducts
98. Other operations on the mouth & face
99. Operations on tonsils and adenoids
100. Operations on the breast
101. Operations on the digestive tract, Kidney and Bladder
102. Operations on the female sexual organs
103. Operations on the prostate & seminal vesicles
104. Other operations on the digestive tract, Kidney and Bladder
105. Operations on the female sexual organs
106. Operations on the prostate & seminal vesicles
122. Open surgical excision and destruction of prostate tissue
123. Radical prostatovesiculectomy
124. Other excision and destruction of prostate tissue
125. Operations on the seminal vesicles
126. Incision and excision of periprostatic tissue
127. Other operations on the prostate

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

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

16. Operations on the spermatic cord, epididymis and ductus deferens
142. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
143. Excision in the area of the epididymis
144. Epididymectomy

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

18. Operations on the urinary system
149. Cystoscopical removal of stones
150. Catheterisation of Bladder

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

20. Operations of bones and joints
159. Surgery for ligament tear
160. Surgery for meniscus tear
161. Surgery for hemoarthrosis/pyoarthrosis
162. Removal of fracture pins/nails
163. Removal of metal wire
164. Closed reduction on fracture, luxation
165. Reduction of dislocation under GA
166. Epiphyseolysis with osteosynthesis
167. Excision of Bursitis
168. Tennis Elbow Release
169. Excision of Various Lesions in Coccyx
170. Arthroscopic knee aspiration
Annexure B : List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>List of expenses generally excluded (&quot;Non-medical&quot;) in hospital indemnity policy</th>
<th>Sr. No.</th>
<th>List of expenses generally excluded (&quot;Non-medical&quot;) in hospital indemnity policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hair removal cream</td>
<td>52</td>
<td>Flexi mask</td>
</tr>
<tr>
<td>2</td>
<td>Baby charges (unless specified/indicated)</td>
<td>53</td>
<td>Gauze</td>
</tr>
<tr>
<td>3</td>
<td>Baby food</td>
<td>54</td>
<td>Hand holder</td>
</tr>
<tr>
<td>4</td>
<td>Baby utilities charges</td>
<td>55</td>
<td>Hansaplast/Adhesive bandages</td>
</tr>
<tr>
<td>5</td>
<td>Baby set</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Baby bottles</td>
<td>57</td>
<td>Lactogen/Infant food</td>
</tr>
<tr>
<td>7</td>
<td>Brush</td>
<td>58</td>
<td>Slings</td>
</tr>
<tr>
<td>8</td>
<td>Cozy towel</td>
<td>Items specifically excluded in the policies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Hand wash</td>
<td>59</td>
<td>Weight control programs/supplies/services</td>
</tr>
<tr>
<td>10</td>
<td>Moisturizer paste brush</td>
<td>60</td>
<td>Cost of spectacles/contact lenses/hearing aids, etc.</td>
</tr>
<tr>
<td>11</td>
<td>Powder</td>
<td>61</td>
<td>Dental treatment expenses that do not require hospitalisation</td>
</tr>
<tr>
<td>12</td>
<td>Razor</td>
<td>62</td>
<td>Hormone replacement therapy</td>
</tr>
<tr>
<td>13</td>
<td>Shoe cover</td>
<td>63</td>
<td>Home visit charges</td>
</tr>
<tr>
<td>14</td>
<td>Beauty services</td>
<td>64</td>
<td>Incontinence/infertility/assisted conception procedure</td>
</tr>
<tr>
<td>15</td>
<td>Belts/braces</td>
<td>65</td>
<td>Obesity (including morbid obesity) treatment</td>
</tr>
<tr>
<td>16</td>
<td>Buds</td>
<td>66</td>
<td>Psychiatric &amp; psychosomatic disorders</td>
</tr>
<tr>
<td>17</td>
<td>Barber charges</td>
<td>67</td>
<td>Corrective surgery for refractive error</td>
</tr>
<tr>
<td>18</td>
<td>Caps</td>
<td>68</td>
<td>Treatment of sexually transmitted diseases</td>
</tr>
<tr>
<td>19</td>
<td>Cold pack/Hot pack</td>
<td>69</td>
<td>Donor screening charges</td>
</tr>
<tr>
<td>20</td>
<td>Carry bags</td>
<td>70</td>
<td>Admission/registration charges</td>
</tr>
<tr>
<td>21</td>
<td>Cradle charges</td>
<td>71</td>
<td>Hospitalisation for evaluation/diagnostic purpose</td>
</tr>
<tr>
<td>22</td>
<td>Comb</td>
<td>72</td>
<td>Expenses for investigation/treatment irrelevant to the disease for which admitted or diagnosed</td>
