SECTION 1. PREAMBLE

This Policy is a contract of insurance issued by Reliance General Insurance Company Limited (herein after called the 'Company') to the Proposer mentioned in the Policy Schedule to cover the person(s) named in the Policy Schedule (hereinafter called the 'Insured Person(s)'). The Policy is based on the statements, declarations provided in the Proposal Form and any other information provided by the Proposer to the Company for issuance of this Policy, and is subject to receipt of the requisite premium

SECTION 2. DEFINITIONS

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.

2.1. STANDARD DEFINITIONS

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

2) **Act** means the Insurance Act 1938.

3) **Any one Illness** means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home centre where treatment was taken.

4) **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

5) **AYUSH Treatment** means the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

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

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

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

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

i. Central or State Government AYUSH Hospital; or

ii. Teaching Hospital attached to AYUSH colleges recognized by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or

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

- Having at-least 05 in-patient beds;
- Having qualified AYUSH Medical Practitioner in charge round the clock;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedure is to be carried out;
- Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representative

8) **Bank Rate** means bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

10) **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 network provider by the Company to the extent pre-authorization is approved.

11) **Complainant** means a Policyholder or prospect or any beneficiary of an insurance policy who has filed a Complaint or Grievance against the Company or a Distribution Channel.

12) **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer, Distribution Channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, DistributionChannels, intermediaries, insurance intermediaries or other regulated entities

Explanation: An inquiry or request would not fall within the definition of the "Complaint" or "Grievance".

13) **Condition Precedent** means a Policy term or condition upon which the Company's liability under the policy is conditional upon.

14) **Congenital Anomaly** means a condition which is present since birth and which is abnormal with reference to form, structure or position.

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i. **Internal Congenital Anomaly**

Congenital Anomaly which is not in the visible and accessible parts of the body.

ii. **External Congenital Anomaly**

Congenital Anomaly which is in the visible and accessible parts of the body.

15) **Co-payment** means a cost sharing requirement under this Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

16) **Cumulative Bonus** means any increase or addition in Sum Insured granted by the Insurer without an associated increase in premium.

17) **Day Care Centre** means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner must comply with all minimum criteria as under.

i. has qualified nursing staff under its employment.

ii. has qualified Medical Practitioner/sin charge;

iii. has a fully equipped Operation theatre of its own, where surgical procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

18) **Day Care Treatment** means medical treatment, and/ or surgical procedure which is:

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

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

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

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

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

21) **Disclosure to information norm** means the policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

22) **Distribution Channels** means persons and entities authorized by the Authority to involve in sale and service of insurance products. For the purpose of this Policy, it means the Distribution Channels who is an Intermediary of the Company.

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

i. the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or

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

24) **Emergency/Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long-term impairment of the Insured person's health.

25) **Grace period** means the specified period of time immediately following the premium due date during which a 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.

26) **Home Care Treatment** means treatment availed by the Insured Person at home which in normal course would require care and treatment at a Hospital but is actually taken at home provided that:

i. The Medical Practitioner advices the Insured Person to undergo treatment at home.

ii. There is a continuous active line of treatment with monitoring of the health status of a Medical Practitioner for each day through the duration of the home care treatment.

iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

27) **Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities, under the Clinical Establishments (Registration & Regulation) Act, 2010 or under enactments specified under the schedule of section 56(1) of the said Act or complies with all 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 15 in-patient beds in all other places;

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

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

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

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

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

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

ii. **Chronic condition** - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests"
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
- it continues indefinitely
- it recurs or is likely to recur

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

31) **In-Patient Care/ In-Patient Treatment** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

32) **Intensive / Critical Care Unit (ICU/CCU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of 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.

33) **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

34) **Maternity Expenses** means

i. **Medical Treatment Expenses** traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

ii. Expenses towards lawful medical termination of pregnancy during the Policy Period.

35) **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

36) **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.

37) **Medically Necessary Treatment** means any treatment, tests, medication or stay in Hospital or part of a stay in Hospital which

i. Is required for the medical management of the illness/injury suffered by the Insured.

ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.

iii. Must have been prescribed by a Medical Practitioner;

iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

38) **Medical Practitioner/Physician** 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 its scope and jurisdiction of license. Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017. The registered practitioner should not be the Policyholder/Insured or their close family member.

39) **Migration** means, the right accorded to health insurance Policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

40) **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility

41) **Newborn baby** means baby born during the Policy Period and is aged upto 90 days.

42) **Non-Network Provider/Hospital** means any Hospital, Day Care center or other provider that is not part of the Network.

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

44) **OPD treatment** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or In-Patient.

45) **Post Hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and

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

46) **Portability** means the right accorded to individual health insurance Policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another insurer.

47) **Pre-existing Disease** means any condition, ailment, Injury or disease:

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

48) **Pre-hospitalization Medical Expenses** means Medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

49) **Proposal** Form means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

Explanation: "Material Information" shall mean all important, essential and relevant information sought by the Company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk

50) **Prospect** means any person who is potential customer of an insurer and is likely to enter into an insurance contract either directly with the insurer or through a Distribution Channel.

51) **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products

52) **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any

state in India.

53) **Reasonable & 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

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

55) **Room Rent** means the amount charged by a Hospitaltowards Room and Boarding expenses and shall include the associated medical expenses.

56) **Senior citizen** means any person who has completed sixty or more years of Age as on the date of commencement or renewal of the Policy.

57) **Surgery / Surgical Procedure / Surgical Operation** 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 Day Care centre by a Medical Practitioner.

58) **Unproven/ Experimental Treatments** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.2. Specific Definitions

1) **Activities of Daily Living** are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available

2) **Age** means "Age as on last birthday" as determined on the date of first Policy issuance or at Renewal. In case of change in Age during the proposal stage then "Age" shall be determined on the date of Proposal Form submission would be considered for premium calculation.

3) **AIDS** means Acquired immunodeficiency syndrome (AIDS), a condition characterized by a combination of signs and symptoms, caused by Human Immunodeficiency Virus(HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions ,as may be specified from time to time.

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

5) **Alzheimer's Disease** means progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed Medical Practitioner. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the 6 Activities of Daily Living for a continuous period of at least 3 months:

i. The following are excluded:

a. Any other type of irreversible organic disorder/dementia

b. Non-organic disease such as neurosis and psychiatric Illnesses; and

i. Alcohol-related brain damage.

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

7) **Company** means Reliance General Insurance Company Limited.

8) **COVID-19**, For the purpose of this Policy, Corona Virus Disease means COVID-19 as defined by the World Health Organization (WHO) and caused by the virusSARS-CoV2

9) **Dependent** means only the family members listed below:

i) Policyholder's legally married spouse as long as she continues to be married to Policyholder;

ii) Policyholder's children Aged between 91 days and 25 years if they are unmarried, financially dependent on the Policyholder and do not have his/her independent source of income;

iii) Policyholder's natural parents or parents that have legally adopted the Policyholder, provided that the parent was below 65 years at his initial participation in this Policy and the parent is financially dependent on Policyholder.

iv) Policyholder parents-in-law as long as Policyholder spouse continues to be married to Policyholder and were below 65 years at his initial participation in this Policy and the parent-in law is financially dependent on Policyholder.

10) **Emergency Assistance Service Provider** means any organization or institution appointed by the Company for providing services to the Insured Person for an insurable event under this Policy and as mentioned in the Schedule

11) **Extended Policy Year** means a period of 13 months from the Policy Commencement Date if the Policy Period specified in the Schedule is one year and a period of 26 months if the Policy Period specified in the Schedule is two years.

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

13) **Insured Person/Insured** means Policyholder and his dependents who are named as Insured Person(s) in the Schedule.

14) **Mental Illness,** as per the Mental Health Act, 2017means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

15) **Parkinson's Disease** means

i. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:
   a. The disease cannot be controlled with medication; and
   b. objective signs of progressive impairment; and
   c. There is an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the Activities of Daily Living for a continuous period of at least 6 months.

ii. Drug-induced or toxic causes of Parkinsonism are excluded.

16) **Policy** means Policyholder/Insured Persons statement in the Proposal form(which are the basis of this Policy),thesePolicy wordings(including endorsements, if any), appendices tothe Policy and the Schedule (as the same may be amended from time to time).

17) **Policy Commencement Date** means the commencement date of this Policy as specified in the Schedule.

18) **Policy Decision** is a decision made by the Company whether to issue the Policy to Policyholder or reject the proposal

19) **Policy Expiry Date** means the end date of this Policy as specified in the Schedule.

20) **Policyholder** means the person named in the Schedule who has concluded this Policy with the Company.

21) **Policy Period** means the period between the Policy Commencement Date and the Policy Expiry Date specified in the Schedule.

22) **Policy Schedule/Schedule** means the Policy Schedule attached to and forming part of this Policy mentioning apart from other details, Policyholder's details, details of the Insured Person, coverage, sections and benefits applicable, the Sum Insured, the Policy Period, Premium paid (including duties, taxes and levies thereon) and the limits to which benefits under the Policy are subject to.

23) **Policy Year** means a period of 12 consecutive months commencing from Policy Commencement Date or any anniversary thereof.

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

25) **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

26) **Sum Insured** means the amount specified asSum Insured in the Schedule.

27) **Super Specialist** means an allopathic Medical Practitioner with post graduate qualification (Doctor of Medicine ('MD' / Master of Surgery ('MS')) who also has been awarded applicable post-doctoral qualification (Doctorate of Medicine ('DM') / Master of Chirurgical ('MCh')) in the selected medical specialization. All the professional qualification must be recognizedby the Dental Council of India for specialization under dentistry and by the National Medical Commission ('NMC') for specializations under any other medical field.

28) **Telemedicine** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

SECTION 3. SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed herein, to compensate the Insured Person as per the covers and limits specified in the Schedule.

Cashless Facility at a Network Provider can be availed for the Benefits mentioned under this Policy unless the Benefit expressly specifies that it can be availed only on a reimbursement basis. If Cashless Facility is not available or is not availed by the Insured Person, then the claim will be considered on a reimbursement basis.

3.1. Basic Benefits:

The following Basic Benefits are available to all Insured Persons. Claims made in respect of any of these Basic Benefits will be subject to the availability of the Sum Insured, any applicable sub-limits for the Benefit claimed.

If any Insured Person suffers an Illness or Injury during the Policy Period that requires that Insured Person's Hospitalisation for Inpatient Care, then the Company will pay:

3.1.1. Inpatient Care

Medical Expenses incurred for:

i. Room Rent,
ii. Nursing,
iii. Intensive Care Unit (ICU) Charges,
iv. Medical Practitioner(s) fees,
v. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
vi. Prosthetic devices if implanted internally during a surgical procedure, unless specifically excluded
vii. Medicines, drugs and allowable consumables,
viii. Investigative tests and diagnostic procedures directly related to the Injury or Illness for which the Insured Person is Hospitalised.

