

RELIANCE HEALTH INFINITY INSURANCE - PROSPECTUS

SECTION-1 INTRODUCTION

A Unique and innovative indemnity product which covers expenses incurred on hospitalisation due to illness or accident in India and overseas alike. Product offers innovative features like MoreCover which offers additional sum insured for claims exceeding the sum insured, MoreTime provides extended policy period, MoreGlobal covers emergency care and planned treatment of illness while travelling overseas. The product provides automatic restoration of Sum Insured. Product also offers various Add On Covers which can be opted to cover Maternity, OPD expenses, Durable and Small Medical Equipment. Limitless cover provides unlimited restoration and cover for Consumables during Hospitalization. Super Charger may be opted to provide regular increases to Sum Insured. The product offers wide customization of Room Rent, Waiting Periods, Co-Pays and Deductibles, making it suitable to the specific needs of each customer.

SECTION-2 ELIGIBILITY CRITERIA

- i. This policy can be availed by persons in the age group 91 days to 65 years.
- ii. The maximum entry age is restricted to 65 years.
- iii. The maximum entry age for a child dependent is 30 years. The child will be ported to an Individual Policy having a separate Sum Insured and treated as an Adult upon attaining age of 31 years at the time of renewal without underwriting.
- iv. There is no maximum cover ceasing age on continuous renewals.
- v. Age means "Age as on last birthday" as on the date of first Policy issuance or at renewal. In case of change in age during the proposal stage, then "age" on the date of proposal form submission would be considered for premium calculation.
- vi. This policy can be issued to an individual and/or family.
- vii. Individual Sum Insured: A maximum of 20 members can be covered in a single individual policy on individual sum insured basis. The family includes spouse, son, daughter-in-law, daughter, son-in-law, father, mother, father-in-law, mother-in-law, grandfather, grandmother, grandson, granddaughter, brother, sister, sister-in-law, brother-in-law, nephew, niece. Minimum one Adult Member to be Insured under the Policy.
- viii. Family Floater Sum Insured: A maximum of 8 members can be covered in a single-family floater policy with a maximum of 2 Adults. The following combinations are allowed as under:
 - a) Self and/or Spouse with up to 6 dependent Children
 - b) 2 Parents
 - c) 2 Parents-in-Law

SECTION-3 POLICY PERIOD

This policy will be issued for a period of 1 year / 2 years / 3 years based on the Policy Period selected and specified in the Schedule. The Sum Insured & the benefits under the Policy will be applicable on Policy Year/Extended Policy Year (if applicable) basis.

SECTION-4 SUM INSURED

Sum Insured options 3lakhs/5lakhs/10lakhs/15lakhs/25lakhs/50lakhs/100lakhs/200lakhs/300lakhs/ 400lakhs/500lakhs.

The policy will cover all insured members on the Same Sum Insured.

SECTION-5 Salient Features and Benefits

5.1 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:

5.1.1 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.

5.1.2 Special Treatment

The Medical Expenses incurred during the Policy Period on Inpatient Care or Day Care Procedure or Domiciliary Hospitalisation 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. Bronchical Thermoplasty
- x. Vaporization of the prostate (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

5.1.3 Day Care Procedures

Medical Expenses incurred for Day Care Treatment which



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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 purpose will not be covered under this Benefit,
- ii. Any Day Care Treatment which also falls within the scope of cover under Basic Benefit 5.1.2 will be considered under Basic Benefit 5.1.2 and not under this Benefit.

5.1.4 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 5.1.7 and Basic Benefit 5.1.8, respectively.

5.1.5 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 5.1.1 Inpatient Care
- iv. The Company will not pay for the Medical Expenses incurred by an Insured Person while donating an organ.

5.1.6 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 5.1.1 Inpatient Care,

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 Hospitalisation in respect of that illness or injury, then the Company will pay:

5.1.7 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 5.1.1 Inpatient Care, 5.1.2 Special Treatment, 5.1.3 Day Care Procedures, 5.1.4 Domiciliary Hospitalization or 5.1.6 AYUSH Benefit.
- iii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

5.1.8 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 5.1.1 Inpatient Care, 5.1.2 Special Treatment, 5.1.3 Day Care Procedures, 5.4 Domiciliary Hospitalization or 5.1.6 AYUSH Benefit.
- iii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

5.1.9 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 5.1.1 Inpatient Care or 5.1.3 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 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 efforts basis. Where Cashless Facility is not available, due to any reason, the Company shall consider the claim on a reimbursement basis.

5.1.10 Transportation Benefit

Reasonable expenses incurred up to the amount specified in the Schedule or Coverage Summary, per Hospitalization, for utilizing a registered radio cab operator's services for transporting the Insured Person to and/or from the Hospitals, 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 5.1.1 Inpatient Care or 5.1.3 Day Care Procedures.
- ii. No Cashless Facility is available under this Basic Benefit and all claims will be considered on a reimbursement basis only.

5.1.11 Restore Benefit

If the Sum Insured, Double Cover (if applicable), MoreCover Sum Insured (if applicable) and Super Charger Sum Insured (if applicable) are exhausted due to claims made and paid during



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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), MoreCover Sum Insured (if applicable) and Super Charger Sum 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 5.1 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) MoreCover (if applicable)
 - d) Super Charger (if applicable)
 - e) Restore Benefit

5.2 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

- i. 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.
- ii. 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
- iii. The Policyholder may 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
- iv. Any changes to the More Options Benefits opted for can be made only on Renewal.

