SECTION-1 PREAMBLE

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

SECTION-2 DEFINITIONS

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

2.1 STANDARD DEFINITIONS

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

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

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

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

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

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

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

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

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

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

   i. Central or State Government **AYUSH Hospital**; or

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

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

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

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

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

10) **Cashless Facility** means a facility extended by the **Company** to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy Terms and Conditions, are directly made to network provider by the Company to the extent pre-authorization is approved.

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

12) **Complaint** or **Grievance** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a **Complainant** with insurer,

13) **Distribution Channels**, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, **Distribution Channels**, intermediaries, insurance intermediaries or other regulated entities.

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

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

15) **Congenital Anomaly** means a condition which is present

since birth and which is abnormal with reference to form, structure or position.

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

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

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

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

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

i. Has qualified nursing staff under its employment.

ii. Has qualified **Medical Practitioner/s** in charge;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Has qualified nursing staff under its employment round the clock;

ii. Has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places;

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

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

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

29) **Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive '**In-patient Care**' hours except for

specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours (**Day Care Treatment**).

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

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

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

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

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

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

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

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

35) **Maternity Expenses** means

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

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

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

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

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

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

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

iii. Must have been prescribed by a **Medical Practitioner**;

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

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

Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017.

The registered practitioner should not be the **Policyholder/ Insured** or their close family member.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54) **Reasonable & Customary** Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved

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

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

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

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

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

2.2 SPECIFIC DEFINITIONS

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

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

2) **Annexure** means document attached and marked as Annexure to this Policy.

3) **Base Sum Insured** means the amount specified as **Base Sum Insured** in the Policy Schedule. Calculation of bonus and sub-limits mentioned under the **Policy** shall be on basis of the **Base Sum Insured.**

4) **Child** means Insured Personís biological or legally adopted son or daughter, whose completed age is between 3 months to 25 years as on **Policy Period Start Date**, and who is financially dependent on the Insured Person and does not have an independent source of income.

5) **Claim** means a demand made by the **Policyholder** or on his behalf, for payment of **Medical Expenses** under any other Benefit, as covered under the **Policy**.

6) **Companion**, For the purposes of this **Policy, Companion** means **Insured Person's** family member/ relative above 18 years of age who is accompanying the **Insured Person** during the **Hospitalization**.

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

8) **Cosmetic Surgery/Treatment** means Surgery/ treatment which is primarily done for the enhancement of appearance through surgical and medical techniques.It concerns with maintaining normal appearance, restoring or enhancing it.

9) **Dependent** means financially dependent on the **Policyholder** and does not have independent source of income.

10) **Family** means as defined in the **Policy Schedule**. For the purposes of this **Policy**, it shall include the **Policyholder** and anyone or more of the family members as mentioned below:

i. legally wedded spouse

ii. Parents and/or Parents- in law

iii. maximum six dependent children(i.e. biological or adopted)

between the age of 3 months to 25 years. If the child is above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

11) **Insured Person/Insured** means a person accepted by the **Company** to be **Insured** under this **Policy** and who meets and continues to meet all the eligibility requirements and whose name specifically appears under **Insured /Insured Person** in the **Policy Schedule** and with respect to whom the premium has been received by the **Company**.

12) **Life Threatening Medical Condition** means a medical condition suffered by the Insured Person which has any of the following characteristics:

i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or

ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

iii. Critical care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or

iv. Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department; and

v. is certified by the attending Medical Practitioner as a Life Threatening Medical Condition.

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

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

15) **Nominee** means the person whose name specifically appears as such in the **Policy Schedule** and is the person to whom the proceeds under this **Policy**, if any, shall become payable in the event of the death of the **Policyholder**. Nominee for all other Insured Person(s) shall be the **Policyholder** himself.

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

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

18) **Policyholder** means the person who is the Proposer and whose name specifically appears in the Policy Schedule as such.

19) **Policy Period** means the period commencing from the **Policy Period Start Date** as specified in **Policy Schedule** and ending on the **Policy Period End Date** as specifically appearing in the **Policy Schedule** or on the date of cancellation of the **Policy**, whichever is earlier.

20) **Policy Period End Date** means the date and time at which the **Policy Period** ends as specified in the **Policy Schedule**.

21) **Policy Period Start Date** means the date and time at which the **Policy Period** commences as specified in the **Policy Schedule**.

22) **Policy Year** means a period of 12 consecutive months starting from the **Policy Period Start Date** and ending on the last day of such 12 month period. For the purpose of subsequent years, **Policy Year** shall mean a period of 12 months commencing from the end of previous **Policy Year** and lapsing on the last day of such 12month period, till the **Policy Period End Date**, as mentioned in the **Policy Schedule**.