3.1.2. Special Treatment

The Medical Expenses incurred during the Policy Period on Inpatient Care or Day Care Procedure or Domiciliary Hospitalization for the below mentioned Special Treatments shall be covered upto the amount specified in the Coverage Summary/Schedule.

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy-Monoclonal Antibody to be given as injection
vi. Intra Vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. BronchicalThermoplasty
x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neutro Monitoring)
xii. Stem Cell therapy: including Hematopoietic stem cells for bone

marrow transplant for hematological conditions

3.1.3. Day Care Procedures

Medical Expenses incurred for Day Care Treatment which is a Surgical Procedure, chemotherapy or radiotherapy or haemodialysis taken by an Insured Person during the Policy Period at a Hospital or Day Care Centre provided that:

i. Any Day Care Treatment carried out for diagnostic purposes shall not be covered under this Benefit.

ii. Any Day Care Treatment which also falls within the Scope of Cover under Basic Benefit 3.1.2 will be considered under Basic Benefits 3.1.2 and not under this Benefit.

3.1.4. Domiciliary Hospitalisation

Medical Expenses for Domiciliary Hospitalisation of the Insured Person provided that:

i. The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case the Company will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and

ii. If the Company has accepted a claim under this Benefit,then the Company will pay Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses in accordance with Basic Benefit 3.1.7 and Basic Benefit 3.1.8 respectively.

3.1.5. Organ Donor

Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for the use of the Insured Person, and

ii. The Company will not pay any Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses or expenses incurred towards any other medical treatment for or attributable to the organ donor consequent to the harvesting, and

iii. The Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Care

iv. The Company will not pay for the Medical Expenses incurred by an Insured Person while donating an organ.

3.1.6. AYUSH Benefit

Expenses incurred on treatment taken in a Hospital under Ayurveda, Unani, Sidha and Homeopathy, provided that:

i. The treatment is taken in an AYUSH Hospital as defined under this Policy

ii. The Company has accepted a claim under Basic Benefit **3.1.1 Inpatient Care**

iii. Cashless Facility will be provided under this Basic Benefit on a best-efforts basis. Where Cashless Facility is not available, due to any reason, the Company shall consider the claim on a reimbursement basis.

If any Insured Person suffers an Illness or Injury during the Policy Period that requires that Insured Person to undergo Hospitalization in respect of that Illness or Injury, then the Company will pay:

3.1.7. Pre-Hospitalisation Medical Expenses

Pre-Hospitalisation Medical Expenses incurred in the 90 days immediately before the Insured Person's Hospitalisation, provided that:

i. Such expenses are incurred for the same Illness or condition for which the Insured Person was subsequently Hospitalised, and

ii. The Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Care ,3.1.2 Special Treatment ,3.1.3 Day Care Procedures, 3.1.4 Domiciliary Hospitalisationor3.1.6 AYUSH Benefit

iii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

3.1.8. Post-Hospitalisation Medical Expenses

Post-Hospitalisation Medical Expenses incurred in the 180 days immediately after the Insured Person's discharge post Hospitalisation provided that:

i. Such expenses are incurred for the same Illness or condition for which the Insured Person was Hospitalised, and

ii. The Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Care, 3.1.2 Special Treatment,3.1.3 Day Care Procedures,3.1.4Domiciliary Hospitalisation or 3.1.6 AYUSH Benefit

iii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

3.1.9. Emergency Ambulance

Expenses incurred on an Ambulance used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency, provided that:

i. The Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Careor 3.1.3 Day Care Procedures.

ii. The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services, provided that the transportation has been prescribed by a Medical Practitioner and is medically necessary, and

iii. This benefit also covers the 'Intercity Ambulance cost' in case where such transportation is required 'intercity' (beyond 100km in distance).

iv. Cashless Facility will be provided under this Basic Benefit on a best effort basis. Where Cashless Facility is not available, due to any reason, the Company shall consider the claims on a reimbursement basis.

3.1.10. Transportation Benefit

Reasonable expenses incurred upto the amount specified in the Schedule or Coverage Summary, per Hospitalisation,for utilizing a registered radio cab operator's services for transporting the Insured Person to and/or from the Hospital, provided that:

i. The Company has approved a Pre-Authorization request for the Insured Person in respect of the same period of Hospitalisation under Basic Benefit 3.1.1 Inpatient Careor 3.1.3 Day Care Procedures.

ii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

3.1.11. Restore Benefit

If the Sum Insured , Double Cover(if applicable), More Cover Sum Insured (if applicable) and Super Charger Sum Insured (if applicable) are exhausted due to claims made and paid during the Policy Year/ Extended Policy Year (if applicable) or made during the Policy Year/ Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a Restore Benefit Sum Insured (equal to 100% of the Sum Insured) will apply to future claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits, provided that:

i. The Restore Benefit Sum Insured will be applied and can be utilised only after the Sum Insured,Double Cover(if applicable), More Cover Sum Insured (if applicable) and Super ChargerSum Insured (if applicable) has been completely exhausted.

ii. The Restore Benefit Sum Insured cannot be used for any claim in respect of an Illness (including its complications) for which a claim has been paid in the current Policy Year/Extended

Policy Year (if applicable) under Benefit 3.1 for the same Insured Person;

iii. For Individual Policies as specified in the Schedule, the Restore Benefit Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);

iv. For Family Floater Policies as specified in the Schedule, the Restore Benefit Sum Insured will be applied only once under the Policy during the Policy Year/Extended Policy Year (if applicable);

v. If the Restore Benefit Sum Insured is not utilised in a Policy Year/Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year.

vi. Under the Policy, this benefit can be utilized in following sequence:

a. Sum Insured
b. Double Cover(if applicable)
c. More Cover(if applicable)
d. Super Charger(if applicable)
e. Restore Benefit

3.2. More Options Benefits

The following More Options Benefits will be applicable to the Insured Person only if the Schedule specifies that the More Options Benefit is in force, provided that

1. The Policyholder may choose any one of the following More Options Benefits (at the time of first inception of the Policy with the Company) and that Benefit will be applied to the Policy with no additional premium. Where more than one Insured Person is covered under the same Policy, the same More Options Benefit shall be applicable for all Insured Persons.
2. Once the benefit is chosen it cannot be exchanged with another More Options Benefits and the Company will continue offering the opted More Options Benefits for the next Policy Years if the Policy is renewed without any break.
3. The Policyholdermay also, additionally, opt for any of the other More Options Benefits which will be applied under the Policy only on receipt of the additional premium payable for that Benefit in full.
4. Any changes to the More Options Benefits opted for can be made only on Renewal.

3.2.1. MoreTime:

If opted, the Company will provide an Extended Policy Year based on the Policy Period in force, provided that:

i. The Extended Policy Year will be 13 months if Policy Period opted is 1 year and 26 months if the Policy Period opted is 2 years. Each Policy Year will be extended by one month's time with no change in the Sum Insured. The MoreTime shall not be available for a 3 year Policy Period.

Policy Period	1 Year	2 Year		3 Year
Policy Year	1st Year	1st Year	2nd Year	Not Applicable
Months	12 Months	12 Months	12 Months	
Additional Month	1 Month	1 Month	1 Month	
Extended Policy Period	13 Months	26 Months		

ii. The Policy will be Renewed after the completion of the Extended Policy Year and premium as per completed Age at Renewal shall be applicable.

iii. If the MoreTime option is continued at the time of the Renewal, the Policy will be extended for 13 months if the Policy Period opted is 1 year and 26 months if the Policy Period opted is 2 years.

iv. The Policy will be Renewed for opted Policy Period only if the MoreTime option is not opted after the completion of the Extended Policy Year.

3.2.2. MoreCover:

If the Sum Insured and Double Cover (if applicable) are exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a MoreCover Sum Insured of the amount specified in the Coverage Summary will apply to claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits-3.1, provided that:

i) The MoreCover Sum Insured will be applied and can be utilised in respect of the same claim or any future claim only after the Sum Insured, Double Cover (if applicable) has been completely exhausted;

ii) For Individual Policies as specified in the Coverage Summary, the MoreCover Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);

iii) For Family Floater Policies as specified in the Coverage Summary, the MoreCover Sum Insured will be applied only once under the Policy during the Policy Year/Extended Policy Year (if applicable);

iv) If the MoreCover Sum Insured is not utilised in a Policy Year/Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year;

3.2.3. MoreGlobal:

If opted, this benefit covers Reasonable and Customary charges towards treatment of illness or conditions during the Policy Year/Extended Policy Year (if applicable) while travelling overseas, provided that:

i. The Insured Person's Treatment was Medically Necessary and was carried out up to limits specified in the Coverage Summary/Schedule.

ii. The Insured Person's condition was certified in writing by the treating Medical Practitioner to be such that Emergency Care is required and treatment cannot be postponed until the Insured Person has returned to India.

For a given Medically Necessary Treatment that is admissible as a Claim under this Benefit, the following are covered:

i) In-Patient Hospitalisation, Day Care Procedure or Out-Patient treatment, taken as Emergency Care shall be covered up to the Sum Insured, provided the same is critical and cannot be deferred till the Insured Person's return to the Republic of India.

ii) In-Patient Hospitalisation for planned treatment shall be covered on Reimbursement basis up to the Sum Insured or Rs. 50 lakhs whichever is lower, provided the symptoms of illness or injury first occurred or manifested in India within the Policy Period.

iii) Medical aid that is prescribed by a Physician as necessary part of the treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).

iv) Cost of Emergency Road Transportation, including necessary medical care en-route, by an Ambulance to the nearest Hospital or to the nearest Physician

v) Cost of being transferred by Road to a special clinic if this is Medically Necessary Treatment and is prescribed by the Physician.

Special Clinic shall mean a Clinic (or Hospital or equivalent medical facility) where the Insured is required to be transferred for a specialized treatment or specialized testing or consultation from an expert Medical Practitioner, which is not available at the current place of treatment.

vi) Emergency Air Ambulance Service: The transportation cost for availing Air Ambulance Service during the Policy Year/Extended Policy Year (if applicable) from the place of first occurrence of the Illness/Accident to the nearest Hospital will be payable only in case of an Medical Emergency which requires immediate and rapid ambulance transportation as prescribed by the Medical Practitioner/Physician and is Medically Necessary, which in actual cannot be provided by a ground Ambulance. The total liability of the Company with respect to Emergency Air Ambulance service shall be upto Rs 5 lakhs, provided that a corresponding claim for Inpatient Care or Day Care Procedure has been made and accepted under this benefit.

vii) Life saving unforeseen emergency measures provided to the Insured Person by the Physician for Hospitalization arising out of a Pre-Existing Disease in case of Life Threatening Medical Conditions. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable. All further medical cost to maintain medically stable condition or to prevent the onset of acute pain would have borne by the Insured Person.