</tr>
<tr>
<td>23</td>
<td>Disposables razors charges (for site preparations)</td>
<td>73</td>
<td>Any expenses when the patient is diagnosed with retro virus or suffering from HIV/AIDS etc is detected/directly or indirectly</td>
</tr>
<tr>
<td>24</td>
<td>Eau-de-cologne/Room fresheners</td>
<td>74</td>
<td>Stem cell implantation/surgery and storage</td>
</tr>
<tr>
<td>25</td>
<td>Eye pad</td>
<td>75</td>
<td>Items which form part of hospital services where separate consumables are not payable but the service is</td>
</tr>
<tr>
<td>26</td>
<td>Eye shield</td>
<td>76</td>
<td>Ward and Theatre booking charges</td>
</tr>
<tr>
<td>27</td>
<td>Email/Internet charges</td>
<td>77</td>
<td>Arthroscopy &amp; Endoscopy instruments</td>
</tr>
<tr>
<td>28</td>
<td>Food charges (other than patient’s diet provided by Hospital)</td>
<td>78</td>
<td>Microscope cover</td>
</tr>
<tr>
<td>29</td>
<td>Foot cover</td>
<td>79</td>
<td>Surgical blades, Harmonic scalpel, shaver</td>
</tr>
<tr>
<td>30</td>
<td>Gown</td>
<td>80</td>
<td>Surgical drill</td>
</tr>
<tr>
<td>31</td>
<td>Leggings</td>
<td>81</td>
<td>Eye drape</td>
</tr>
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<td>32</td>
<td>Laundry charges</td>
<td>82</td>
<td>X-ray film</td>
</tr>
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<td>33</td>
<td>Mineral water</td>
<td>83</td>
<td>Spurium cup</td>
</tr>
<tr>
<td>34</td>
<td>Oil charges</td>
<td>84</td>
<td>Boyle’s apparatus charges</td>
</tr>
<tr>
<td>35</td>
<td>Sanitary pad</td>
<td>85</td>
<td>Blood grouping and cross matching of donors samples</td>
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<tr>
<td>36</td>
<td>Slippers</td>
<td>86</td>
<td>Savlon</td>
</tr>
<tr>
<td>37</td>
<td>Telephone charges</td>
<td>87</td>
<td>Band aids, bandages, sterile injections, needles, syringes</td>
</tr>
<tr>
<td>38</td>
<td>Tissue paper</td>
<td>88</td>
<td>Cotton</td>
</tr>
<tr>
<td>39</td>
<td>Tooth paste</td>
<td>89</td>
<td>Cotton bandage</td>
</tr>
<tr>
<td>40</td>
<td>Toothbrush</td>
<td>90</td>
<td>Microspore/Surgical tape</td>
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<tr>
<td>41</td>
<td>Guest services</td>
<td>91</td>
<td>Blade</td>
</tr>
<tr>
<td>42</td>
<td>Bed Pan</td>
<td>92</td>
<td>Apron</td>
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<tr>
<td>43</td>
<td>Bed under pad charges</td>
<td>93</td>
<td>Tourniquet</td>
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<tr>
<td>44</td>
<td>Camera cover</td>
<td>94</td>
<td>Orthobundle, Gynaec bundle</td>
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<tr>
<td>45</td>
<td>Cliniplast</td>
<td>95</td>
<td>Urine container</td>
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<tr>
<td>46</td>
<td>Crepe bandage</td>
<td>96</td>
<td>Elements of room charge</td>
</tr>
<tr>
<td>47</td>
<td>Curapore</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Diaper of any type</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>DVD, CD charges</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Eyelet collar</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Face mask</td>
<td>101</td>
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ENHANCE - UN: IRDA/AM:HLT/RHIF/HV/36/13-14
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</thead>
<tbody>
<tr>
<td>96</td>
<td>Luxury tax</td>
<td>143</td>
<td>Arm sling</td>
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<tr>
<td>97</td>
<td>HVAC</td>
<td>144</td>
<td>Thermometer</td>
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<tr>
<td>98</td>
<td>House keeping charges</td>
<td>145</td>
<td>Cervical collar</td>
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<tr>
<td>99</td>
<td>Service charges where nursing charge also charged</td>
<td>146</td>
<td>Sling</td>
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<tr>
<td>100</td>
<td>Television &amp; Air conditioner charges</td>
<td>147</td>
<td>Diabetic foot wear</td>
</tr>
<tr>
<td>101</td>
<td>Surcharges</td>
<td>148</td>
<td>Knee braces (long/short/hinged)</td>
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<tr>
<td>102</td>
<td>Attendant charges</td>
<td>149</td>
<td>Knee immobilizer/Shoulder immobilizer</td>
</tr>
<tr>