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

24) **Second Opinion** means an additional medical opinion obtained from a **Medical Practitioner** solely on the **Policyholder's** or **Insured Person's** express request in relation to listed Critical Illness (specified in Benefit no-3.7.10.3 Second Opinion) which the **Insured Person** has been diagnosed with during the **Policy Year.**

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

26) **Sum Insured** means the maximum, total and cumulative liability of the **Company** to pay the claims made under the **Policy** in respect of that **Insured Person** (on Individual basis) or all **Insured Persons** (on Floater basis) during the **Policy Year** basis, for the following covers and in this order:

i. **Base Sum Insured**

ii. Benefit- 3.2.2-Extra Sum Insured or Benefit-3.7.2-Double Cover(whichever is applicable)

iii. Benefit-3.5.1-Cumulative bonus

iv. Benefit-3.6.3-Policy Service Guaranteed Sum Insured(if applicable)

v. Benefit-3.2.1 Reinstated Sum Insured or Benefit-3.7.1.2 Unlimited Reinstatement of Base Sum(which ever is applicable)

27) **Survival Period** means the period that the **Insured Person** has to survive before a claim becomes valid, commencing from the date of First Diagnosis.

28) **Telemedicine** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted

in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

29) **Total Liability** means the sum total of **Sum Insured** and below listed covers

i. Benefit-3.1.1.3-Accomodation Bonus

ii. Benefit-3.3.1 -Accidental Death Cover

iii. Benefit-3.4.1-Waiver of Premium

iv. Benefit-3.5.3-Loyalty Cover

v. Benefit-3.7.7-Hospital Cash (if opted)

vi. Benefit-3.7.8.4-Convalescence Cover (if opted)

vii. Benefit-3.7.9.1-Health Check Up (if opted)

viii. Benefit-3.7.9.2-Vaccination Cover (if opted)

ix. Benefit-3.7.11.2-Companion Cover (if opted)

x. Benefit-3.7.11.3-Child Care Cover (if opted)

SECTION-3 SCOPE OF COVER

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

3.1 HOSPITALIZATION COVERS

3.1.1 HOSPITALIZATION EXPENSES

If any of the **Insured Person** is diagnosed with any **Illness** or suffers any **Injury** that requires **Hospitalization**, (including **Hospitalization** under **AYUSH Treatment**), during the **Policy Period**, then the **Company** shall pay **Medical Expenses** incurred by the **Policyholder/ Insured Person**, subject to the limits, terms, conditions and exclusions mentioned under this **Policy**.

The **Medical Expenses** as mentioned above shall mean the Reasonable and Customary Charges which include the following:

i. **Room Rent**

ii. Nursing expense

iii. Intensive care Unit (ICU) charges,

iv. Medical Practitioner(s) fees,

v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses,

vi. Medicines, drugs and Consumables expenses

vii. Diagnostic procedures expenses

viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure, unless specifically excluded.

3.1.1.1 IN-PATIENT TREATMENT

The **Company** shall indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred during the **Policy Year**, if the **Insured Person** undergoes **Hospitalization** for In-**Patient Treatment**, on the written advice of a **Medical Practitioner**.

3.1.1.2 DAY CARE TREATMENT

The **Company** shall indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred during the **Policy Year**, if the **Insured Person** undergoes a **Day Care Treatment** as defined under this **Policy**, on the written advice of a **Medical Practitioner**.

3.1.1.3 ACCOMMODATION BONUS

The **Company** shall pay a fixed daily amount of Rs 1000 to the **Policyholder/Insured Person**, if during the **Policy Year**, the **Insured Person** undergoes **Hospitalization** for **In-Patient Treatment** and occupies the following Room Categories:

i. For Plus and Power: Twin sharing Room or below

ii. For Prime: Single Private Air-Conditioned Room or below

Provided that:

a. The above mentioned fixed daily amount shall be payable for each continuous and completed 24 hours of such **Hospitalization**

b. The daily amount mentioned above shall not be payable for the number of completed days the **Insured Person** is admitted into an ICU Room.

c. If the **Policyholder** has opted Benefit-3.7.3 Change in Room Rent Limits, then daily amount mentioned above shall be payable only on occupying a category of Room lower than that selected under optional Benefit-3.7.3 Change in Room Rent Limits

d. The daily amount mentioned above shall not be payable for the Room Category opted by the Insured Person Benefit - 3.7.3 Change in Room Rent Limits

e. The **Company** has accepted the claim under Benefit - 3.1.1.1. **In Patient Treatment**

3.1.2 DOMESTIC ROAD AMBULANCE

The **Company** shall indemnify the **Policyholder/Insured Person** up to the amount specified in the **Policy Schedule**, per **Hospitalization**, for expenses incurred on availing **Road Ambulance** services offered by a **Hospital** or by an **Ambulance** service provider, provided that

i. Company has accepted the Inpatient Hospitalization claim under Benefit 3.1.1.1 In Patient Treatment.

ii. The coverage includes the cost of the transportation of the **Insured Person** to the nearest **Hospital** in case of an emergency **Life Threatening Medical condition**, or from one **Hospital** to another **Hospital** which is prepared to admit the **Insured Person** and provide the necessary medical services

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. Subject to all other conditions mentioned above, in case where such transportation is required 'intercity' (beyond 100km in distance), the coverage limit under this benefit shall be extended upto the amount specified in the **Policy Schedule** for 'Intercity Ambulance cost' (beyond 100km in distance).

3.1.3 DOMICILIARY HOSPITALIZATION

The **Company** shall indemnify the **Policyholder/Insured Person**

up to an amount specified in the **Policy Schedule**, for the **Medical Expenses** incurred for **Domiciliary Hospitalization** during the **Policy Year**, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days, in which case the **Company** shall pay the **Reasonable and Customary Charges** for necessary medical treatment for the entire period.