Specific Conditions applicable for Benefit-3.2.3 MoreGlobal

i. **Total Liability:** The Company's total liability to pay the claim under this benefit during each Policy Year/Extended Policy Year (if applicable) shall be limited to the Sum Insured as specified in the Policy.

ii. **Duration:** This benefit is available up to 45 days of international travel on cumulative basis during the Policy Year/ Extended Policy Year (if applicable)

iii. **Deductible:** Deductible of USD 100 shall be applicable on each and every OPD claim made under this benefit.

iv. **Basis of Settlement:** The Medical expenses under this benefit are payable on Reimbursement basis. The Company shall endeavor to provide the Cashless facility, wherever available. The contact details of the Emergency Assistance Service Provider and the updated list of Network Hospitals shall be available on the Company's website.

v. **Non-Indian Resident:** No claim under this More Options Benefits will be considered if the Insured Person was not an Indian resident per applicable Indian law on the date of the event giving rise to the claim.

vi. **Payment:** The payment of any claim under this More Options Benefit will be based on the rate of exchange as on the date of invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

vii. **Treating Physician:** For the purpose of MoreGlobal Cover, the Medical Practitioner /Physician must hold a valid license issued by the appropriate authority in the Country of treatment.

Specific Exclusions applicable for Benefit-3.2.3 MoreGlobal

The Company shall not be liable to make any payment under this benefit in connection with or in respect of any expenses whatsoever incurred by the Insured Person for:

i. **Travelling for Medical Treatment only:** Traveling against the Medical advice of the Medical Practitioner or for receiving Medical treatment abroad if that is the reason for temporary stay abroad.

ii. **Pre and Post Hospitalization Expenses**

iii. **Pre-existing Diseases:** Any claim arising in relation to Pre-Existing Disease except for Lifesaving unforeseen emergency measures as described under Benefit -3.2.3 MoreGlobal

iv. **Treatment that could be delayed:** Treatment which could reasonably be delayed until the Insured/Insured Person's return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner/ Physician and the Emergency Assistance Service Provider.

v. **Degenerative, Orthopedic and Cancer related:** Treatment of orthopedic, degenerative, diseases and any cancer, malignant / benign tumors and such related conditions to Neoplasm, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life or measures solely designed to relieve acute pain in any case excluding chemotherapy or radiotherapy expenses.

vi. **Maternity Expenses**

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

b. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Year

vii. **Pregnancy related check-ups:** Medical check-ups during pregnancy or treatment of the pregnancy.

viii. **Standard and Specific Exclusions:** Any exclusion mentioned in the Section-4 of this Policy.

For the purpose of this More Options Benefit alone, Hospital means "Any institution established for In-patient Treatment 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 regulation applicable for the country where the treatment is taken".

3.3. Renewal Benefit: Stay Healthy Discount

The Insured Person will be entitled to a discount on the premium at the time of Renewal of the Policy irrespective of claims made during the Policy Period, if an annual health check-up is carried out during the Policy Year/(s) and the results of the same are shared with the Company then,

i. The Insured Person will be entitled to the discount irrespective of the results of the tests,

ii. The annual health check-up tests must include these tests: blood glucose, blood pressure, cholesterol and weight assessment,

iii. The results of respective Policy Year/(s) must be submitted to the Company at least 30 days prior to the expiry of the Policy,

iv. For Individual Policies, this Benefit would be applicable to Insured Persons who are Aged 18 and above on the Policy Commencement Date,

v. For Family Floater Policies, this Benefit would not be based on Dependent Children covered under the Policy,

vi. The cost of the health check-up will be borne by the Insured Person, and

vii. The discount available will be as follows:

Discount applicable per adult for the Policy Period for an Individual Sum Insured Policy	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 2 adults	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 1 adult
10.00%	5.00%	10.00%

viii. The Company will not reassess or alter Insured Persons existing coverage based on annual health check-up report submitted to the Company for availing Stay Healthy Discount.

ix. However, in the event of any fraud, misrepresentation or non-disclosure of material facts, the Company will re-evaluate the Insured Persons coverage in accordance with the Policy terms and conditions.

3.4. Add OnCovers

The covers listed below are Add On Covers that can be made available under the Policy, for appropriate premium, subject to below mentioned terms, conditions, and exclusions.

3.4.1. Voluntary Co-payment

The Company offers a discount on the premium if Policyholder opt for a Voluntary Co-payment. If the Schedule specifies that a Co-payment has been opted for, the Company shall not be liable for the Co-payment share of the Medical Expenses incurred, and

i. The Co-payment shall be applicable to each and every claim, and

ii. The Co-payment as specified in the Coverage Summary shall be applicable, and

iii. The Co-payment is applicable on the admissible amount under all the Benefits except forBenefit-3.4.4 Mother and Child Care, Benefit-3.4.5 OPD Cover and Benefit-3.4.6.2 Small Medical Equipment.

3.4.2. Limitless Cover

3.4.2.1. Consumables Cover

The Company shall pay the Reasonable and Customary expenses incurred by the Insured Person, during the Policy Year/Extended Policy Year (if applicable), for items which are listed in 'Annexure A-List I as Optional Items' of this Policy, provided:

i. such consumables or items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In-Patient Care or Day Care Procedure, and

ii. the Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Care or 3.1.3 Day Care Procedures. The amount payable towards this benefit, in conjunction with the other items under In-Patient Care or Day Care Procedures shall be within the Sum Insured limit.

3.4.2.2. Unlimited Restore Benefit

The Company shall Restore the Sum Insured unlimited times during that Policy Year/Extended Policy Year (if applicable) after occurrence and payment of claim amount under the Policy, provided:

i. the Sum Insured shall be restored to full extent immediately after settlement of a claim under Section 3.1 and such restored part shall become part of Restored Sum Insured

ii. The Restored Sum Insured can be utilized in the following manner:

a. Policies with Sum Insured 5 lakhs
   - Unlimited utilization for subsequent claims for unrelated illness or injury.
   - Upto 100% of Sum Insured, for subsequent claims which has arisen in respect of an Illness (including its complications) for which a claim has been paid in the current Policy Year/Extended Policy Year (if applicable) under Section 3.1 for the same Insured Person.

b. Policies with Sum Insured >=10 lakhs
   - Unlimited utilization for subsequent claims for related or unrelated illness/ injury

iii. The Restored Sum Insured can be utilized only after the Sum Insured, Double Cover (if applicable), More Cover Sum Insured (if applicable) and Super Charger Sum Insured (if applicable) have been completely exhausted.

iv. The Restored Sum Insured shall be available only for all subsequent claims.

v. The Unlimited Restore benefit shall be available at each Policy Year/Extended Policy Year (if applicable). The Restored Sum Insured at given time shall not exceed the Sum Insured mentioned in the Schedule.

vi. Restored Sum Insured will be available on individual basis for individual policies and on floater basis for Family Floater Policies during a Policy Year/Extended Policy Year (if applicable)

vii. If the Unlimited Restore Benefit is not utilized in a Policy Year/ Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year/Extended Policy Year (if applicable).

viii. The Unlimited Restore Benefit supersedes the existing Benefit 3.1.11 Restore Benefit

ix. Under the Policy, this benefit can be utilized in following sequence:
   1) Sum Insured
   2) Double Cover (if applicable)
   3) MoreCover Sum Insured (if applicable)
   4) Super Charger (if applicable)
   5) Unlimited Restored Benefit

3.4.3. Smart Protector

3.4.3.1. Super Charger

The Company shall provide an additional Sum Insured as Super Charger Sum Insured at the end of each completed and continuous Policy Year/Extended Policy Year (if applicable) with the Company, irrespective of any number of claims made in the immediate expiring Policy. This benefit is subject to the following:

i. The Super Charger Sum Insured shall not be reduced on making a claim under the Policy, except to the extent utilized toward the claim.

ii. The unutilized Super Charger Sum Insured, in whole or in part shall be allowed to be carried forward to Renewed Policy.

iii. In any given Policy Year/Extended Policy Year (if applicable), the total amount available under this benefit shall not exceed the maximum limit specified in Coverage Summary.

iv. This benefit shall be applicable on an annual basis subject to continuous Renewal of the Policy with the Company and shall be available to those Insured Persons who are continuously covered under the immediate expiring Policy.

v. The Super Charger Sum Insured can be utilized only after exhaustion of Sum Insured, Double Cover (if applicable) and More Cover (if applicable) and can be utilized for same or subsequent claims.

vi. Entire Super Charger Sum Insured will be lost if Policy is not continued / renewed on or before expiry of Grace Period.

vii. The Super Charger Sum Insured will be available on individual basis for individual policies and on floater basis for family floater policies.

viii. Condition Precedent: For a claim to be admissible under this benefit it should be admissible under the Section 3.1 Basic Benefits.

3.4.3.2. Air Ambulance

The Company shall indemnify the Insured Person upto the limit specified in the Schedule, for the expenses incurred on availing Air Ambulance services during the Policy Year/Extended Policy Year (if applicable), provided that:

i. The Company has accepted a claim under Basic Benefit 3.1.1 Inpatient Care or 3.1.3 Day Care Procedures

ii. The coverage includes the cost of the transportation of the Insured Person from the place of first occurrence of the Illness/ Accident to the nearest Hospital in case of an emergency Life Threatening Medical condition, or from one Hospital to another Hospital which is prepared to admit the Insured Person and provide the necessary medical services, only in case where the Insured Person requires immediate and rapid ambulance transportation which cannot be provided by a Road Ambulance.

iii. Such Life-Threatening Medical Condition is certified by the Medical Practitioner

iv. The transportation from one Hospital to another Hospital has been prescribed by a Medical Practitioner and is medically necessary.

v. The Origin and Destination of Air Ambulance Service are within the geographical boundaries of Republic of India.

vi. This benefit can be availed once in a Policy Year/Extended Policy Year (if applicable).

vii. Cashless Facility will be provided under this benefit on a best effort basis. Where Cashless Facility is not available, due to any reason, the Company shall consider the claims on a reimbursement basis.

viii. Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.

3.4.4. Mother and Child Care

3.4.4.1. Maternity Cover

The Company will indemnify the Insured Person up to the limit specified in the Schedule towards the Maternity Expenses incurred on Inpatient Care during the Policy Year subject to the following:

i. This benefit is available only to female members between the age group of 18 years to 45 years.

ii. This benefit is available only to policies with three-year policy period.

iii. This benefit shall become available only after the expiry of 12/24 (as opted) months of continuous coverage from the date of inception of the first Policy with the Company.

iv. The benefit also covers expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner

v. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person.

vi. For a covered delivery or termination, Pre-natal Inpatient Treatment Medical Expenses from the date of conception and up to the childbirth and Post-natal Inpatient Treatment Medical Expenses for a period of one month from the date of childbirth or termination shall be covered within the Maternity limit.

vii. For an admissible claim, this benefit also covers the Pre- natal and Post-natal Medical Expenses maximum up to Rs 10000 on OPD basis

viii. The total of all expenses paid under this benefit shall not exceed the Maternity limit opted and specified in the Schedule.

ix. The limits for Maternity Cover fall within the Sum Insured of the Policy.

x. MoreCover (if applicable), Restore Benefit/Unlimited Restore Benefit (whichever is applicable) or Double Cover (if applicable) shall not be applicable for claim under this benefit. This benefit supersedes the Standard Exclusion mentioned in Clause 4.1.18 Maternity (Code: Excl 18) of this Policy.