5.2.1 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.

5.2.2 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 in Section 5, 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;

5.2.3 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 upto 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



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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:

- a) 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.
- b) 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.
- c) 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).
- d) Cost of Emergency Road Transportation, including necessary medical care en-route, by an Ambulance to the nearest Hospital or to the nearest Physician
- e) Cost of being transferred by Road to a special clinic if this is Medically Necessary Treatment and is prescribed by the Physician.
- f) 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.
- g) 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
- h) Lifesaving 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 5.2.3 MoreGlobal

- 1) **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.
- 2) **Duration:** This benefit is available up to 45 days of international travel on cumulative basis during the Policy Year/ Extended Policy Year (if applicable)
- 3) **Deductible:** Deductible of USD 100 shall be applicable on each and every OPD claim made under this benefit.
- 4) **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.

- 5) **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.
- 6) **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.
- 7) **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.
- 8) **Eligibility:** For the purpose of MoreGlobal Cover, this cover is not available under this policy and no claim shall be admissible under this cover where either the policyholder or any of the Insured Person(s) is a Foreign National or their Residence Status at the time of proposal or anytime during the policy period/ renewal is:
 - Non-Resident Indian (NRI); or
 - Overseas Citizen of India (OCI)

Specific Exclusions applicable to Benefit 5.2.3 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:

- a. **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.
- b. **Pre and Post Hospitalization Expenses**
- c. **Pre-existing Diseases:** Any claim arising in relation to Pre-Existing Disease except for Lifesaving unforeseen emergency measures as described under Benefit -MoreGlobal
- d. **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.
- e. **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.
- f. **Maternity Expenses**
 1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic



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pregnancy;

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

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

h. Standard and Specific Exclusions: Any exclusion mentioned in the Section-6 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".

Illustrations for Restore Benefit and More options benefits

Scenario 1 - Restore Benefit + MoreCover

Sum Insured	300000
MoreCover Sum Insured	100000
Procedure undergone	Angioplasty
Claim Amount	350000
Restore Sum Insured Triggered	No

Restore Benefit is not triggered as sum of sum insured and MoreCover sum insured has not completely exhausted

Scenario 2 - Restore Benefit + MoreCover

Sum Insured	300000
MoreCover Sum Insured	100000
Procedure undergone	Angioplasty
Claim Amount	400000
Restore Sum Insured Triggered	Yes

Restore Benefit triggered as sum of sum insured and MoreCover sum insured has been completely exhausted

Illustrations for Restore Benefit + MoreTime

Scenario 1 - Claim in Extended Policy Period

Sum Insured	300000
Claim 1	During Policy Period
Procedure undergone / Illness	Angioplasty
Claim Amount	250000
Sum Insured after claim	50000
Restore Sum Insured Triggered	No
Claim 2	During Extended Policy Period
Procedure undergone / Illness	Dengue
Claim Amount	100000
Restore Sum Insured Triggered	Yes

Illustrations for Restore Benefit + MoreGlobal

Scenario 1 - Claim of emergency hospitalisation in abroad

Sum Insured	300000
Claim 1	Hospitalisation in India
Procedure undergone / Illness	Angioplasty
Claim Amount	250000

Sum Insured after claim	50000
Restore Sum Insured Triggered	No
Claim 2	Emergency Hospitalisation In abroad
Procedure undergone / Illness	Dengue
Claim Amount	100000
Restore Sum Insured Triggered	Yes

5.3 – 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

5.4 – Add-On Covers

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.

5.4.1 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



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- 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 for Benefit-5.4.4 Mother and Child Care, Benefit-5.4.5 OPD Cover and Benefit-5.4.6.2 Small Medical Equipment .

5.4.2 Limitless Covers

5.4.2.1 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 5.1.1 Inpatient Care or 5.1.3 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

5.4.2.2 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 5.1 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 5.1 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), MoreCover 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).
- vi. The Restored Sum Insured at given time shall not exceed the Sum Insured mentioned in the Schedule.
- vii. 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);

- viii. 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).
- ix. The Unlimited Restore Benefit supersedes the existing Benefit 5.1.11 Restore Benefit
- x. 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 Restore Benefit

5.4.3 Smart Protector

5.4.3.1 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 5.1 Basic Benefits.

5.4.3.2 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 5.1.1 Inpatient Care or 5.1.3 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



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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

5.4.4 Mother and Child Care

5.4.4.1 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, within Maternity limit.
- 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. 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.
- xi. This benefit supersedes the Standard Exclusion mentioned in Clause 6.1.18 Maternity (Code: Excl 18)

5.4.4.2 Newborn Baby and Vaccination Cover

The Company will indemnify the Insured Person up 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- 5.4.4.1 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 maybe 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 vaccination 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-5.4.4.1 Maternity Cover
- v. The limits for this benefit fall within the Sum Insured of the Policy.
- vi. 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.

5.4.5 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).

- i. **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.
- ii. **Diagnostic Tests:** Cost for Diagnostic Tests prescribed by the consulting Super Specialist
- iii. **Prescription drugs expenses:** Cost of prescription drugs prescribed by the consulting Super Specialist

The benefit is subject to following:

- a) 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.
- b) Condition Precedent: The claim for Diagnostic Tests and Prescription drugs shall become payable only in relation to an OPD consultation which is payable.
- c) The expenses under this benefit are covered only for



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Allopathy Treatment.