The **Company** shall not be liable for payment of any **Claim** under this Benefit in relation to treatment of any of the following diseases:

i. Asthma
ii. Bronchitis
iii. Chronic Nephritis and Chronic Nephritic Syndrome
iv. Diarrhea and all types of Dysenteries including Gastro-enteritis
v. Diabetes Mellitus and Insipidus
vi. Epilepsy
vii. Hypertension
viii. Influenza, Cough and Cold
ix. All Psychiatric or Psychosomatic Disorders
x. Pyrexia of unknown origin for less than 10 days
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis

Arthritis, Gout and Rheumatism

3.1.4 MODERN TREATMENT

The **Company** shall indemnify the **Insured Person** up to the limit as specified in the **Policy Schedule** for the **Medical Expenses** incurred during the **Policy Year** on **Inpatient Treatment** or **Day Care Treatment** or **Domiciliary Treatment** of below mentioned Modern Treatment Methods:

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 prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neutro Monitoring)
xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Benefits 3.1.1, 3.1.3, 3.1.5, 3.1.6 and3.1.7

3.1.5 PRE-HOSPITALIZATION

The **Company** shall indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred in the 60 days immediately before the **Insured Person** was Hospitalized, provided that:

i. Such **Medical Expenses** are incurred in respect of the same condition for which the **Insured Person** has taken **Hospitalization**, and
ii. The **Company** has accepted the claim for these **Hospitalization** expenses under any one of the following Benefits: 3.1.1,3.1.3,3.1.4

3.1.6 POST-HOSPITALIZATION

The **Company** shall indemnify the **Policyholder/Insured Person** for the **Medical Expenses** incurred in the 60 or 90 days (as specified in the **Policy Schedule**) immediately after the **Insured Person** was discharged post **Hospitalization**, provided that:

i. Such costs are incurred in respect of the same condition for which the **Insured Person** has taken **Hospitalization**, and
ii. The **Company** has accepted the claim for these **Hospitalization** expenses under any one of the following Benefits: 3.1.1,3.1.3,3.1.4

3.1.7 ORGAN DONOR EXPENSES

The **Company** shall indemnify the **Policyholder/Insured Person** up to an amount specified in the **Policy Schedule** for the **Medical Expenses** incurred, during **In Patient Treatment**, in respect of donor of any organ transplant surgery conducted on the **Insured Person** during the **Policy Year**, provided that:

i. The organ donated is for the **Insured Person's** use.
ii. The **Company** has accepted **In-Patient Hospitalization Claim** under Benefit **3.1.1.1 In Patient Treatment**.
iii. The **Company** shall not pay the donor's **Pre** and **Post Hospitalization** Expenses

An organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended).

3.2 EXTRA COVER

3.2.1 REINSTATEMENT OF BASE SUM INSURED

The **Company** shall carry out one reinstatement, upto the **Base Sum Insured**, after the **Base Sum Insured**, Double Cover or Extra Sum Insured (whichever is applicable), **Cumulative Bonus** and Policy Service Guarantee Sum Insured (if any) have been utilized completely for claims incurred under the **Policy**, for the particular **Policy Year**, provided that:

i. For a claim to be admissible under Re-instated Sum Insured it should be admissible under the Benefits- 3.1 Hospitalization Covers
ii. The limits of claims in aggregate under Re-instated Sum Insured during a **Policy Year** shall be as per follows:
    a. Up to 100% of **Base Sum Insured**
    - For subsequent claims for unrelated illness or injury.
    b. Upto 20% of **Base Sum Insured**
    - for subsequent claim which has arisen out of or is a consequence of or its related to or is a complication of an illness/injury for which a claim has already been admitted under the current or any previous Policy in relation to an **Insured Person**.

iii. The Re-instated **Sum Insured** for a particular **Policy Year** can be utilized only after the Base Sum Insured, Double Cover or Extra Sum Insured (whichever is applicable), Cumulative Bonus and Policy Service Guarantee Sum Insured (if applicable)have been completely exhausted in that **Policy Year**.

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

v. The **Company's** overall liability for all claims, in aggregate, within a **Policy Year** under this cover shall not exceed the **Base Sum Insured**

vi. While calculating **Cumulative Bonus**, Re-instated **Sum Insured** shall not be considered.

vii. The Reinstatement of **Sum Insured** shall be done on Individual basis for Individual Policies and on Floater basis for Floater policies

viii. The unutilized Re-instated **Sum Insured** cannot be carried forward to any subsequent **Policy Year**.

3.2.2 EXTRA SUM INSURED

The **Company** shall provide an additional 20% of **Base Sum Insured** as Extra **Sum Insured** on the same claim, which can be utilized after the **Base Sum Insured** has been utilized completely for claims incurred under the **Policy**, for the particular **Policy Year**, provided that:

i. For a claim to be admissible under this benefit it should be admissible under the Benefit- 3.1 Hospitalization Covers

ii. The Extra **Sum Insured** shall be available only for the same claim, which is payable under the Base Sum Insured during a single hospitalization.

iii. The Extra Sum Insured for a particular **Policy Year** can be utilized only after the **Base Sum Insured** has been completely exhausted in that **Policy Year**.

iv. The **Company's** overall liability for all claims, in aggregate, within a **Policy Year** under this benefit shall be limited to 20% of the **Base Sum Insured**

v. The benefit can be utilized once in **Policy Year**.

vi. While calculating **Cumulative Bonus**, Extra Sum Insured shall not be considered.

vii. The Extra **Sum Insured** shall be available on Individual basis for Individual Policies and on Floater basis for Floater policies

viii. Any unutilized Extra **Sum Insured** shall not be carried forward to any subsequent **Policy Year**.