3.4.4.2. Newborn Baby and Vaccination Cover

The Company will indemnify the Insured Personup to the limits specified in the Schedule towards the treatment of Newborn baby as In-Patient Care or Day Care Procedure during the Policy Year/ Extended Policy Year (if applicable), provided:

i. The Company has accepted the claim under Benefit no-3.4.4.1 Maternity Cover

ii. Medical Expenses incurred by the Insured Person's Newborn Baby from date of birth till 90 days of age towards In Patient Treatment or Day Care Procedure shall be payable under this benefit.

Newborn Baby beyond 90 days may be added to the Policy through an endorsement, only after the receipt of requisite premium for the addition, and shall be covered as an Insured Person under the Policy, subject to the terms and conditions herein.

iii. This coverage also includes the cost of the following vaccines for mandatory New-born baby immunization up to 90 days of birth.

- Hepatitis B(Hep B)
- Rotavirus(RV)
- Diphtheria, Tetanus and Acellular Pertussis (DTaP)
- Hemophilus Influenza type b(Hib)
- Pneumococcal Conjugate (PCV13)
- Inactivated Poliovirus (IPV)

iv. The limits for this benefit are over and above the limits mentioned for Benefit-3.4.4.1 Maternity Cover

v. The limits for this benefit fall within the Sum Insured of the Policy.

vi. More Cover (if applicable), Restore Benefit/Unlimited Restore Benefit (whichever is applicable) or Double Cover (if applicable) shall not be applicable for claim under this benefit.

3.4.5. OPD Cover

Plan A:

The Company will cover Reasonable and Customary charges for the following up to the limits specified in the Coverage Summary/ Schedule, during the Policy Year/Extended Policy Year (if applicable).

- **OPD consultations:** Expenses toward Consultation from the below listed Super Specialist on Outpatient basis. The expenses of such consultations will be reimbursable for the specialties directly associated with the presenting symptoms or with illness or injury suffered presently or in the past.
- **Diagnostic Tests:** Cost for Diagnostic Tests prescribed by the consulting Super Specialist
- **Prescription drugs expenses**: Cost of prescription drugs prescribed by the consulting Super Specialist.

The benefit is subject to following:

i. The amount under this benefit shall be payable only if the Insured Person has consulted the Super Specialist for the illness or injury which is related to his/her specific area of specialization.

ii. Condition Precedent: The claim for Diagnostic Tests and Prescription drugs shall become payable only in relation to an OPD consultation which is payable under this benefit.

iii. The expenses under this benefit are covered only for Allopathic Treatment.

iv. This benefit will be available with minimum two-years Policy Period, where Policy S.I is 5lacs.

v. The benefit is available on individual basis for individual policies and on floater basis for family floater policies.

vi. The Company's maximum liability to pay the claim under this benefit is limited to the selected OPD limit, as specified in the Schedule.

vii. Any unutilized OPD limit shall not be carried forward to next Policy Year/Extended Policy Year (if applicable).

viii. This benefit shall be available on Reimbursement basis. Bills and receipts can be submitted for reimbursement twice in a Policy Year/Extended Policy Year (if applicable) towards each Policy.

ix. The amount claimed under this Benefit is over and above the Sum Insured

x. OPD Expenses for any Cosmetic / routine preventive health check-ups /dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substancesshall not be covered.

Covered List of Super Specialists from the field of Medicine or Surgery:

1. Cardiologist
2. Endocrinologist

3. Neurologist
4. Nephrologist
5. Oncologist
6. Orthopedist
7. Pulmonologist
8. Hepatologist
9. Gastroenterologists
10. Maxillofacial Surgeon

Plan B:

The Company will cover Reasonable and Customary charges for the following up to the limits specified in the Coverage Summary/ Schedule, during the Policy Year/Extended Policy Year (if applicable).

i. **OPD consultations**: Expenses toward Consultation from a Medical Practitioner on Outpatient basis. The expenses of such consultations will be reimbursable for the specialties directly associated with the presenting symptoms or with illness or injury suffered presently or in the past.

ii. **Diagnostic Tests:** Cost for Diagnostic Tests prescribed by the consulting Medical Practitioner.

iii. **Prescription drugs expenses:** Cost of prescription drugs prescribed by the consulting Medical Practitioner.

iv. **OPD for Dental Treatment** and related Diagnostic Tests and prescription drugs for the following:
   - Root Canal Treatment
   - Extractions

v. **Surgical Treatments:** Minor Surgical procedure such as POP, suturing, dressings for accidents and animal bite related Outpatient procedures etc. carried out by a Medical Practitioner, which are supported with requisite diagnostic results (wherever applicable).

The benefit is subject to following:

a. Condition Precedent: The claim for Diagnostic Tests and Prescription drugs shall become payable only in relation to an OPD consultation which is payable.

b. The expenses under this benefit are covered only for Allopathy Treatment.

c. Dental Implants, CAD/CAM restorations and bone graft are not covered

d. The benefit is available on individual basis for individual policies and on floater basis for family floater policies.

e. The Company's maximum liability to pay the claim under this benefit is limited to the selected OPD limit, as specified in the Schedule.

f. Any unutilized OPD limit shall not be carried forward to next Policy Year/Extended Policy Year (if applicable).

g. This benefit shall be available on Reimbursement basis. Bills and receipts can be submitted for reimbursement twice in a Policy Year/Extended Policy Year (if applicable) towards each Policy.

h. The amount claimed under this Benefit is over and above the Sum Insured

i. OPD Expenses for any Cosmetic/routine preventive health check-ups/dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances shall not be covered.

Note:

a. Under this Policy, Policyholder can choose either Plan A or Plan B for OPD Cover

b. The OPD Cover shall be available on Cashless basis only. Where the Insured opts the settlement of claim on reimbursement basis a Co-Payment of 10% shall be applicable on each and every claim made under this benefit.

3.4.6. Medical Equipment Cover

The Company shall pay the Reasonable and Customary expenses incurred by the Insured Person up to limits specified in the Schedule, for procuring listed Medical equipment or devices as medical aid, during the Policy Year/Extended Policy Year (if applicable).

The limits under this benefit shall be applicable on individual basis for individual policies and floater basis for floater policies.

3.4.6.1. Durable Medical Equipment (DME):

DME means long lasting equipment that are intended to be used solely by the Insured Person for medical purposes on the advice of the Medical Practitioner on occurrence of an illness or injury.

- **Manual Wheelchairs and power mobility devices:** Power wheelchairs or scooters needed for use inside the home by Insured with mobility difficulties and impairments, whether permanent or temporary, caused by Illness or Accident.
- **Hearing aids** excluding battery (Hearing loss above 55 db HL)
- **Hospital beds:** Required where the insured person's mobility is so affected that the insured person's condition requires being in a specific position, and the condition makes it difficult for the patient to transfer from the bed to the floor, and the condition increases the patient's risk of respiratory infection or unwanted muscle contracture

  This would be payable in the following cases:

  Severe arthritis, foot or leg injury, nervous system injury, paralysis, a heart condition that makes it dangerous for the patient to strain to get in or out of bed. Any other condition that satisfies the Medical Practitioner's certification condition may be considered by the Company basis the merits of the case.
- **CPM Machines**
- **BiPAP and CPAP devices**
- **Oxygen Concentrator** (required for management of Chronic Illness)
- **Patient Lifts:** To enable safe lifting and transferring of weak, obese, or disabled patient (Insured Person) where the insured person's mobility is so affected that the patient needs 90 to 100 percent assistance getting in and out of bed.
- **Traction equipment's**
- **Commode Chairs/toilet seat frames/risers, Bath Bench or Shower Chairs**: Where Insured person is eligible for either wheelchair, Walker or Hospital bed
- **Infusion Pumps** (when medically necessary to administer certain drugs)
- **Suction Pumps**
- **DVT pump**
- **Artificial limbs**
- **Walker, Crutches, Canes:** Where the Insured Person has suffered an illness or injury resulting in one or more of the following:
  - o Decreased weight bearing such that the Insured person can't rely on one or both legs to stand.
  - o Extreme Fatigue or significantly decreased endurance.
  - o Poor balance such that the Insured person needs help with stability and steadiness while walking.
- **Pressure-reducing support surfaces (beds, air, gel or water mattresses**) used to prevent bed sores in bed-ridden patients.
- **Blood Glucose Meter** (without test strips)
- **Sphygmomanometer** (Blood Pressure Monitor)

Provided that,

i. The Durable Medical Equipment is medically necessary following the occurrence of an Illness or Injury and is supported by prescription from a Medical Practitioner indicating requirement of a minimum of three months of use.

ii. This benefit shall be available through Company's Network Providers (For details refer Company's website: www.reliancegenera.co.in). In case the listed equipment is not available with the Network Provider, the Company may admit a claim for purchase of listed equipment through non-network provider on pre-authorization basis.

iii. Any Durable Medical Equipment which was required by the Insured Person at the time of inception of the first Policy in connection to a Pre-Existing Disease or condition shall not be covered under the Policy or its subsequent renewals.

iv. Each item under Durable Medical Equipment can be claimed once per Policy in three continuous and consecutive Policy Years/Extended Policy Years (if applicable) with the Company.

v. This benefit includes the cost of repair of the above listed (either new or existing) Durable Medical Equipment

vi. The total amount payable under this benefit is limited to 5% of Sum Insured subject to max of Rs 2.5 lacs in a given Policy Year/Extended Policy Year (if applicable)

vii. A Co-payment of 20% is applicable on each and every claim under this benefit. Voluntary copayment, if opted under the Policy, shall apply over and above this Copayment of 20%.

viii. Payments made under this Benefit shall not be claimable under any other Benefit.