- d) This benefit will be available with minimum two-years Policy Period, where Policy S.I is 5lacs.
- e) The benefit is available on individual basis for individual policies and on floater basis for family floater policies.
- f) The Company's maximum liability to pay the claim under this benefit is limited to the selected OPD limit, as specified in the Schedule.
- g) Any unutilized OPD Limit shall not be carried forward to next Policy Year/Extended Policy Year (if applicable).
- h) 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.
- i) The amount claimed under this Benefit is over and above the Sum Insured
- j) 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.

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. **Dental OPD**

The Company shall pay expenses incurred by Insured Person for below mentioned Dental related covers with a mandatory Co-Payment of 20% on each and every claim, subject to terms, conditions and definitions, exclusions, up to the limit specified in the Policy Schedule.

a) Dental Consultation:

The Company shall pay expenses up to the limits specified in the Policy Schedule related to the dental consultation from Dentist

b) Dental Treatment/Surgery:

The Company shall pay expenses up to the limits specified in the Policy Schedule incurred for Dental Treatment/Surgery which includes simple fillings related to cavities or decay, root canal treatment, surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy, surgical removal of cysts, Orthognathic surgeries for the correction of malocclusion.

The company shall also pay the expenses related to prescription drugs and diagnostic test related to the dental surgery including laboratory tests, X-rays, CT scans and MRI(s).

c) Periodontics

The Company shall pay expenses up to the limits specified in the Policy Schedule incurred for treatment related to gum disease.

Exclusions under Dental OPD:

- a. Dental surgery under Dental Cover does not cover surgical treatment that relates to dental implants.
- b. Dental Prostheses, dental implants, orthodontics are not covered under Dental Cover.
- c. Expenses related to the Dental cover within 30 days from the first Policy year shall not be payable
- 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:

- 1. Condition Precedent: The claim for Diagnostic Tests and Prescription drugs shall become payable only in relation to an OPD consultation which is payable.
- 2. The expenses under this benefit are covered only for Allopathy Treatment.
- 3. Dental Implants, CAD/CAM restorations and bone graft are not covered
- 4. The benefit is available on individual basis for individual policies and on floater basis for family floater policies.
- 5. The Company's maximum liability to pay the claim under this benefit is limited to the selected OPD limit, as specified in the Schedule.
- 6. Any unutilized OPD limit shall not be carried forward to next Policy Year/Extended Policy Year (if applicable).
- 7. 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.
- 8. The amount claimed under this Benefit is over and above the Sum Insured
- 9. 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



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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.

5.4.6 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.

5.4.6.1 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

- i. **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.
- ii. **Hearing aids** excluding battery (Hearing loss above 55 db HL)
- iii. **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.

- iv. **CPM Machines**
- v. **BiPAP and CPAP devices**
- vi. **Oxygen Concentrator** (required for management of Chronic Illness)
- vii. **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.
- viii. **Traction equipment's**
- ix. **Commode Chairs/toilet seat frames/risers, Bath Bench or Shower Chairs:** Where Insured person is eligible for either wheelchair, Walker or Hospital bed
- x. **Infusion Pumps** (when medically necessary to administer certain drugs)
- xi. **Suction Pumps**
- xii. **DVT pump**
- xiii. **Artificial limbs**
- xiv. **Walker, Crutches, Canes:** Where the Insured Person has suffered an illness or injury resulting in one or more of the following:
 - a) Decreased weight bearing such that the Insured person can't rely on one or both legs to stand.

- b) Extreme Fatigue or significantly decreased endurance.
- c) Poor balance such that the Insured person needs help with stability and steadiness while walking.

xv. **Pressure-reducing support surfaces (beds, air, gel or water mattresses)** used to prevent bed sores in bed-ridden patients.

xvi. **Blood Glucose Meter** (without test strips)

xvii. **Sphygmomanometer** (Blood Pressure Monitor)

Provided that,

- a) 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.
- b) 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.
- c) 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.
- d) 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.
- e) This benefit includes the cost of repair of the above listed (either new or existing) Durable Medical Equipment
- f) 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)
- g) 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%.
- h) Payments made under this Benefit shall not be claimable under any other Benefit.

5.4.6.2 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, bronchiectasis or for respiratory infection in children upto 5 years of age)

*Must be supported by Medical Prescription from Ophthalmologist



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Provided that,

- a) The Small Medical Equipment is medically necessary following the occurrence of an Illness or Injury
- b) 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 Policy Year/ Extended Policy Year(if applicable) of continuous coverage under this Policy.
- c) 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).
- d) 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.
- e) Payments made under this Benefit shall not be claimable under any other Benefit.

5.4.7 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-5.1 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.
- iv. 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).
- v. Any unutilized Double Cover Sum Insured, in whole or in part shall not be carried forward to subsequent Policy Years.
- vi. 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
- vii. The Double Cover will be available on individual basis for individual policies and on floater basis for floater policies

5.4.8 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 $\geq 10\%$
 - 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

5.4.9 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 6.1.1 to 48 months, 24 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Schedule.

5.4.10 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 6.1.2 to 12 months. Such reduction, if allowed, shall be expressly mentioned in the Schedule.

5.4.11 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 5 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.