<td>103</td>
<td>Im Iv Injection charges</td>
<td>150</td>
<td>Lumbo Sacral belt</td>
</tr>
<tr>
<td>104</td>
<td>Clean sheet</td>
<td>151</td>
<td>Nimbus bed or water or air bed charges</td>
</tr>
<tr>
<td>105</td>
<td>Extra diet of patient (other than that which forms part of bed charge)</td>
<td>152</td>
<td>Ambulance collar</td>
</tr>
<tr>
<td>106</td>
<td>Blanket/Warmer blanket</td>
<td>153</td>
<td>Ambulance equipment</td>
</tr>
<tr>
<td>107</td>
<td>Admission kit</td>
<td>154</td>
<td>Microshield</td>
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<tr>
<td>108</td>
<td>Birth certificate</td>
<td>155</td>
<td>Abdominal binder</td>
</tr>
<tr>
<td>109</td>
<td>Blood reservation charges &amp; Ante-natal booking charges</td>
<td>156</td>
<td>Items payable if supported by a prescription</td>
</tr>
<tr>
<td>110</td>
<td>Certificate charges</td>
<td>157</td>
<td>Betadine/Hydrogen peroxide/Spirit/Disinfectants etc.</td>
</tr>
<tr>
<td>111</td>
<td>Courier charges</td>
<td>158</td>
<td>Nutrition planning charges - Dietician charges - Diet charges</td>
</tr>
<tr>
<td>112</td>
<td>Conveyance charges</td>
<td>159</td>
<td>Sugar free tablets</td>
</tr>
<tr>
<td>113</td>
<td>Diabetic chart charges</td>
<td>160</td>
<td>Creams, powders, lotions (toiletries are not payable, only prescribed medical pharmaceuticals payable)</td>
</tr>
<tr>
<td>114</td>
<td>Documentation charges/Administrative expenses</td>
<td>161</td>
<td>Digestion gels</td>
</tr>
<tr>
<td>115</td>
<td>Discharge Procedure charges</td>
<td>162</td>
<td>Ecg electrodes</td>
</tr>
<tr>
<td>116</td>
<td>Daily chart charges</td>
<td>163</td>
<td>Gloves</td>
</tr>
<tr>
<td>117</td>
<td>Entrance pass/Visitors pass charges</td>
<td>164</td>
<td>HIV kit</td>
</tr>
<tr>
<td>118</td>
<td>Expenses related to prescription on discharge</td>
<td>165</td>
<td>Listerine/Antiseptic mouthwash</td>
</tr>
<tr>
<td>119</td>
<td>File opening charges</td>
<td>166</td>
<td>Lozenges</td>
</tr>
<tr>
<td>120</td>
<td>Incidental expenses/Misc. charges (not explained)</td>
<td>167</td>
<td>Mouth paint</td>
</tr>
<tr>
<td>121</td>
<td>Medical certificate</td>
<td>168</td>
<td>Nebulisation kit</td>
</tr>
<tr>
<td>122</td>
<td>Maintenance charges</td>
<td>169</td>
<td>Novarapid</td>
</tr>
<tr>
<td>123</td>
<td>Medical records</td>
<td>170</td>
<td>Volini gel/Analgesic gel</td>
</tr>
<tr>
<td>124</td>
<td>Preparation charges</td>
<td>171</td>
<td>Zytee gel</td>
</tr>
<tr>
<td>125</td>
<td>Photocopies charges</td>
<td>172</td>
<td>Vaccination charges</td>
</tr>
<tr>
<td>126</td>
<td>Patient identification band/Name tag</td>
<td>173</td>
<td>Part of hospital’s own costs and not payable</td>
</tr>
<tr>
<td>127</td>
<td>Washing charges</td>
<td>174</td>
<td>AHD</td>
</tr>
<tr>
<td>128</td>
<td>Medicine box</td>
<td>175</td>
<td>Alcohol swabs</td>
</tr>
<tr>
<td>129</td>
<td>Mortuary charges</td>
<td>176</td>
<td>Scrub solution/Sterillium others</td>
</tr>
<tr>
<td>130</td>
<td>Medico legal case charges (MLC charges)</td>
<td>177</td>
<td>Vaccine charges for baby</td>
</tr>
<tr>
<td>131</td>
<td>External durable devices</td>
<td>178</td>
<td>Aesthetic treatment/Surgery</td>
</tr>
<tr>
<td>132</td>
<td>Walking aids charges</td>
<td>179</td>
<td>TPA charges</td>
</tr>
<tr>
<td>133</td>
<td>BIPAP machine</td>
<td>180</td>
<td>Viscobelt charges</td>
</tr>
<tr>
<td>134</td>
<td>Commode</td>
<td>181</td>
<td>Any kit with no details mentioned, Delivery kit, Orthokit, Recovery kit, etc.</td>
</tr>
<tr>
<td>135</td>
<td>CPAP/CAFD equipments</td>
<td>182</td>
<td>Examination gloves</td>
</tr>
<tr>
<td>136</td>
<td>Infusion pump - cost</td>
<td>183</td>
<td>Kidney tray</td>
</tr>
<tr>
<td>137</td>
<td>Oxygen cylinder (for usage outside the hospital)</td>
<td>184</td>
<td>Mask</td>
</tr>
<tr>
<td>138</td>
<td>Spacer</td>
<td>185</td>
<td>Ounce glass</td>
</tr>
<tr>
<td>139</td>
<td>Spirometer</td>
<td>186</td>
<td>Outstation consultant/s/Surgeon’s fees</td>
</tr>
<tr>
<td>140</td>
<td>SpO2 Probe</td>
<td>187</td>
<td>Oxygen mask</td>
</tr>
<tr>
<td>141</td>
<td>Nebulizer Kit</td>
<td>188</td>
<td>Paper gloves</td>
</tr>
<tr>
<td>142</td>
<td>Steam Inhaler</td>
<td></td>
<td>Pelvic traction belt</td>
</tr>
</tbody>
</table>