3.4.6.2. Small Medical Equipment:

Small Medical Equipment means medical equipment which have limited useful lifetime and are solely used by the Insured Person to serve a medical requirement.

i. Spectacles lens for Refractive Error +/-2 diopter (excluding frames) *

ii. Medically necessary Contact Lenses (only in case of Aphakia, Keratoconus Irregular Corneal astigmatism, Anisometropia greater than 3.50 Diopters, Post traumatic Facial deformity, Corneal deformity) *

iii. Corrective splints (To support broken bone)

iv. Compression stockings

v. Cervical Collar

vi. Elbow Hand, Shoulder, Knee, Foot and Ankle Braces, Lumbo-sacral belt for Back

vii. Nebulizer (required for asthma, Chronic Obstructive Pulmonary Disease (COPD), Cystic fibrosis, bronchiectasisor for respiratory infection in children upto 5 years of age)

*Must be supported by Medical Prescription from Ophthalmologist

Provided that,

i) The Small Medical Equipment is medically necessary following the occurrence of an Illness or Injury

ii) Each item under Small Medical Equipment can be claimed once per Policy in three continuous and consecutive Policy Years/Extended Policy Years (if applicable) with the Company.

iii) The total amount payable under this benefit shall be limited to 1% of Sum Insured subject to maximum of Rs 20000 in a given Policy Year/Extended Policy Year (if applicable).

iv) This benefit will be payable on Reimbursement basis and the bills towards the purchase of Medical Equipment's can be submitted twice in a Policy Year/ Extended Policy Year (if applicable) across all Insured Person(s) under the Policy.

v) Payments made under this Benefit shall not be claimable under any other Benefit.

3.4.7. Double Cover

Under this option, the Company shall provide an additional 100% of Sum Insured as Double Cover on the same claim, which can be utilized after the Sum Insured has been utilized completely for claims incurred under the Policy, for the particular Policy Year/Extended Policy Year (if applicable), provided that:

i. The benefit shall be available only if the Company has accepted the claim under Benefit-3.1 Basic Benefits.

ii. The benefit shall be available only after full exhaustion of Sum Insured under the Policy.

iii. The Double Cover can be utilized only on the same claim, which is payable under the Sum Insured, during a single hospitalization. Once this cover has been utilized (whether in full or part) towards a Claim, the benefit under this cover shall lapse for that particular Policy Year/ Extended Policy year (if applicable).

iv. Any unutilized Double Cover Sum Insured, in whole or in part shall not be carried forward to subsequent Policy Years.

v. The Company's overall liability for all claims, in aggregate, within a Policy Year Extended Policy Year (if applicable) under this benefit shall be limited to 100% of the Sum Insured

vi. The Double Cover will be available on individual basis for individual policies and on floater basis for floater policies.

3.4.8. Home Care Treatment

The Company shall indemnify the Insured Person for the Medical Expenses, incurred during the Policy Year/Extended Policy Year (if applicable), towards Home Care Treatment of any of the listed treatments taken by the Insured Person, on the written advice of a Medical Practitioner, provided that:

i. the services under this benefit shall be offered by registered homecare provider.

ii. the benefit can be availed on reimbursement basis only

iii. the claim under this benefit shall be payable towards Medical Expenses incurred during the Period of Treatment. The 'Period of Treatment' for this benefit shall be considered as the continuous period for which health status of the Insured Person was monitored by a Medical Practitioner, supported by records of treatment and Daily Monitoring Chart duly signed by such Medical Practitioner.

iv. the benefit can be availed for maximum 15 days, per Insured Person, during the Policy Year/Extended Policy Year (if applicable)

v. The following treatments or illnesses shall be covered under Home Care Treatment:
   a. Treatment for COVID-19
   b. Chemotherapy excluding any supporting medication
   c. Dialysis
   d. Gastroenteritis: Severe Gastroenteritis with dehydration level >=10%
   e. Bronchopneumonia supported by radiological evidence
   f. Lower Respiratory tract infection supported by radiological (X-ray) evidence
   g. Non-alcoholic Pancreatitis
   h. Dengue with platelet count less than 1 lakh and supported by positive Dengue Antigen report
   i. Hepatitis supported by positive diagnosis through blood reports

3.4.9. Change in Pre-Existing Waiting Period

Under this Option, the Policyholder shall be allowed to change the 36 months Waiting Period for Pre-Existing Diseases as mentioned in Section 4.1.1 to 48 months, 24 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Schedule.

3.4.10. Reduction in Specific Illness Waiting Period

Under this option, the Company shall reduce the 24 months Waiting Period for Specific Diseases as mentioned in Section 4.1.2 to 12 months. Such reduction, if allowed, shall be expressly mentioned in the Schedule.

3.4.11. Reduction in Room Rent

Under this option, the Policyholder shall be allowed to opt the Room Rent category (as specified in the Annexure-I Coverage Summary) for Hospitalizations allowable under Section 3 of this Policy, if so requested by the Policyholder and explicitly accepted by the Company. The agreed Room Rent category shall be expressly mentioned in the Schedule.

3.4.12. Discount for Removal of More Options Benefits

Under this option, the Company shall provide a discount in the Policy premium, if the Policyholder opts not to choose one complementary More Options Benefits under the Policy, if so requested by the Policyholder and explicitly accepted by the Company. The removal shall be expressly mentioned in the Policy Schedule.

3.4.13. Voluntary Aggregate Deductible

Under this option, the Company shall provide a discount in the premium, if the Policyholder opts for an annual Aggregate Deductible under the Policy. The agreed limits of annual Aggregate Deductible shall be expressly mentioned in the Policy Schedule.

This benefit is subject to following:

i. Deductible under this benefit is an annual Aggregate Deductible. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Year/ Extended Policy Year (if applicable) has to exceed the annual Aggregate Deductible as mentioned in the Policy Schedule.

ii. Incase of Individual Policy, the Aggregate Deductible shall apply on individual basis and incase of a floater policy, shall apply on floater basis.

iii. The annual Aggregate Deductible shall not be applicable on Benefit-3.4.4 Mother and Child Care, Benefit-3.4.5 OPD Cover and Benefit-3.4.6. Medical Equipment Cover

SECTION 4. EXCLUSIONS

4.1. Standard Exclusions

4.1.1. Pre-Existing Disease Waiting Period (Code: Excl01)

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

ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

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

iv. Coverage under the Policy after the expiry of 36 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by the Company.

4.1.2. Specific waiting period (Code: Excl02)

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

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

iii. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply

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

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

vi. List of specific diseases/procedures in respect of which waiting period is imposed is mentioned below:

Organ / Organ System	Illness /Diagnosis (irrespective of treatment being medical or surgical)	Surgeries / Surgical Procedure (irrespective of any Illness / diagnosis)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps, including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed uterus	• Hysterectomy unless necessitated by malignancy
Orthopaedic	• Non-infective arthritis • Gout and rheumatism • Osteoporosis • Ligament, tendon and meniscal tear • Prolapsed intervertebral disk	• Joint replacement surgery

Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/ fistula in anus, haemorrhoids, pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), ulcer and erosion of stomach and duodenum • Cirrhosis (however alcoholic cirrhosis is permanently excluded) • Perineal and perianal abscess • Rectal prolapse	• Cholecystectomy • Surgery of hernia
Urogenital	• Calculus diseases of urogenital system including kidney, ureter, bladder stones • Benign hyperplasia of prostate • Varicocele	• Surgery on prostate unless necessitated by malignancy • Surgery for hydrocele/ rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Surgery for correction of eye sight due to refractive error above dioptre 7.5
Others	• Congenital internal disease	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems / organs whether or not described above)	• Benign tumors of non-infectious etiology Such as cysts, nodules, polyps, lumps or growth.	• Nil

4.1.3. 30-Day Waiting Period (Code: Excl03)

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

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

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

4.1.4. Investigation & Evaluation (Code: Excl04)

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

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

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

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

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

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

4.1.6. Obesity/ Weight Control (Code: Excl06):

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

i. Surgery to be conducted is upon the advice of the Doctor

ii. The surgery/Procedure conducted should be supported by clinical protocols

iii. The member has to be 18 years of age or older and

iv. Body Mass Index (BMI);

- greater than or equal to 40 or
- greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

o Obesity-related cardiomyopathy

o Coronary heart disease

o Severe Sleep Apnea

o Uncontrolled Type 2 Diabetes

4.1.7.Change-of-Gender treatments (Code: Excl 07):

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

4.1.8.Cosmetic or Plastic Surgery (Code: Excl 08):

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

4.1.9.Hazardous or Adventure sports (Code: Excl 09):

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

4.1.10.Breach of law (Code: Excl 10):

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

4.1.11.Excluded Providers (Code:Excl11):

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

4.1.12.Substance Abuse and Alcohol (Code:Excl12):

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

4.1.13.Wellness and Rejuvenation(Code:Excl13):

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

4.1.14.Dietary Supplements & Substances (Code:Excl14):

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of hospitalization claim or Day Care procedure

4.1.15.Refractive Error (Code:Excl15):

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

4.1.16.Unproven Treatments-Code (Code:Excl16):

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

4.1.17.Sterility and Infertility (Code:Excl17):

Expenses related to Birth Control, sterility and infertility. This includes:

i. Any type pf contraception, sterilization
ii. Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

4.1.18.Maternity (Code:Excl18)

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

4.2. Specific Exclusions

4.2.1.15 days Waiting Period for Covid-19:

i. Any Expenses related to the treatment of Covid-19 within 15 days from the first Policy commencement date shall be excluded.
ii. This exclusion shall not apply if the Insured Person has continuous coverage for more than twelve months.
iii. The within referred Waiting Period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

4.2.2.12/24 months Maternity Waiting Period

The Add On Benefit-3.4.4.1 Mother Cover defined under this Policy shall become available only after the expiry of 12/24months(as opted) from the date of inception of the first Policy with the Company.

4.2.3.Alternative Treatments

Alternative Treatment or any other non-allopathic treatment, except to the extent covered under Basic Benefit 3.1.6, subject to the conditions contained therein.

4.2.4.Circumcision

Circumcision (unless necessitated by Illness or Injury and forming part of medical treatment).

4.2.5.Convalescence or Rehabilitation

Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").

4.2.6. Dental Treatments

Dental Treatments of any kind, unless requiring Hospitalisation necessitated due to illness or injury or except to the extent covered under Benefit-3.4.5 OPD Cover, subject to the conditions contained therein.

4.2.7. Unprescribed Drugs or treatments

Any drugs or treatments which are not supported by a prescription.

4.2.8. External Congenital Anomaly

External Congenital Anomaly and genetic disorders.

4.2.9. Hearing aids

Provision or fitting of hearing aids, except to the extent covered under Benefit-3.4.6 Medical Equipment Cover, subject to the conditions contained therein.

4.2.10. Hormonal therapies

i. Growth hormonal therapy
ii. Any form of hormone replacement therapy (HRT) and or administration of other hormonal medication.

4.2.11. Non-Medically Necessary Treatment

Any treatment or part of a treatment that is not Medically Necessary Treatment

4.2.12. Medical supplies

Medical supplies including elastic stockings, diabetic test strips, and similar products, except to the extent covered under Benefit-3.4.6 "Medical Equipment Cover", subject to the conditions contained therein.

4.2.13. Non-medical expenses

Any non-medical expenses mentioned in 'Annexure A- List I as Optional Items'. This exclusion shall be waived off, if Optional Benefit-3.4.2.1 "Consumable Cover" has been opted under the Policy.

4.2.14. Outpatient Treatment (OPD)

Conditions for which treatment could have been done on an outpatient basis without any Hospitalization except to the extent covered under Benefit-3.2.3 "MoreGlobal" and under Benefit 3.4.5 "OPD Cover", subject to the conditions contained therein.