5.4.12 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.

5.4.13 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. In case of Individual Policy, the Aggregate Deductible shall apply on individual basis and in case of a floater policy, shall apply on floater basis.



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- iii. The annual Aggregate Deductible shall not be applicable on Benefit-5.4.4 Mother and Child Care, Benefit-5.4.5 OPD Cover and Benefit-5.4.6. Medical Equipment Cover

SECTION-6 EXCLUSIONS

6.1 Standard Exclusions

6.1.1 Pre-Existing Disease (Code: Excl01)

- 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 Reliance Health Infinity Insurance Policy with the Company.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase
- If You are 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
- 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.

6.1.2 Specific waiting period (Code: Excl02)

- 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.
- In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase
- 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
- The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion
- 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
- 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)	<ul style="list-style-type: none"> Sinusitis Rhinitis Tonsillitis 	<ul style="list-style-type: none"> Adenoidectomy Mastoidectomy Tonsillectomy Tympanoplasty Surgery for nasal septum deviation Surgery for turbinate hypertrophy Nasal concha resection Nasal polypectomy

Gynaecological	<ul style="list-style-type: none"> Cysts, polyps, including breast lumps Polycystic ovarian diseases Fibromyoma Adenomyosis Endometriosis Prolapsed uterus 	<ul style="list-style-type: none"> Hysterectomy unless necessitated by malignancy
Orthopaedic	<ul style="list-style-type: none"> Non-infective arthritis Gout and rheumatism Osteoporosis Ligament, tendon and meniscal tear Prolapsed intervertebral disk 	<ul style="list-style-type: none"> Joint replacement surgery
Gastrointestinal	<ul style="list-style-type: none"> 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 prolapsed 	<ul style="list-style-type: none"> Cholecystectomy Surgery of hernia
Urogenital	<ul style="list-style-type: none"> Calculus diseases of urogenital system including kidney, ureter, bladder stones Benign hyperplasia of prostate Varicocele 	<ul style="list-style-type: none"> Surgery on prostate unless necessitated by malignancy Surgery for hydrocele/ rectocele
Eye	<ul style="list-style-type: none"> Cataract Retinal detachment Glaucoma 	<ul style="list-style-type: none"> Surgery for correction of eye sight due to refractive error above dioptr 7.5
Others	<ul style="list-style-type: none"> Congenital internal disease 	<ul style="list-style-type: none"> Surgery of varicose veins and varicose ulcers



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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
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6.1.3 30 Days Waiting Period (Code: Excl03)

- 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
- This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
- The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently

6.1.4 Investigation & Evaluation (Code: Excl04)

- Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

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

- Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - 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.
 - Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6.1.6 Obesity/ Weight Control (Code: Excl06)

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

- Surgery to be conducted is upon the advice of the Doctor
- The surgery/Procedure conducted should be supported by clinical protocols
- The member has to be 18 years of age or older and
- 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:
 - Obesity-related cardiomyopathy
 - Coronary heart disease
 - Severe Sleep Apnea
 - Uncontrolled Type2 Diabetes

6.1.7 Change-of-Gender treatments (Code: Excl07)

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

6.1.8 Cosmetic or Plastic Surgery (Code: Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove

a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

6.1.9 Hazardous or Adventure sports (Code: Excl09)

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

6.1.10 Breach of law (Code: Excl10)

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

6.1.11 Excluded Providers (Code: Excl11)

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in the website / notified to You 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)

6.1.12 Substance Abuse and Alcohol (Code: Excl12)

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

6.1.13 Wellness and Rejuvenation (Code: Excl13)

Treatments received in health 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.

6.1.14 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

6.1.15 Refractive Error (Code: Excl15)

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

6.1.16 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.

6.1.17 Sterility and Infertility (Code: Excl17)

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

- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- Gestational Surrogacy
- Reversal of sterilization

6.1.18 Maternity (Code: Excl18)

- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- Expenses towards miscarriage (unless due to an accident)



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and lawful medical termination of pregnancy during the policy period.

6.2 Specific Exclusions

6.2.1 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.

6.2.2 12/24 months Maternity Waiting Period

The Add On Benefit-5.4.4 Mother and Child Care defined under this Policy shall become available only after the expiry of 12/24 months (as opted) from the date of inception of the first Policy with the Company

6.2.3 Alternative Treatments

Alternative Treatment or any other non-allopathic treatment, except to the extent covered under Basic Benefit 5.1.6, subject to the conditions contained therein.

6.2.4 Circumcision

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

6.2.5 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").

6.2.6 Dental Treatments

Dental Treatments of any kind, unless requiring Hospitalisation necessitated illness or injury, or except to the extent covered under Benefit-5.4.5 OPD Cover, subject to the conditions contained therein.

6.2.7 Unprescribed Drugs or treatments

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

6.2.8 External Congenital Anomaly

External Congenital Anomaly and genetic disorders.

6.2.9 Hearing aids

Provision or fitting of hearing aids, except to the extent covered under Benefit-5.4.6 Medical Equipment Cover, subject to the conditions contained therein

6.2.10 Hormonal therapies

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

6.2.11 Non - Medically Necessary Treatment

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

6.2.12 Medical supplies

Medical supplies including elastic stockings, diabetic test strips, and similar products, except to the extent covered under Benefit-5.4.6 "Medical Equipment Cover", subject to the conditions contained

therein.