3.3 PERSONAL ACCIDENT COVER

3.3.1 ACCIDENTAL DEATH COVER

If the **Insured Person**, sustains an injury, from an **Accident** during the **Policy Year** and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the **Insured Person**, then the **Company** shall be liable to pay 5% of the **Base Sum Insured** subject to a minimum of Rs 1 lakh to Nominee /Legal Heir/ Assignee as stated in the **Policy Schedule**.

The payment under this benefit shall not reduce the **Base Sum Insured.**

Exclusions applicable to Benefit-3.3.1 Accidental Death Cover

The **Company** shall not be liable for payment of any claim under this benefit directly or indirectly arising out of or relating to:

i. Any pre-existing injury or physical condition

ii. Whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.

iii. An Insured Person flying in an aircraft other than as a fare paying passenger in any Scheduled Airlines in the world.

iv. Any intentional self-inflicted Injury unless in self-defense or to save life, suicide or attempted suicide, sexually transmitted conditions, mental and nervous, insanity, disorder, anxiety, stress or depression.

v. Whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury/accident through under influence of intoxication.

vi. Insured Person engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports, unless declared beforehand and agreed by the Company subject to additional premium being paid and incorporated accordingly in the Policy.

vii. Insured Person serving in any branch of the Military, Navy or Air-force or any branch of Armed Forces or any paramilitary forces except during peace time

viii. Insured person working in/with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs work or ship crew services or as jockeys or circus personnel or aerial photography or engaged in Hazardous Activities

ix. Results from pregnancy or child-birth

x. Impairment of an Insuredís intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance.

3.4 CRITICAL ILLNESS COVER

3.4.1 WAIVER OF PREMIUM

If the **Policyholder** (who is also an **Insured Person**) as covered under the **Policy** is diagnosed for the first time, with any of the listed **Critical Illness** which is admissible and payable under this cover, during the **Policy Year**, then the renewal **Policy** premium for a period of one year shall be waived off. For a long-term Policy, the **Company** shall waive one year proportionate renewal Policy premium. This is subject to following:

i. This benefit is provided once in the lifetime to the **Policyholder**.

ii. The **Critical Illness** has been diagnosed for the first time during the **Policy Year**.

iii. Such **Renewal** shall be done on the same basis as the expiring **Policy**.

iv. The **Cumulative Bonus** will not be accrued in the year claim has been made under the **Policy**.

For the purpose of this Benefit, Critical illness is as defined below: -

"Critical Illness" means disease / illness / surgery limited to the following.

i. **Cancer of specified severity**

A malignant tumour characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded —

a. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

c. Malignant melanoma that has not caused invasion beyond the epidermis;

d. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

f. Chronic lymphocytic leukaemia less than RAI stage 3

g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

i. All tumors in the presence of HIV infection.

ii. Open chest Coronary Artery Bypass Graft (CABG)

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

iii. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical finding in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting at least 3 months has to be produced.

The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions

iv. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE and HIV are excluded.

3.5 RENEWAL BENEFITS

3.5.1 CUMULATIVE BONUS

The **Company** shall provide 33.33 % (one third) of the **Base Sum Insured as Cumulative Bonus** at the end of each completed and continuous **Policy Year**, provided that no **Claim** has been made in the expiring **Policy Year**. This benefit is subject to the following:

i. In any **Policy Year**, the accrued **Cumulative Bonus**, including the one credited under **Portability** if any, shall not exceed 100% of the of **Base Sum Insured** available in this renewed **Policy**.

ii. The **Cumulative Bonus** shall not enhance the available Room Category limit and other such limits which are a function of **Sum Insured** which shall always be applicable on the **Base Sum Insured.**

iii. In relation to a Floater, the **Cumulative Bonus**, shall be available on Floater basis. The **Cumulative Bonus** which accrued during a claim-free **Policy Year** will only be available to those **Insured Person(s)** who were insured in such claim-free **Policy Year** and continue to be insured in the subsequent **Policy Year**.

iv. If the **Insured Persons** in the expiring **Policy** are covered on an Individual basis and the expiring **Policy** has been Renewed on a Floater basis, then the **Cumulative Bonus** to be carried forward for such Renewed **Policy** shall be the one that is the lowest among all the **Insured Persons**.

v. In case of Floater Policy where **Insured Persons** renew their expiring **Policy** by splitting the **Policy** in to two or more Floater Policies/Individual Policies, the **Cumulative Bonus** shall be split equally amongst **Insured Persons**; except where the **Policy** is split due to the child attaining the age of 25 years, in which case both the renewed Policies shall carry the full accrued **Cumulative Bonus**.