4.2.15. Overseas Treatment

Treatment availed outside India except in case of where the Benefit 3.2.3 "MoreGlobal" is in force for the Insured Person, subject to the conditions contained therein.

4.2.16. Peritoneal dialysis

Charges related to peritoneal dialysis, including supplies.

4.2.17. Prosthetic and other devices

Prosthetic and other devices which are self-detachable/ removable without surgery involving anesthesia. This exclusion shall not apply to the extent covered under the Benefit-3.4.6 "Medical Equipment Cover",subject to the conditions contained therein.

4.2.18. Charges other than Reasonable& Customary Charges

Any Medical Expenses which are not Reasonable & Customary Charges.

4.2.19. Self-injury or suicide

Intentional self-injury or attempted suicide.

4.2.20. Spinal subluxation, manipulation and muscle stimulation

Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

4.2.21. Treatment by a family member

Treatment rendered by a Medical Practitioner who is a member

of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

4.2.22. Treatment outside discipline

Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

4.2.23. Vaccination and immunisation

Vaccination including inoculation and immunisation, except in case of post-bite treatment or to the extent covered under Benefit-3.4.4 "Mother and Child Care", subject to the conditions contained therein.

4.2.24. Nuclear Attack

Nuclear, Chemical or Biological attack/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 Clause :

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

Also excluded herein is 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.

4.2.25. War (whether declared or not)

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.3. Permanent Exclusion

A permanent exclusion will be applied on Pre-Existing medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule. This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) listed under Annexure E that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

SECTION 5. GENERAL TERMS AND CLAUSES

5.1. Standard General Terms and Clauses

5.1.1. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the Policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by Insurer in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

5.1.2. Condition Precedent

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

5.1.3. Claim Settlement (provision of Penal Interest)

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

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

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

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the Bank Ratefrom the date of receipt of last necessary document to the date of payment ofclaim.

5.1.4. Complete Discharge

Any payment to the Policyholder, Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case maybe, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.5. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be for feited.

Any amount already paid against claims made under this policybut which are found fraudulent later shall be repaid by all recipient(s)/ Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to theinsurer.

For the purpose ofthis clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or thehospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an Insurance Policy:

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to betrue;

ii. the active concealmento fafact by the Insured Person having knowledge or belief of thefact;

iii. any other act fitted to deceive;and

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

The Company shall not repudiate the claim and/or for feit the policy benefits on the ground of Fraud, if the Insured Person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of theinsurer.

5.1.6. Multiple Policies

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

according to the terms of the chosen Policy.

ii. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / Policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.

iii. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured Person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy

5.1.7. Moratorium Period

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

5.1.8. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

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

iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

5.1.9. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

5.1.10. Premium Payment in Instalments (wherever applicable)

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Lumpsum, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (not with standing any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the Policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods' 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period

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

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

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

5.1.11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

5.1.12. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for migration of the Policy atleast 30 days before the Policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

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

5.1.13. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the Policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in Waiting Periods as per IRDAI guidelines onportability.

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

5.1.14. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/ migrating the policy.

The Insured Person shall be allowed free look period of fifteen days (30 days if the policy is sold through distance marketing or if the Policy Period is 3 years) from date of receipt of the policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the Insured shall be entitled to

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

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

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

5.1.15. Nomination

The Policyholder is required at thein ception of the Policy to make

anomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder.The Company will pay the nominee (asnamed in the Policy Schedule/Policy Certificate/Endorsement (if any)) and incase there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharg eshall be treated asful land final discharge of its liability under thePolicy

5.1.16.Cancellation (other than Free Look Period)

The Policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below:

Retention % to be applied on Policy Premium

Cancellation date up to (x months) From Policy Period Start Date	**Retention % (of Full Policy Period Premium)**		
Policy Period	**1 Year**	**2 Years**	**3 Years**
Upto 1 Month	25.00%	12.50%	8.30%
Upto 3 Months	50.00%	25.00%	16.70%
Upto 6 Months	75.00%	37.50%	25.00%
Upto 9 Months	100.00%	50.00%	33.30%
Upto 12 Months	100.00%	75.00%	50.00%
Upto 18 Months	NA	100.00%	75.00%
Upto 24 Months	NA	100.00%	87.50%
Beyond 24 Months	-	NA	100.00%

*Where premium is paid in installments, the final refund shall be calculated net of any balance installment due to the Company.

Not with standing anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the Policy.

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

5.1.17.Redressal of Grievance

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

Website: www. Relianceada.com

Toll free: 1800-3009

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: rgicl.services@relianceada.com

Fax:+91 22 3303 4662 Courier: Any branch office, the correspondence address, during normal business hours.

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

Insured Person may also approach the grievance cell at any of the Our branches with the details of grievance.

If the Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured may contact the grievance officer at:

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor,

Krishe Block, Krishe Sapphire, Madhapur

Hyderabad – 500 081

Grievance Redressal officer email ID:
rgicl.headgrievances@relianceada.com

(For updated details of grievance officer, kindly refer the link.

https: / / reliance general.co.in/ Insurance/About -Us/Grievance-Redressal.aspx

If Insured is not satisfied with the redressal of grievance through above methods, Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B

Grievance may also be lodged at IRDAI Integrated Grievance Management System https://igms. irda.qov. in/

5.2. Specific Terms and Clauses

5.2.1. Geography & Currency

This Policy is applicable solely to an Insured Person who is an Indian resident per applicable Indian law. In the event of a change in status other than Indian resident of such Insured Person, the same should be informed to the Company and the Company shall cancel the Policy with refund of premium paid for the remaining Policy Period provided that no claims have been made.

This Policy only covers medical treatment taken within India, unless section 3.2.3 MoreGlobal Benefit is opted and in force for the Insured Person under the Policy. All payments under this Policy will only be made in Indian Rupees within India.

5.2.2. Insured Person

Only those persons named as Insured Persons in the Schedule will be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by the Company, additional premium has been paid and the Company has issued an endorsement confirming the addition of such person as an Insured Person.

5.2.3. Endorsements and Alterations in the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except the Company, and any change the Company make will 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 subject to Company's underwriting decision. If Insured Person increase the sum insured, the case may be subject to health check-up. In case of increase in the Sum Insured, the waiting periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at Company's discretion and subject to Company's underwriting guidelines. Additional premium if any, shall be charged as per terms and conditions of the Policy.

5.2.4. Change of Policyholder

The change of Policyholder is permitted only at the time of Renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Company's acceptance post underwriting and payment of premium (if any). The renewed Policy shall be treated as having been renewed without Break. The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

5.2.5. Notices

Any notice, direction or instruction under this Policy will be in writing and if it is to:

i. Any Insured Person, then it will be sent to Policyholder at Policyholder's address specified in the Schedule and Policyholder will act for all Insured Persons for these purposes.

ii. The Company, it will be delivered to Company's address specified in the Schedule.

No insurance agents, insurance intermediaries or other person or entity is authorised to receive any notice, direction or instruction on the Company's behalf.

5.2.6. Governing Law &Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy will be determined by the Indian Courts and subject to Indian law.

If any administrative or judicial body imposes any condition on this Policy for any reason, the Company is bound to follow the same which may include suspension of all Benefits and obligations under this Policy.

If the Company's performance or any of Company's obligations are in any way prevented or hindered as a consequence of any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances beyond Company's anticipation or control, the performance of this Policy shall be wholly or partially suspended during the continuance of such force majeure. The Company will resume Company's obligations under the Policy, to the extent possible, after the force majeure conditions cease to exist even for the period during which the force majeure conditions existed.

SECTION 6. OTHER TERMS AND CONDITIONS

6.1. Pre-Policy Check-up (PPC)

In case of a prospect whose medical check-up is conducted for the purpose of underwriting and for whom the Company grants an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, the Company shall re-imburse 100% of the cost of such medical check-up.

6.2. Notification of Claim

It is a Condition Precedent to Company's liability under this Policy that the following procedures must be followed strictly in respect of all claims:

	Treatment, Consultation or Procedure:	The Company must be notified:
1.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission to Hospital.
2.	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an emergency:	Within 24 hours of the Insured Person's admission to Hospital.
3.	For all benefits which are contingent on Company's prior acceptance of a claim under Section 3.1 .1:	Within 7 days of the Insured Person's discharge from the Hospital.

6.3. Cashless Facility

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Facility is Available:	The Company must be given notice that the Insured Person wishes to take advantage of the Cashless Facility accompanied by full particulars:
1)	For any planned treatment, consultation or procedure for which a claim may be made:	Network Provider	Yes, the Company will make payment to the extent of Company's liability directly to the Network Provider.	At least 48 hours before the planned treatment or Hospitalisation.
2)	For any treatment, consultation or procedure for which a claim may be made to be taken in an emergency:	Network Provider	Yes, the Company will make payment to the extent of Company's liability directly to the Network Provider.	Within 24 hours after the treatment or Hospitalisation.
3)	For any planned or emergency treatment, consultation or procedure for which a claim may be made:	Non- Network Provider	No, the Company will consider claims on a reimbursement basis only.	N/A

6.4. Supporting Documentation & Examination

For all requests for pre-authorisation of Cashless Facility, the Company shall be provided with the following necessary information and documentation:

i. The Company's pre-authorization form duly completed and signed for or on behalf of the Insured Person and the treating Medical Practitioner, as applicable, provided that no signatures are required if the same is being completed or populated digitally in the Company's website.

ii. Copy of the identification document of the Insured Person such as voter ID card, driving license, passport, PAN card or Aadhar card.