6.2.13 Non-medical expenses

Any non-medical expenses mentioned in Annexure A. This exclusion shall be waived off, if Optional Benefit-5.4.2.1 "Consumable Cover" has been opted under the Policy..

6.2.14 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-5.2.3 "MoreGlobal" and under Benefit 5.4.5 "OPD Cover", subject to the conditions contained therein.

6.2.15 Overseas treatment

Treatment availed outside India except in case of where the Benefit 5.2.3 "MoreGlobal" is in force for the Insured Person, subject to the conditions contained therein.

6.2.16 Peritoneal dialysis

Charges related to peritoneal dialysis, including supplies.

6.2.17 Prosthetic and other devices

Prosthetic and other devices which are self-detachable/ removable without surgery involving anaesthesia. This exclusion shall not apply to the extent covered under the Benefit-5.4.6 "Medical Equipment Cover", subject to the conditions contained therein.

6.2.18 Charges other than Reasonable & Customary Charges

Any Medical Expenses which are not Reasonable & Customary Charges.

6.2.19 Self-injury or suicide

Intentional self-injury or attempted suicide.

6.2.20 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.

6.2.21 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.

6.2.22 Treatment outside discipline

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

6.2.23 Vaccination and immunisation

Vaccination including inoculation and immunisation, except in case of post-bite treatment or to the extent covered under Benefit-5.4.4 "Mother and Child Care", subject to the conditions contained therein.

6.2.24 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



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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.

6.2.25 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.

6.3 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-7 DISCOUNTS, LOADING AND PREMIUM ILLUSTRATION

For premium rates & applicable discounts and loadings please refer to the premium chart attached herewith.

Below is the Premium Illustration:

Benefit Illustration in respect of policies offered on Individual and Family Floater basis

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
51	12907	500,000	12907	10%	11,616	500,000	23897	0%	23897	5,00,000
44	8501	500,000	8501		7,651	500,000				
23	6299	500,000	6299		5,669	500,000				
18	5199	500,000	5199		4,679	500,000				
Total Premium for all members of the family is Rs.32,906 when each member is covered separately.			Total Premium for all members of the family is Rs. 29,616 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 23,897			
Sum insured available for each individual is Rs.5 lakhs			Sum insured available for each family member is Rs.5 lakhs				Sum insured of Rs 5 lakhs is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates without any discount for Rest of India zone. Also, the premium rates are exclusive of taxes applicable.

SECTION-8 MEDICAL UNDERWRITING

Tele Underwriting will be carried out basis age and Sum Insured opted under the Policy.

The underwriter may also carry out tele underwriting depending on the details and declarations provided in the Proposal form.

The Company may also ask for Pre-Policy Medical Check-up on case-to-case basis depending on the Tele underwriting outcome.

In case the Insured Person undergoes a medical check-up then 100% cost for such test shall be borne by the Company, where the Proposal is accepted, and Policy is issued.

The cases where the Proposal is rejected, or the Proposer denies the

accepted proposal then 100% cost for such tests shall be borne by the Customer.

SECTION-9 ZONE WISE CO-PAYMENT

Zone A: Delhi, New Delhi & NCR including Faridabad, Noida, Ghaziabad, Gurugram, Noida, Gautam Buddha Nagar, Mumbai & Suburbs, MMR (Mumbai Metropolitan Region), Navi Mumbai & Suburbs, Thane City & Suburbs, Mira Road, Bhayandar, Panvel, Kalyan & Dombivali, State of Gujarat, Kolkata & Suburbs.

Zone B: Rest of India

If the Insured Person has paid the premium for Zone A then Insured can avail treatment anywhere in India without any Co-Payment.



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If the Insured Person has paid the premium for Zone B and avails the treatment in Zone B then no Co-Payment shall be applicable but if the Insured Persons avails the treatment in Zone A then Co-Payment of 20% shall be applicable.

Below is the illustration on the Zone-Wise Co-Payment Applicability:

Pricing/ Premium Paying Zone	Claims Zone	Co -pay (Yes/No)
Zone A	Zone A	No Co-pay
Zone B	Zone B	No Co-pay
Zone A	Zone B	No Co-pay
Zone B	Zone A	Co -pay of 20%

The basis of Co-payment would primarily prevent any claims leakage prevalent due to treatment in a zone different than the pricing zone.

Please Note-In addition to above, on each and every claim made under this Policy, Voluntary Co-Payment, if opted under the Policy, shall apply over and above the Zone wise Co-Payment.

SECTION-10 TERMS OF RENEWAL

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

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period
- 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 available during the grace period, in case the premium is paid in instalment.
- No loading shall apply on renewals based on individual claims experience.

SECTION-11 SUM INSURED ENHANCEMENT

The Sum Insured can be enhanced only at the time of Renewal subject to the underwriting norms and acceptability criteria of the Policy. If the Policyholder increases 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 the 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.

The Company shall be entitled to call for any information or documentation before agreeing to renew the Policy. Policyholder's Policy terms may be altered based on the information received.

SECTION-12 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.

SECTION-13 CLAIMS NOTIFICATION AND PAYMENT

i. 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 1a	Within 7 days of the Insured Person's discharge from the Hospital.