**Sr. No. List of expenses generally excluded ("Non-medical") in hospital indemnity policy**

**TOILETRIES/COSMETICS/PART OF PERSONAL COMFORT OR CONVENIENCE ITEMS**
<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>List of expenses generally excluded (&quot;Non-medical&quot;) in hospital indemnity policy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS</strong></td>
</tr>
<tr>
<td>189</td>
<td>Referral doctor’s fees</td>
</tr>
<tr>
<td>190</td>
<td>Accu check (glucometry/strips)</td>
</tr>
<tr>
<td>191</td>
<td>Pan can</td>
</tr>
<tr>
<td>192</td>
<td>Sofnet</td>
</tr>
<tr>
<td>193</td>
<td>Trolley cover</td>
</tr>
<tr>
<td>194</td>
<td>Urometer, Urine jug</td>
</tr>
<tr>
<td>195</td>
<td>Ambulance</td>
</tr>
<tr>
<td>196</td>
<td>Tegaderm/Vasofix safety</td>
</tr>
<tr>
<td>197</td>
<td>Urine bag</td>
</tr>
<tr>
<td>198</td>
<td>Sofovac</td>
</tr>
<tr>
<td>199</td>
<td>Stockings</td>
</tr>
</tbody>
</table>
Annexure C - Service Request Form - For Change in Occupation / Nature of Job
(Refer Clause 7.4 of Policy Terms and Conditions)

Please Note:
1) To be filled in by Policyholder in CAPITAL LETTERS only.
2) If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
3) This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Details of the Insured Persons for whom details are to be updated

Name:

Mr. Ms.
(First Name) (Last Name)

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and/or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide/request for updation of the details on behalf of Insured Persons.

Date: / / (DD/MM/YYYY) Signature of the Policyholder:

Place: (On behalf of all the persons insured under the Policy)

Note: The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and/or premium payable accordingly.