For all claims under the Policy, the Company must be provided with all documentation, medical records and information that is required to establish the circumstances of the claim, its quantum or the Company's liability for the claim within 15 days of the earlier of Company's request or the Insured Person's discharge from Hospitalisation or completion of treatment. The necessary information and documentation includes the following:

Benefit No.	Covers	List of Claim Documents
Benefit - 3.1	**Basic Cover:** Inpatient Care, Special Treatment, Day Care Procedures, Domiciliary Hospitalisation Organ Donor, AYUSH Benefit, Pre and Post Medical Expenses, Emergency Ambulance, Transportation Benefit, Restore Benefit	a. The Company's claim form duly completed and signed for on behalf of the Insured Person, provided that no signatures are required if the same is being completed or populated digitally in Company's website. b. Original bills/certified true copies (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto such as receipts or prescriptions in support of any amount claimed which will then become Company's property. c. Ambulance receipt and bill d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries. e. A precise diagnosis of the treatment for which a claim is made. f. A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up). g. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.
		h. All pre- and post-investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made. i. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnosis or detection. j. Treating Medical Practitioner's certificate regarding missing information in case histories e.g. circumstance of Injury and alcohol or drug influence at the time of Accident. k. Copy of settlement letter from other insurance company or TPA. l. Stickers and invoice of implants used during surgery. m. Copy of MLC (medico legal case) records and FIR (First Information Report), in case of claims arising out of an Accident. n. Original Cancelled cheque in CTS 2010 format (Printed A/C No. IFSC Code, Printed Name), In case the Name is not printed on the cheque Leaf, duly attested scanned copy of the first page of the Pass-book or the authorized bank statement for NEFT (to enable direct credit of claim amount in bank account) and KYC (recent photo ID/address proof and photograph) requirements. o. Regulatory requirements as amended from time to time. p. Legal heir certificate, in the event of death.
Benefit -3.2	**More Options Benefits:** MoreTime, MoreCover, MoreGlobal	i. Same Documents as mentioned for Benefit-3.1-Basic Cover ii. Passport and Visa (applicable for MoreGlobal)
Benefit -3.3	**Renewal Benefit:** Stay Healthy Discount	i. Duly completed and signed Claim Form, in original ii. Health Check upresults, bills and Receipts
Benefit-3.4-Add Ons Cover		
Benefit -3.4.1	Voluntary Co-Payment	i. Same Documents as mentioned for Benefit-3.1-Basic Cover

Benefit No.	Covers	List of Claim Documents
Benefit -3.4.2	**Limitless Cover:** Consumables Covers, Unlimited Restore Benefit	i. Same Documents as mentioned for Benefit-3.1-Basic Cover
Benefit -3.4.3	**Smart Protector:** Super Charger, Air Ambulance	i. Same Documents as mentioned for Benefit-3.1-Basic Cover ii. Air Ambulance receipt and bill accompanied with Medical Practitioner's written recommendation
Benefit - 3.4.4	**Mother and Child Care:** Maternity Cover, Newborn Baby and Vaccination Cover	i. Same Documents as mentioned for Benefit-3.1-Basic Cover ii. Medical Practitioner's written recommendation in case of medical termination of pregnancy iii. New Born baby Vaccination bills and receipts.
Benefit - 3.4.5	**OPD Cover**	i. Duly completed and signed Claim Form, in original ii. All consultation bills and prescriptions of Super Specialist/Medical Practitioner (depending on Plan opted) iii. Diagnostic test bills along with copy of reports iv. Medicine bills along with the Super Specialist/Medical Practitioner Prescription
Benefit - 3.4.6	**Medical Equipment Cover**	i. Duly completed and signed Claim Form, in original ii. Medical Practitioner prescription specifying requirement of Medical Equipment iii. Original bills and receipts for Medical Equipment.
Benefit- 3.4.7	**Double Cover**	i. Same Documents as mentioned for Benefit-3.1-Basic Cover
Benefit - 3.4.8	**Home Care Treatment**	i. Same Documents as mentioned for Benefit-3.1-Basic Cover
Benefit -3.4.9	**Change in Pre-Existing Waiting Period**	i. Same Documents as mentioned for Benefit-3.1-Basic Cover
Benefit -3.4.10	**Reduction in Specific Waiting Period**	b. Same Documents as mentioned for Benefit -3.1-Basic Cover
Benefit -3.4.11	**Reduction in Room Rent**	i. Same Documents as mentioned for Benefit -3.1-Basic Cover
Benefit -3.4.12	**Discount for Removal of More Options Benefits**	i. Not Applicable
Benefit -3.4.13	**Voluntary Aggregate Deductible**	i. Same Documents as mentioned for Benefit-3.1-Basic Cover

Benefit No.	Covers	List of Claim Documents
Note-The Company may call for any other documents as required by the Company to assess the Claim.		

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/ provider have to be submitted.

If any claim is not notified/made within the timelines set out above then the Company will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.

The Insured Person will have to undergo medical examination by the Company's authorized Medical Practitioner, as and when the Company may reasonably require, to obtain an independent opinion for the purpose of processing any claim. The Company will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

6.5. Claims Payment

i. The Company will be under no obligation to make any payment under this Policy unless the Company has received all premium payments in full in time and all payments have been realised and the Company has been provided with the documentation and information. The Company had requested to establish the circumstances of the claim, its quantum or the Company's liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii. The Company will only make payment to or at Policyholders direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable by the Company for whichthe expenses are incurred, this person will be deemed to be authorised by the Policyholder to receive the concerned payment. In the event of the death of the Policyholder or an Insured Person, the Company will make payment to the Nominee (as named in the Schedule) in India.

iii. The assignment of benefits of under the Policy shall be allowed subject to applicable law.

iv. The Company is not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

6.6. Proportionate Deductions

Subject to the other Terms and Conditions of this Policy, The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

i. The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.

ii. The Insured Person chooses a room category in which the room rent charges are more than the applicable Base Sum Insured sub-limit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit-3.1.1 (Inpatient Care) barring the below mentioned expense break ups:

i. Cost of Pharmacy and Consumables

ii. Cost of Implants and Medical Devices

iii. Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table:

Sr. No.		Header	Explanation
I		Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
II		Eligible Room Rent Limit	Room Rent allowed as per policy is Single Private A.C Room (upto Deluxe Room)
A		Actual Medical Bills Incurred	As per submitted documents
	(-)	Any expense not covered under Policy Benefits	
B	=	Covered Medical Expenses	
	(-)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
D	=	Covered Medical Expenses which shall be subject to Proportionate Deduction	
	(*)	(Eligible Room Rent Limit)/(Actual Room Rent)	
E	=	Claim after Proportionate Deduction	If Actual Room Rent is within eligibility, then no deduction to be applied [E=D]
	(+)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
F	=	Assessed Claim amount	
	(-)	Deduction for Copay	
G	=	Ground up claim amount	
	(-)	Deductions for Policy Deductibles and Limits*	
H	=	Payable claim amount	

The Final Claim amount would be deducted, in the following progressive order, from:

a. Sum Insured
b. Double Cover (if applicable)
c. More Cover (if applicable)
d. Super Charger (if applicable)
e. Restore Benefit or Unlimited Restore Benefit

Proportionate Deduction is subject to the following:

i. Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced
ii. If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Company shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Insurer.
iii. ICU charges shall not be proportionately reduced in all cases.

6.7. Maximum Liability

The maximum, total and cumulative liability of the Company to pay the claims made under the Policy in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year/ Extended Policy Year (if applicable)shall be sum total of following benefits.

i. Sum Insured
ii. Double Cover (if applicable)
iii. More Cover (if applicable)
iv. Super Charger (if applicable)
v. Restore Benefit or Unlimited Restore Benefit
vi. OPD Cover (if applicable)

Annexure-I Coverage Summary

Sum Insured mentioned below for

- Per Insured Person per Policy Year/ Extended Policy Year (if applicable) for Individual policies.
- Per Policy per Policy Year/ Extended Policy Year (if applicable) for Family Floater policies

Sum Insured (in lakhs)	3lakhs / 5lakhs / 10lakhs / 15lakhs / 25lakhs / 50lakhs / 100lakhs / 200lakhs / 300 lakhs / 400 lakhs / 500lakhs			
Benefit No.	**Cover Name**	**Limits**	**Basis of Payment**	**Pre-Requisite for Claim**
		3.1: Basic Benefits		
3.1.1	Inpatient Care	Covered	Indemnity	Not Applicable
3.1.2	Special Treatment	Sum Insured (in Rs) / Special Treatment limits (in Rs) <10 lakhs / 50% of S.I >=10lakhs / 100% of S.I	Indemnity	3.1.1 Inpatient Care or 3.1.3 Day Care Procedures or 3.1.4 Domiciliary Hospitalisation
3.1.3	Day Care Procedures	Within Sum Insured	Indemnity	Not Applicable

<table>
<tr><td>3.1.4</td><td>Domiciliary Hospitalisation</td><td>Within Sum Insured</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td>3.1.5</td><td>Organ Donor</td><td>Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care</td></tr>
<tr><td>3.1.6</td><td>AYUSH Benefit</td><td>Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care</td></tr>
<tr><td>3.1.7</td><td>Pre-Hospitalisation Medical Expenses</td><td>Covered upto 90 days, Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care, 3.1.2 Special Treatment, 3.1.3 Day Care Procedures or 3.1.4 Domiciliary Hospitalisation, 3.1.6 AYUSH Treatment</td></tr>
<tr><td>3.1.8</td><td>Post-Hospitalisation Medical Expenses</td><td>Covered, upto 180 days, Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care, 3.1.2 Special Treatment, 3.1.3 Day Care Procedures or 3.1.4 Domiciliary Hospitalisation, 3.1.6 AYUSH Treatment</td></tr>
<tr><td>3.1.9.</td><td>Emergency Ambulance</td><td>Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care,3.1.3 Day Care Procedures</td></tr>
<tr><td>3.1.10</td><td>Transportation Benefit</td><td>Maximum upto Rs. 500 per Hospitalization (Within Sum Insured)</td><td>Indemnity</td><td>3.1.1 Inpatient Care,3.1.3 Day Care Procedures</td></tr>
<tr><td>3.1.11</td><td>Restore Benefit</td><td>On subsequent claim, one restore up to 100% of Sum Insured for unrelated illness/injury</td><td>Indemnity</td><td>3.1 Basic Benefits</td></tr>
<tr><td colspan="5">3.2 : More Options Benefits*</td></tr>
<tr><td>3.2.1</td><td>MoreTime*</td><td>Extended Policy Year of 13 months if Policy period is 1 year and Extended Policy Year of 26 months if Policy Period is 2 years</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td>3.2.2</td><td>MoreCover (in Rs.)*</td><td><table><tr><td>Sum Insured (in Rs)</td><td>More Cover Sum Insured (in Rs)</td></tr><tr><td>300000</td><td>1,00,000</td></tr><tr><td>500000</td><td>2,00,000</td></tr><tr><td>1000000</td><td>3,00,000</td></tr><tr><td>1500000</td><td>5,00,000</td></tr><tr><td>2500000</td><td>7,50,000</td></tr><tr><td>5000000</td><td>15,00,000</td></tr><tr><td>10000000</td><td>30,00,000</td></tr><tr><td>20000000</td><td>60,00,000</td></tr><tr><td>30000000</td><td>90,00,000</td></tr><tr><td>40000000</td><td>1,20,00,000</td></tr><tr><td>50000000</td><td>1,50,00,000</td></tr></table></td><td>Indemnity</td><td>3.1 Basic Benefits</td></tr>
<tr><td>3.2.3</td><td>MoreGlobal (in Rs.)*</td><td>upto 100% of Sum Insured, (Within Sum Insured)
Sub-limit of Rs 50 lakhs or S.I whichever is lower for Planned In-Patient Treatment.</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td colspan="5">3.3 Renewal Benefit – Stay Healthy Discount</td></tr>
<tr><td>3.3</td><td>Renewal Benefit Stay Healthy Discount</td><td>Upto 10% discount on renewal premium</td><td>Not Applicable</td><td>Not Applicable</td></tr>
<tr><td colspan="5">3.4 Add Ons Covers*</td></tr>
<tr><td>3.4.1</td><td>Voluntary Co-payment*</td><td>10%, if opted</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td colspan="5">3.4.2 Limitless Cover</td></tr>
<tr><td>3.4.2.1</td><td>Consumables Cover</td><td>Within Sum Insured</td><td>Indemnity</td><td>3.1.1 Inpatient Care, 3.1.3 Day Care Procedures</td></tr>
<tr><td>3.4.2.2</td><td>Unlimited Restore Benefit</td><td>On subsequent claim.</td><td>Indemnity</td><td>3.1. Basic Benefits</td></tr>
<tr><td colspan="5">3.4.3 Smart Protector</td></tr>
</table>