II. 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



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III Supporting Documentation & Examination

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

- a) 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.
- b) Copy of the identification document of the Insured Person such as voter ID card, driving license, passport, PAN card or Aadhar card.
- i) 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 include the following:

Benefit No.	Covers	List of Claim Documents
Benefit - 5.1	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	<ol style="list-style-type: none"> 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.

Benefit No.	Covers	List of Claim Documents
		<ol style="list-style-type: none"> 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 -5.2	More Options Benefits: MoreTime, MoreCover, MoreGlobal	<ol style="list-style-type: none"> i. Same Documents as mentioned for Benefit-5.1- Basic Cover ii. Passport and Visa (applicable for MoreGlobal)
Benefit -5.3	Renewal Benefit: Stay Healthy Discount	<ol style="list-style-type: none"> i. Duly completed and signed Claim Form, in original ii. Health Check up results, bills and Receipts
Benefit-5.4-Add Ons Cover		
Benefit -5.4.1	Voluntary Co-Payment	<ol style="list-style-type: none"> i. Same Documents as mentioned for Benefit-5.1- Basic Cover



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Benefit No.	Covers	List of Claim Documents
Benefit -5.4.2	Limitless Cover: Consumables Covers, Unlimited Restore Benefit	i. Same Documents as mentioned for Benefit-5.1-Basic Cover
Benefit -5.4.3	Smart Protector: Super Charger, Air Ambulance	i. Same Documents as mentioned for Benefit-5.1-Basic Cover ii. Air Ambulance receipt and bill accompanied with Medical Practitioner's written recommendation
Benefit - 5.4.4	Mother and Child Care: Maternity Cover, Newborn Baby and Vaccination Cover	i. Same Documents as mentioned for Benefit-5.1-Basic Cover ii. Medical Practitioner's written recommendation in case of medical termination of pregnancy iii. New Born baby Vaccination bills and receipts.
Benefit - 5.4.5	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 - 5.4.6	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- 5.4.7	Double Cover	i. Same Documents as mentioned for Benefit-5.1-Basic Cover
Benefit - 5.4.8	Home Care Treatment	i. Same Documents as mentioned for Benefit-5.1-Basic Cover
Benefit -5.4.9	Change in Pre-Existing Waiting Period	i. Same Documents as mentioned for Benefit-5.1-Basic Cover
Benefit -5.4.10	Reduction in Specific Waiting Period	b. Same Documents as mentioned for Benefit - 5.1-Basic Cover
Benefit -5.4.11	Reduction in Room Rent	i. Same Documents as mentioned for Benefit - 5.1-Basic Cover
Benefit -4.4.12	Discount for Removal of More Options Benefits	i. Not Applicable

Benefit No.	Covers	List of Claim Documents
Benefit -5.4.13	Voluntary Aggregate Deductible	i. Same Documents as mentioned for Benefit-5.1-Basic Cover
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.

iv. Claims Payment

- 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 realized and company has been provided with the documentation and information the Company had requested to establish the circumstances of the claim, its quantum or Company's liability for it, and unless the Insured Person has complied with his obligations under this Policy.
- The Company will only make payment to or at Policyholder's direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to the Company of having incurred the expenses, this person will be deemed to be authorized by Policyholder to receive the concerned payment. In the event of the death of an Insured Person, Company will make payment to the Nominee (as named in the Schedule) in India.
- The assignment of benefits of under the Policy shall be allowed subject to applicable law.
- 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.

v. Claim Settlement (provision of Penal Interest)

- 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.
- 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.
- However, where the circumstances of a claim warrant



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

- d) 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 rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

vi. 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 the payable amount of the corresponding Claim, in the event of (as the case maybe):

- a) 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.
- b) 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-5.1 (i.e. Inpatient Treatment) barring the below mentioned expense break ups:

- 1) Cost of Pharmacy and Consumables
- 2) Cost of Implants and Medical Devices
- 3) 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:

- A. Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced
- B. 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.
- C. ICU charges shall not be proportionately reduced in all cases.

SECTION-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 thirty days 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



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- 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;

SECTION-15. CANCELLATION (OTHER THAN FREE LOOK PERIOD)

- i. The Policyholder may cancel this policy by giving 7 days written notice to the Company and in such an event, the Company shall refund the premium as detailed below:

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

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

Calculation of Pro-Rata refund:

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

For e.g. If Policy Premium for a two-year (730 days) policy is Rs. 20000, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = $20000 * (1 - (243 / 730)) = \text{Rs. } 13342.47$.

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

Where any claim has been admitted or has been lodged by the person under the Policy, there shall be no refund of premium for the Policy Year in which the claim occurs. All other provisions of Section 4.2.10i.a above shall apply.

For e.g. If Policy Premium for a three-year (1095 days) policy is Rs. 20000. Considering the claim year is 2nd Year, then no refund shall be made up to the end of the 2nd Policy Year (730 days)

Cancellation before the expiry of the year of claim: If cancellation is effected on expiry of 600 days from policy inception, then no refund shall be made for the first 730 days. The Return Premium = $20000 * (1 - (730 / 1095)) = \text{Rs. } 6666.67$.

Cancellation after the expiry of the year of claim: If cancellation is effected on expiry of 865 days from policy inception, then no refund shall be made for the first 865 days. The Return Premium = $20000 * (1 - (865 / 1095)) = \text{Rs. } 4200.91$.

- ii. 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 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

SECTION-16. 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 on portability.