vi. If the **Policyholder** opts to reduce the **Base Sum Insured** at the time of **Renewal**, the applicable **Cumulative Bonus** shall be reduced in the same proportion to the **Base Sum Insured** in renewed **Policy**.

vii. If a claim is made in the expiring **Policy Year** and is notified to the **Company** after the acceptance of **Renewal** premium, any incremental **Cumulative Bonus** awarded basis the expiring **Policy Year** shall be withdrawn.

viii. Entire **Cumulative Bonus** will be lost if **Policy** is not continued / renewed on or before expiry of **Grace Period**.

ix. **Cumulative Bonus** shall be applicable on an annual basis subject to continuation of the **Policy**.

x. In case of a claim in any given **Policy Year** the **Cumulative Bonus** shall be decreased by 33.33% (one third) of the **Base Sum Insured** in the subsequent year. However, the reduction in **Cumulative Bonus** shall not reduce the **Base Sum Insured**.

xi. **Cumulative Bonus** shall decrease to the extent (in-part or

whole) of **Cumulative Bonus** amount utilized for settlement of claim.

xii. The accrued **Cumulative Bonus** will be carried forward to the renewed **Policy**. This shall apply even if the **Policyholder** avails the Benefit -3.5.2 (Call Option for Enhancement of **Base Sum Insured**)

xiii. For a claim to be admissible under **Cumulative Bonus** it should be admissible under the Benefit3.1 Hospitalization Covers.

3.5.2 CALL OPTION FOR ENHANCEMENT OF BASE SUM INSURED

At the end of four consecutive and continuous **Policy Years**, if no claim has been made under Benefit -3.1-Hospitalization Covers and Benefit - 3.4 Critical Illness Cover in respect of any of the **Insured Persons** in the **Policy**, the **Company** shall provide the **Policyholder**, the Call option for enhancement of **Base Sum Insured** by an amount equal to the accumulated **Cumulative Bonus**. If the **Policyholder** chooses to exercise this option, and make appropriate payment for such option, the **Base Sum Insured** of the renewed **Policy** shall be the sum total of:

- Expiring Policy's **Base Sum Insured**
- Accumulated **Cumulative Bonus**

This is subject to the following:

i. The enhanced **Base Sum Insured** on exercising the call option shall not exceed four times the **Base Sum Insured** limit under the first **Policy Year** with the **Company**.

ii. The enhanced **Base Sum Insured** on exercising the Call Option shall not exceed Rupees one crore, irrespective of expiring Policy's **Base Sum Insured**.

iii. The call option shall cease to be available:

a. In relation to an individual cover, once the **Insured Person** attains the **Age** of 60 years.

b. In relation to a floater cover, once the eldest **Insured Person** attains the **Age** of 60 years.

iv. In relation to a Floater, the enhanced **Base Sum Insured** after exercising the Call option shall be available on Floater basis.

v. Under a Floater Policy the Call option shall be available only if all the **Insured Person(s)** who are to be insured under the enhanced **Base Sum Insured** were also continuously covered in the immediate preceding 4 **Policy Years**, and had no claim under any of the benefits listed in Benefit-3.1-Hospitalization Covers and Benefit -3.4 Critical Illness Cover during this period and continue to be insured under the subsequent **Policy Year**. However, if a new member is to be added at the time of renewal, the **Company** may cover that particular member under the renewed **Policy** subject to receipt of appropriate premium, underwriting and applicability of **Waiting Periods** as defined under clause 4.1.1, 4.1.2 & 4.1.3 and 4.2.1 of the Policy.

vi. Under an Individual Policy the Call option shall be available only if the **Insured Person(s)** who is to be insured under the enhanced **Base Sum Insured** was also continuously covered in the immediate preceding 4 **Policy Years** and had no claim under any of the benefits listed in Benefit-3.1-Hospitalization Covers and Benefit -3.4 Critical Illness Cover during this period and continues to be insured in the subsequent **Policy Year**.

vii. Call Option shall not be available if **Policy** is not renewed on or before expiry of **Grace Period**.

viii. In case the **Insured Person(s)** in the expiring 4 consecutive and continuous **Policy Years** are covered on individual basis and desire to renew such expiring policy with the **Company** on a Floater basis and are eligible for Call option then the amount available for call option shall be basis the lowest of the **Base Sum Insured** amongst all the **Insured Person(s)**.

ix. In case where the **Insured Person(s)** in the expiring 4 consecutive and continuous **Policy Years** are covered on a floater basis and desire to renew such expiring Policy with the **Company** on an Individual/floater basis and are eligible for Call option then the **Base Sum Insured** available as call option shall be split into 2 or more Floater / individual covers in the proportion of the number of lives insured under such renewed policies,except where the **Policy** is split due to the child attaining the age of 25 years in which casethe **Base Sum Insured** available as call option shall be carried forward in full to both policies.

x. If the **Policyholder** chooses to forgo this option then the same would be available at time of next renewal, provided that the **Policy** was in force for four consecutive and continuous years immediately preceding such renewal and no claim has been made under Benefit - 3.1 Hospitalization Covers and Benefit -3.4 Critical Illness Cover during this period.

xi. In case of multiple **Insured Persons** covered under individual **Base Sum Insured** under the same **Policy** then all those who become eligible for Call option would have to opt for or forgo the Call option without selection.

xii. On exercising of the Call option, **Insured Person** will be offered continuity of coverage to the extent of the full amount of the enhanced **Sum Insured**, in terms of **Waiting Period** with respect to **Pre-Existing Diseases** and time bound exclusions as specified in Section-4 of this **Policy**.

xiii. This benefit will not affect the accumulated **Cumulative Bonus**.

xiv. If Call Option is exercised, then the **Cumulative Bonus** shall be carried forward including any **Cumulative Bonus** earned for the expiring **Policy Year**.