<table>
<tr><td>3.4.3.1</td><td>Super Charger</td><td>Additional Sum Insured is provided at the end of the Policy Year/ Extended Policy Year (if applicable)
(Option 1): 20% of S.I, maximum up to 100% of S.I
(Option 2): 33.33% of S.I, maximum up to 100% of S.I</td><td>Indemnity</td><td>3.1 Basic Benefits</td></tr>
<tr><td>3.4.3.2</td><td>Air Ambulance</td><td>S.I< 1crores: 7.5% of Sum Insured or Rs 5 Lakhs whichever is higher
S.I >=1crores: 10% of Sum Insured
(Within Sum Insured)</td><td>Indemnity</td><td>3.1.1 Inpatient Care, 3.1.3 Day Care Procedures</td></tr>
<tr><td colspan="5">3.4.4 Mother and Child Care</td></tr>
<tr><td>3.4.4.1</td><td>Maternity Cover</td><td><table><tr><td>Sum Insured</td><td>Maternity Limits (Normal C-Section)</td></tr><tr><td>5 lakhs</td><td>1 lakh</td></tr><tr><td>>=10lakhs</td><td>Option 1- 1lakh
Option 2- 2 lakhs</td></tr></table>Maternity Waiting Period Option:
12 months or 24 months.
Cover is available only to 3 year Policy Period.
(Within Sum Insured)</td><td>Indemnity</td><td>3.1.1 Inpatient Care</td></tr>
<tr><td>3.4.4.2</td><td>Newborn baby and Vaccination Cover</td><td>1 lac (Within Sum Insured)</td><td>Indemnity</td><td>3.4.4.1 Maternity Cover</td></tr>
<tr><td>3.4.5</td><td>OPD Cover**</td><td>(Over and above the S.I)
Plan A: (Available from S.I 5 lakhs and above)
a. OPD Consultations with 10 Super Specialist
b. Diagnostic Tests
c. Prescription Drugs: 35% of OPD limit OPD Limits: 10000 to 20000 (in multiples of 5000)
Plan B: (Available from S.I 10 lakhs and above)
a. OPD Consultations with Medical Practitioners
b. Diagnostic Tests
c. Prescription Drugs: 35% of OPD limit
d. OPD for Dental Treatment & related Diagnostic Tests& prescription drugs
e. Surgical Treatments OPD Limits: 25000 to 50000 (in multiples of 5000)</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td>3.4.6</td><td>Medical Equipment Cover</td><td>a. Durable Medical Equipment: Limit: 5% of Sum Insured subject to max. of Rs 2.5 lacs
b. Small Medical Equipment: 1% of Sum Insured subject to max. of 20000 (Within Sum Insured)</td><td>Indemnity</td><td>Not applicable</td></tr>
<tr><td>3.4.7</td><td>Double Cover</td><td>This benefit provides additional 100% of Sum Insured for Same claim</td><td>Indemnity</td><td>3.1 Basic Benefits</td></tr>
<tr><td>3.4.8</td><td>Home Care Treatment</td><td>Within Sum Insured</td><td>Indemnity</td><td>Not Applicable</td></tr>
<tr><td>3.4.9</td><td>Change in Pre-Existing Waiting Period*</td><td>This benefit allows to change the Pre-Existing Waiting Period to 48 months*, 24 months ,12 months</td><td>Not Applicable</td><td>3.1Basic Benefits</td></tr>
<tr><td>3.4.10</td><td>Reduction in Specific Illness Waiting Period</td><td>This benefit reduces the Specific Illness Waiting Period to 12 months</td><td>Not Applicable</td><td>3.1 Basic Benefits</td></tr>
</table>

3.4.11	Reduction in Room Rent*	Room Category Options: Single Private A.C Room OR Twin Sharing Room	Indemnity	3.1 Basic Benefits
3.4.12	Discount for Removal of More Options Benefit*	This benefit gives discount in Policy Premium if one complementary More Option Benefit is not opted under the Policy	Not Applicable	Not Applicable
3.4.13	Voluntary Aggregate Deductible*	Options are: 10000, 25000, 50000, 100000	Indemnity	3.1 Basic Benefits

* Benefit-3.4.5 OPD Cover has 2 plans, the Policyholder can opt either Plan A or Plan B

Annexure-II Service-related Information:

Policyholder/Insured Person can reach the Company through any of the following methods for any service related issue and assistance:

Claims Servicing	
Name	RCareHealth: Claims and Care management
Correspondence Address :	Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081.
Contact No. :	1800 3009(toll free)/022-41112600
E-mail :	rgicl.rcarehealth@relianceada.com

Annexure-III Claim Related Information& Claim Procedure

Please review your Reliance Health Infinity Insurance Policy and familiarize yourself with the benefits available and the exclusions.

To help the Company to provide Policyholder/Insured with fast and efficient service, the Company kindly ask the Policyholder/ Insured to note the following:

1. The Company recommend that Insured keep copies of all documents submitted to Reliance General Insurance Company Limited
2. Please quote Insured member ID/policy number in all your correspondences

Intimation & Assistance	Please contact Reliance General Insurance Company at least 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact Reliance General Insurance Company within 24 hours of the event. Reliance General Insurance Company can be contacted through: Website : www.reliancegeneral.co.in Email : rgicl.rcarehealth@relianceada.com Helpline : 1800 3009(toll free)/022-41112600 Courier : Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081
Procedure for Reimbursement of Medical Expenses	Please send the duly signed claim form and all the information/ Documents mentioned therein to the Company within 15 days of the occurrence of incident. Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by Policyholder/Insured, the Company will send the deficiency letter within 10 days of receipt of the claim documents. • On receipt of the complete set of claim documents, the Company will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. Note: Payment will only be made for items covered under the policy and upto the limits therein.
Procedure to avail Cashless facility	For any emergency hospitalization, Reliance General must be informed no later than 24 hours after hospitalization. For any planned hospitalization, kindly seek cashless authorization from Reliance General at least 48 hours prior to the start of the Insured Person's hospitalization. The Company will check the coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 4 hours of receipt of documents. Please pay the non-medical and expenses not covered to the hospital prior to the discharge. For details on non-medical expenses, please refer Annexure A of Policy wording. In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 4 hours. Note: • Insured person is entitled for cashless only in the Company's network hospitals. • Please refer to the list of network hospitals on Company's website. • Please refer to the list of non-medical expenses not covered in the policy in Annexure Aof Policy wordings. • Rejection of cashless in no way indicates rejection of the claim.

Illustration on Utilization of Sum Insured and Unlimited Restore Benefit

The Sum Insured shall be utilized in following sequence:

1. Sum Insured
2. Double Cover (once on Same claim)
3. More Cover Sum Insured (On Same or subsequent Claims)
4. Super Charger (On same or subsequent Claims)
5. Restore or Unlimited Restored Sum Insured (Only on Subsequent Claims)

Illustration-1: Unlimited Restore of S.I 5 lakhs

Limitless Cover (Unlimited Restore): Opted
Double Cover: Opted
More Cover: Opted
Smart Protector (Super Recharger): Opted-option-1(20% of S.I, max up to 100%)

	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	Base Sum Insured	Double Cover	More Cover S.I	Super Charger	Unlimited Restore	Treatment taken for Disease/ Injury/Illness	Hospitalization Amount	Base Sum Insured	Double Cover	More Cover S.I	Super Recharge	Unlimited Restore	Claim amount payable
Claim 1	500000	500000	200000	100000	0	Stroke	500000	500000	0	0		0	500000
Claim 2	0	500000	200000	100000	500000	Cancer	1200000	0	500000	200000	100000	400000	1200000
Claim 3	0	0	0	0	500000	Cancer (related illness)	700000	0	0	0		500000	500000
Claim 4	0	0	0		500000	Pneumonia	200000	0	0	0	0	200000	200000

In the above scenario,Total Hospitalization Amount is of Rs 26 lakhs and Claim outgo is of Rs 24lakhs. Policyholder has to pay Rs 2 lakhs from his pocket. For future claims, Policyholder has Unlimited Restore S. I of 5lakhs which can be utilized for unrelated illness.

Illustration-2: Unlimited Restore of S.I 10 lakhs & above

Limitless Cover (Unlimited Restore): Opted
Double Cover: Opted
More Cover: Opted
Smart Protector (Super Recharger): Opted-option-1(20% of S.I, max up to 100%)

	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	Base Sum Insured	Double Cover	More Cover S.I	Super Charger	Unlimited Restore	Treatment taken for Disease/ Injury/Illness	Hospitalization Amount	Base Sum Insured	Double Cover	More Cover S.I	Super Recharge	Unlimited Restore	Claim amount payable
Claim 1	1000000	1000000	300000	200000	0	Stroke	500000	500000	0	0		0	500000
Claim 2	500000	1000000	300000	200000	500000	Cancer	1200000	500000	700000	0	0	0	1200000
Claim 3	0	0	300000	200000	1000000	Cancer (related illness)	700000	0	0	300000	200000	200000	700000
Claim 4	0	0	0		1000000	Pneumonia	200000	0	0	0	0	200000	200000

In the above scenario,Total Hospitalization Amount is of Rs 26 lakhs and Claim outgo is of Rs 26lakhs. Policyholder does not have to pay anything from his pocket. For future claims, Policyholder has Unlimited Restore S. I of 10 lakhs which can be utilized for related and unrelated illness.

Illustration for Voluntary Aggregate Deductible

Below is the illustration on application of Voluntary Aggregate Deductible.

A policy with Sum Insured 5 lakhs has made following three claims in the policy year. Assuming the available SI is 5 lakhs with no other benefits enhancing the SI, the table below illustrates the claim payable by the Company under each Deductible option:

Aggregate Voluntary Deductible Illustration

Claim	Treatment taken for disease/ illness	Assessed Hospitalisation amount	Claim payable under each deductible option			
			10000	25000	50000	100000
1	Pneumonia	50000	40000	25000	0	0
2	Accident	100000	100000	100000	100000	50000
3	CABG	400000	360000	375000	400000	400000
Total		550000	500000	500000	450000	
Out of pocket expenses for policyholder under each deductible option			50000	50000	50000	100000