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

SECTION-17. 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)

SECTION-18. TAX BENEFIT

The premium amount paid under this policy qualifies for deduction as per the provisions of Section 80D of the Income Tax Act, 1961 and any amendments made thereto, from time to time.

SECTION-19. DISCLOSURE OF INFORMATION

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

SECTION-20. 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 forfeited.

Any amount already paid against claims made under this policy but 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 the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/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 be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- 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 forfeit 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 the insurer.

SECTION-21. MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium



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period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

SECTION-22. 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 (notwithstanding any terms contrary elsewhere in the policy)

- i. Grace Period of 30 days would be given to pay the instalment premium due for the Policy.
- ii. During such grace period, coverage will 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.

SECTION-23. 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.

SECTION-24. 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.

SECTION-25. 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.

SECTION-26. 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

SECTION-27. 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 the Policy Holder at his/her address specified in the Schedule and Policyholder will act for all Insured Persons for these purposes.
- ii. The Company, it will be delivered to the company's address specified in the Schedule.
- iii. No insurance agents, insurance intermediaries or other person or entity is authorised to receive any notice, direction or instruction on Company's behalf.

SECTION-28. 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-29. PROHIBITION ON REBATES

Section 41 of the Insurance Act 1938 stipulates as follows:

- (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole



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or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

- (2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

SECTION-30. CONTACT US

Policyholder can reach the Company through any of the following methods:

Website: www.reliancegeneral.co.in

Email: rgicl.rcarehealth@relianceada.com

Helpline: 022 4890 3009 (paid)/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

If the Policyholder has grievance that He/She wish the Company to redress, Policyholder may contact the Company with details of Policyholder's grievance through.

For resolution of any query or grievance, Insured may contact the respective branch office of the Company or may call at 022 4890

3009 (paid) or may write an email at rgicl.services@relianceada.com. In case the insured is not satisfied with the response of the office, insured may contact the Nodal Grievance Officer of the Company at rgicl.grievances@relianceada.com. In the event of unsatisfactory response from the Nodal Grievance Officer, insured may email to Head Grievance Officer at rgicl.headgrievances@relianceada.com.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI. Tax benefits are subject to changes in tax laws. Please consult your financial/tax advisor for more details.

Disclaimer: This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification

SECTION-31. 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/ 300lakhs/ 400lakhs/ 500lakhs				
Benefit No.	Cover Name	Limits		Basis of Payment	Pre-Requisite for Claim
5.1: Basic Benefits					
5.1.1	Inpatient Care	Covered		Indemnity	Not Applicable
5.1.2	Special Treatment	Sum Insured (in Rs)	Special Treatment limits (in Rs)	Indemnity	5.1.1 Inpatient Care or 5.1.3 Day Care Procedures or 5.1.4 Domiciliary Hospitalisation
		<10 lakhs	50% of S.I		
		>=10lakhs	100% of S.I		
5.1.3	Day Care Procedures	Within Sum Insured		Indemnity	Not Applicable
5.1.4	Domiciliary Hospitalisation	Within Sum Insured		Indemnity	Not Applicable
5.1.5	Organ Donor	Within Sum Insured		Indemnity	5.1.1 Inpatient Care
5.1.6	AYUSH Benefit	Within Sum Insured		Indemnity	5.1.1 Inpatient Care
5.1.7	Pre-Hospitalisation Medical Expenses	Covered upto 90 days, Within Sum Insured		Indemnity	5.1.1 Inpatient Care, 5.1.2 Special Treatment, 5.1.3 Day Care Procedures or 5.1.4 Domiciliary Hospitalisation, 5.1.6 AYUSH Treatment
5.1.8	Post-Hospitalisation Medical Expenses	Covered, upto 180 days, Within Sum Insured		Indemnity	5.1.1 Inpatient Care, 5.1.2 Special Treatment, 5.1.3 Day Care Procedures or 5.1.4 Domiciliary Hospitalisation, 5.1.6 AYUSH Treatment
5.1.9.	Emergency Ambulance	Within Sum Insured		Indemnity	5.1.1 Inpatient Care, 5.1.3 Day Care Procedures
5.1.10	Transportation Benefit	Maximum upto Rs. 500 per Hospitalization (Within Sum Insured)		Indemnity	5.1.1 Inpatient Care, 5.1.3 Day Care Procedures
5.1.11	Restore Benefit	On subsequent claim, one restore up to 100% of Sum Insured for unrelated illness/injury		Indemnity	5.1 Basic Benefits