3.5.3 LOYALTY COVER

At the end of each completed and continuous **Policy Year**, the **Company** shall provide Loyalty Cover to the **Policyholder** (who is also an **Insured Person**) as per below:

Year-wise availability of Sum Insured for Loyalty Cover ('Earned' Loyalty Cover Sum Insured)

Policy Year	Accidental Death and Permanent Total Disability	Critical Illness	Hospital Cash	Leave Compensation Benefit
Year 2	10% of Base Sum Insured			
Year 3	20% of Base Sum Insured	10% of Base Sum Insured		

Year 4	30% of Base Sum Insured	20% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	
Year 5	40% of Base Sum Insured	30% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Rs. 1000 per day
Year 6	50% of Base Sum Insured	40% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Rs. 1000 per day
Year 7 onward	50% of Base Sum Insured	50% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime Plus: Rs. 3000	Rs. 1000 per day
Maximum limit	50% of Base Sum Insured or 25 lakhs, whichever is lower	50% of Base Sum Insured or 25 lakhs, whichever is lower	30 days of payment	30 days of payment

The detailed coverage under each of these benefits shall be as below:

3.5.3.1 ACCIDENTAL DEATH

If the **Policyholder** (who is also an **Insured Person**) as covered under the **Policy**, sustains an injury, from an **Accident** during the **Policy Year** and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the **Policyholder**, the **Company** shall be liable to pay the earned Loyalty Cover Sum Insured (as specified in the **Policy Schedule**) to the Nominee /Legal Heir/Assignee as stated in the **Policy Schedule**.

3.5.3.2 PERMANENT TOTAL DISABILITY

If the **Policyholder** shall sustain any injury, resulting solely and directly, from an **Accident** during the **Policy Year** and if such injury shall, within twelve calendar months of its occurrence, be the sole and direct cause of

i. The total and irrecoverable loss of:

- sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand and one entire foot, or of such loss of sight of one eye and such loss of one entire hand or one entire foot, or
- Use of two hands or two feet, or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot,

OR

ii. Immediate, permanent, total and absolute disablement of the **Policyholder** from engaging in, being occupied with or giving attention to any employment or occupation of any description whatsoever

then the **Company** shall be liable to pay the earned Loyalty Cover Sum Insured to the **Policyholder**/Nominee /Legal Heir/Assignee as stated in the **Policy Schedule**.

Conditions applicable to Accidental Death and Permanent Total Disability

i. The benefit of claim under Accidental Death and Permanent Total Disability shall be payable only once during the lifetime of the Policy.

ii. If the **Policyholder/ Nominee** / Legal Heir / Assignee makes a claim under either Accidental Death or Permanent Total Disability and the same is admitted by the **Company**, then no further claim shall be payable under either of these benefits (Accidental Death and Permanent Total Disability) to the Policyholder or any of the other Insured Persons and these benefits shall become inoperative.

iii. The Exclusions applicable to Benefit-3.3.1 Accidental Death Cover shall also be applicable on Benefit-3.5.3.1 Accidental Death and Benefit-3.5.3.2 Permanent Total Disability benefits.

3.5.3.3 CRITICAL ILLNESS

If the **Policyholder** (who is also an Insured Person) as covered under the **Policy** is diagnosed for the first time, with any of the listed Critical Illness which is admissible and payable under this cover, during the **Policy Year**, then the **Company** shall be liable to pay the earned Loyalty Cover Sum Insured (as specified in the **Policy Schedule**) to the **Policyholder**. This is subject to following:

- The Critical Illness has been diagnosed for the first time
- Such diagnosis is made during the **Policy Year**
- The Insured Person survives the 30 days **Survival Period**
- This benefit is claimable once in the lifetime of the **Policyholder**

For the purpose of this Benefit, Critical illness is as defined below: -

"Critical Illness" means disease / illness / surgery limited to the following and as defined under **Section 3.4 Critical Illness Cover**:

i. Cancer of specified severity

ii. Open chest Coronary Artery Bypass Graft (CABG)

iii. Stroke resulting in permanent symptoms

iv. Multiple Sclerosis with persisting symptoms

3.5.3.4 HOSPITAL CASH

A. IN-PATIENT CASH

If the **Company** has accepted a claim under Benefit-3.1.1.1 I**n-Patient Treatment**, then the **Company** shall pay the **Policyholder** an amount equal to the Daily Cash amount specified in the **Policy Schedule** per day of **Hospitalization**, provided,

i. The Daily Cash amount shall be payable for each 24 hours of continuous and completed Hospitalization as **In-Patient**.

ii. In a given **Policy Year**, the amount under this benefit shall be payable for a maximum of 30 days in a Policy Year

iii. Time Deductible: If the Hospitalization is for less than a continuous and consecutive period of 72 hours, no amount

shall be payable under this benefit. If the Hospitalization extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of Hospitalization.

iv. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the **Policy**.

B. ICU CASH

If the **Company** has accepted a claim under Benefit-3.1.1.1 In-Patient Treatment where the **Policyholder** is admitted in an **Intensive Care Unit (ICU)** of a Hospital on the written advice of a **Medical Practitioner**, then the **Company** shall pay the **Policyholder** additional 100% of Daily Cash amount as specified in the **Policy Schedule** per day of ICU **Hospitalization** provided,

i. The additional Daily Cash amount shall be payable for each 24 hours of continuous and completed **ICU In-Patient Hospitalization**

ii. In a given Policy Year, the amount under this benefit shall be payable for a maximum of 15 days in a Policy Year

iii. Time Deductible: If the Hospitalization is for less than a continuous and consecutive period of 72 hours, no amount shall be payable under this benefit. If the Hospitalization extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of Hospitalization

iv. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the **Policy**.

3.5.3.5 LEAVE COMPENSATION BENEFIT

If during the **Policy Year**, the **Policyholder** (who is also an **Insured Person**) as covered under the **Policy** suffers an Illness or Injury for which **Policyholder** undergoes **Hospitalization** for a minimum period of 7 continuous and consecutive days, then the **Company** shall compensate the **Policyholder** (whether salaried or self-employed),for availing leaves (for the period of Hospitalization) from his/her place of work provided:

i. The **Company** has accepted the claim under Benefit-3.1.1.1 In-Patient Treatment

ii. The amount payable under this benefit shall be Rs. 1000, payable for each 24 hours of continuous and completed **Hospitalization** as **In-Patient**, starting from the first day of **Hospitalization**. An additional two days of payment shall be made to such Insured **Person** post **Hospitalization** for recuperation.

iii. The amount under this benefit shall be payable maximum up to 30 days in a Policy Year.

iv. The benefit shall be available to **Policyholder** until attainment of 66 years of age.

Exclusions related to Leave Compensation Benefit

- It is imperative that the **Policyholder** stays employed as on the Date of Discharge. If the **Policyholder** is not employed on the Date of Discharge, then no compensation is payable under this benefit.
- No consequential loss due to the leave availed during **Hospitalization** apart from as provided above is payable under this cover.
- Loss of Employment is not covered under this benefit

Conditions Applicable to Benefit 3.5.3-Loyalty Cover

a. The Loyalty Sum Insured shall be credited at the end of each **Policy Year** as per the table provided, irrespective of claim under the Policy.

b. The payment under this benefit shall not reduce the **Base Sum Insured.**

c. In case the Policy is split due to the child attaining the age of 25 years in that case the earned Loyalty cover Sum Insured shall remain only with the Parent Policy.

d. In case of merging of two or more Policies into one **Policy**, where the **Policyholders** (who are also an **Insured Person**) were different, the Loyalty Cover shall be the higher count of Loyalty benefits of the two policies and granted only to the **Policyholder** of the renewal **Policy**.

3.6 VALUE ADDED COVERS

3.6.1 WELLNESS SERVICES

The **Company** shall provide the following Services under this benefit either on its own or through a **Service Provider**:

a. Doctor Anytime /Free Health Helpline: The **Insured Person** shall have the option of seeking medical advice from a **Medical Practitioner** through the telephonic or online mode.

b. Health Portal: The **Insured Person** shall have the option to access health related information and services through the **Company's**/designated website.

Specific Conditions applicable to this Benefit:

i. In case the Services are availed over phone or through online mode, the **Insured Person** will be required to provide the details as sought by the **Company/ Service Provider** in order to establish authenticity and validity prior to availing such services.

ii. It is entirely for the **Policyholder/Insured Person** to decide whether to obtain these Services and also to decide the use (if any) to which these Services is to be put for.

iii. The Service is intended for additional information purpose only and does not substitute the **Insured Person's** visit/ consultation to an independent **Medical Practitioner**.

The **Company** will have no liability on the availability and quality of the Services.

3.6.2 CLAIM SERVICE GUARANTEE

I. CASHLESS INTIMATION

If the **Insured Person** notifies a request for Cashless facility for Benefit 3.1.1 Hospitalization Expenses as per Section-6.1, along with complete set of documents & information then the **Company** will respond within 6 business hours of receipt of such information with either

- Approval; or
- Rejection; or
- Query seeking further information.

In the event that the **Company** fails to respond within 6 business hours then the **Company** shall be liable to pay the **Insured Person** for the delay in the following manner:

a. For delay beyond 6 business hours and upto 12 hours– 1% of Delayed Claim Amount. For delay beyond 12 hours additional 1% for every additional delay of 6 business hours. The total

liability under this clause shall be subject to a maximum of 6% of Delayed Claim Amount.

II. REIMBURSEMENT INTIMATION

The **Company** shall process the **Claim** for Benefit 3.1.1 Hospitalization Expenses within 21 days of the actual receipt of complete information and all documents as specified in Section 6.1 ("Claims Intimation, Assessment and Management")

In the event that the **Company** fails to send a response within 21 days then the **Company** shall be liable to pay the **Insured Person** for the delay in the following manner:

a. For delay beyond 21 days and upto 42 days – 1% of Delayed Claim amount. For delay beyond 42 days, 1% for every additional delay of 21 days. The total liability under this clause shall be subject to a maximum of 6% of Delayed Claim Amount.