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5.2 : More Options Benefits*					
5.2.1	MoreTime*	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		Indemnity	Not Applicable
5.2.2	MoreCover (in Rs.)*	Sum Insured (in Rs)	More Cover Sum Insured (in Rs)	Indemnity	5.1 Basic Benefits
		300000	1,00,000		
		500000	2,00,000		
		1000000	3,00,000		
		1500000	5,00,000		
		2500000	7,50,000		
		5000000	15,00,000		
		10000000	30,00,000		
		20000000	60,00,000		
		30000000	90,00,000		
		40000000	1,20,00,000		
		50000000	1,50,00,000		
5.2.3	MoreGlobal (in Rs.)*	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.		Indemnity	Not Applicable
5.3 Renewal Benefit – Stay Healthy Discount					
5.3	Renewal Benefit Stay Healthy Discount	Upto 10% discount on renewal premium		Not Applicable	Not Applicable
5.4 Add Ons Covers					
5.4.1	Voluntary Co-payment*	10%, if opted		Indemnity	Not Applicable
5.4.2 Limitless Cover					
5.4.2.1	Consumables Cover	Within Sum Insured		Indemnity	5.1.1 Inpatient Care, 5.1.3 Day Care Procedures
5.4.2.2	Unlimited Restore Benefit	On subsequent claim. Policies with Sum Insured 5 lakhs: Unlimited restore of S.I on unrelated illness or injury, sub-limit of 100% of Sum Insured for related illness/injury. Policies with Sum Insured >=10lakhs Unlimited restore of S.I on related or unrelated illness or injury This benefit supersedes Basic Benefit 5.1.11 Restore Benefit		Indemnity	5.1. Basic Benefits
3.4.3 Smart Protector					
5.4.3.1	Super Charger	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		Indemnity	5.1 Basic Benefits
5.4.3.2	Air Ambulance	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)		Indemnity	5.1.1 Inpatient Care, 5.1.3 Day Care Procedures


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5.4.4 Mother and Child Care										
5.4.4.1	Maternity Cover	<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> <p>Maternity Waiting Period Option: 12 months or 24 months. Cover is available only to 3 year Policy Period. (Within Sum Insured)</p>	Sum Insured	Maternity Limits (Normal C-Section)	5 lakhs	1 lakh	>=10lakhs	Option 1- 1lakh Option 2- 2 lakhs	Indemnity	5.1.1 Inpatient Care
Sum Insured	Maternity Limits (Normal C-Section)									
5 lakhs	1 lakh									
>=10lakhs	Option 1- 1lakh Option 2- 2 lakhs									
5.4.4.2	Newborn baby and Vaccination Cover	1 lac (Within Sum Insured)	Indemnity	5.4.4.1 Maternity Cover						
5.4.5	OPD Cover*	<p>(Over and above the S.I)</p> <p>Plan A: (Available from S.I 5 lakhs and above)</p> <p>a. OPD Consultations with 10 Super Specialist</p> <p>b. Diagnostic Tests</p> <p>c. Prescription Drugs: 35% of OPD limit</p> <p>OPD Limits: 10000 to 20000 (in multiples of 5000)</p> <p>Plan B: (Available from S.I 10 lakhs and above)</p> <p>a. OPD Consultations with Medical Practitioners</p> <p>b. Diagnostic Tests</p> <p>c. Prescription Drugs: 35% of OPD limit</p> <p>d. Dental OPD</p> <ul style="list-style-type: none">Dental ConsultationDental Treatment/SurgeryPeriodontics <p>e. Surgical Treatments</p> <p>OPD Limits: 25000 to 50000 (in multiples of 5000)</p>	Indemnity	Not Applicable						
5.4.6	Medical Equipment Cover	<p>a. Durable Medical Equipment: Limit: 5% of Sum Insured subject to max. of Rs 2.5 lacs</p> <p>b. Small Medical Equipment: 1% of Sum Insured subject to max. of 20000 (Within Sum Insured)</p>	Indemnity	Not applicable						
5.4.7	Double Cover	This benefit provides additional 100% of Sum Insured for Same claim	Indemnity	5.1 Basic Benefits						
5.4.8	Home Care Treatment	Within Sum Insured	Indemnity	Not Applicable						
5.4.9	Change in Pre-Existing Waiting Period*	This benefit allows to change the Pre-Existing Waiting Period to 24 months, 12 months	Not Applicable	5.1Basic Benefits						
5.4.10	Reduction in Specific Illness Waiting Period	This benefit reduces the Specific Illness Waiting Period to 12 months	Not Applicable	5.1 Basic Benefits						
5.4.11	Reduction in Room Rent*	Room Category Options: Single Private A.C Room OR Twin Sharing Room	Indemnity	5.1 Basic Benefits						
5.4.12	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						
5.4.13	Voluntary Aggregate Deductible*	Options are: 10000, 25000, 50000, 100000	Indemnity	5.1 Basic Benefits						



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* Benefit-5.4.5 OPD Cover has 2 plans, the Policyholder can opt either Plan A or Plan B

Illustration on Utilization of Sum Insured and Unlimited Restore Benefit

The Sum Insured shall be utilized in following sequence:

- Sum Insured
- Double Cover (once on Same claim)
- More Cover Sum Insured (On Same or subsequent Claims)
- Super Charger (On same or subsequent Claims)
- 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													
MoreCover: 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	MoreCover S.I	Super Recharge	Unlimited Restore	Claim amount payable
Claim 1	500000	500000	200000	100000	0	Stroke	500000	500000	0	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	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 24 lakhs. Policyholder has to pay Rs 2 lakhs from his pocket. For future claims, Policyholder has Unlimited Restore S. I of 5 lakhs 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													
MoreCover: 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	MoreCover S.I	Super Recharge	Unlimited Restore	Claim amount payable
Claim 1	1000000	1000000	300000	200000	0	Stroke	500000	500000	0	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	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. 26 lakhs. 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:



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022 4890 3009 (Paid)



74004 22200 (WhatsApp)

IRDAI Registration No. 103. Reliance General Insurance Company Limited.

An ISO 9001:2015 Certified Company

For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License.

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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	500000	450000
Out of pocket expenses for policyholder under each deductible option			50000	50000	50000	100000



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