SPECIFIC CONDITIONS APPLICABLE TO THIS BENEFIT

- Delayed Claim Amount for the purposes of this benefit shall mean the minimum of authorization request amount, authorization amount issued, final claim amount or balance Sum Insured.
- The **Company** shall not be liable to pay under above mentioned point i) and ii) in case of any force majeure, natural event or manmade disturbances which impedes the Company's ability to make a decision or to communicate such decision to the **Policyholder/Insured Person**.
- Any amount paid under i) and ii) will not affect the **Base Sum Insured** as specified in the **Policy Schedule**. The **Company's** maximum liability to make payment under this benefit shall not exceed the amount specified in above point i) and ii)
- The payment under this benefit is over and above that payable under Standard General Terms and Clauses, Clause-5.1.3 Claim Settlement (provision for Penal Interest)

3.6.3 POLICY SERVICE GUARANTEE

In the event of delay in the process of issuing a **Policy** beyond 10 Working days from the date of receipt of all completed documents (including Medical reports, as applicable) and premium, the **Company** shall provide a one-time additional amount of **Sum Insured**, as mentioned in **Policy Schedule** which shall be applicable only for the first **Policy Year** and shall not be applicable or carried forward for subsequent **Policy Years**, renewals/auto-renewals. This **Sum Insured** shall not be taken into consideration for calculating the Cumulative Bonus, Double Cover or Extra Sum Insured(whichever is applicable)&/or the Re-instatement Sum Insured.

3.7 OPTIONAL COVERS

The covers listed below are optional covers and are available to the **Insured Persons**, on payment of additional premium, subject to below mentioned terms, conditions, and exclusions.

3.7.1 ENHANCED COVERS

3.7.1.1 GUARANTEED CUMULATIVE BONUS

This cover is an extension to Benefit no-3.5.1 **Cumulative Bonus**. The **Company** shall provide 33.33 % (one third) of the **Base Sum Insured** at the end of each completed and continuous **Policy Year**, provided that no **Claim** has been made in the expiring **Policy Year**.

All the conditions and provisions stated under Benefit no-3.5.1 **Cumulative Bonus** shall also be applicable on this benefit, except for clause ix which shall stand modified as below:

i. In case of a claim in any given **Policy Year** the accrued **Cumulative Bonus** amount shall not be reduced in the subsequent year, except to the extent of the **Cumulative Bonus** amount utilized for settlement of claim.

3.7.1.2 UNLIMITED REINSTATEMENT OF BASE SUM INSURED

The Company shall reinstate the **Base Sum Insured** unlimited times, during the **Policy Year**, after occurrence and payment of claim amount under the **Policy**, subject to below mentioned terms and conditions.

i. the **Base Sum Insured** shall be reinstated to full extent immediately after settlement of a claim under Benefit-3.1 Hospitalization Covers and such reinstated part shall become part of **Reinstated Sum Insured**

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

a. Unlimited utilization for subsequent claims for unrelated illness or injury.

b. Up to 100% of **Base Sum Insured**, for subsequent claim which has arisen out or is a consequence of or its related to or is a complication of an illness/injury for which a claim has already been admitted under the current or any previous Policy in relation to an **Insured Person**

iii. The Re-instated **Sum Insured** for a particular **Policy Year** can be utilized only after the **Base Sum Insured**, Double Cover or Extra Sum Insured (whichever is applicable), **Cumulative Bonus** and Policy Service Guarantee Sum Insured (if applicable) have been completely exhausted.

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

v. This benefit shall be available at each **Policy Year**.

vi. The Reinstated Sum Insured at given time shall not exceed the **Base Sum Insured**

vii. Reinstatement of **Base Sum Insured** will be available on individual basis for individual policies and on floater basis for family floater policies.

viii. While calculating **Cumulative Bonus**, Unlimited Re-instatement of **Base Sum Insured** shall not be considered.

ix. The unutilized Re-instated **Sum Insured** cannot be carried forward to any subsequent **Policy Year**.

x. This benefit supersedes the existing Benefit no-3.2.1 Reinstatement of Base Sum Insured.

3.7.1.3 CONSUMABLES COVER

The **Company** shall pay the **Reasonable and Customary** expenses incurred by the **Policyholder /Insured Person**, during the **Policy Year**, 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 **or Daycare Treatment**, and

ii. The **Company** has accepted Claim for Hospitalization expenses under the **Policy**.

iii. The amount payable towards this benefit, in conjunction with the other items under Hospitalization Expenses shall be within

the Sum Insured limit.

3.7.2 DOUBLE COVER

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

i. The benefit shall be available only if the **Company** has accepted the claim under Benefit-3.1 Hospitalization Covers.

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

iii. The Double Cover can be utilized only on the same claim, which is payable under **Base Sum Insured**, during a single hospitalization.

iv. The benefit can be utilized once in **Policy Year**.

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

vi. While calculating **Cumulative Bonus**, Double Cover shall not be considered.

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

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

ix. This benefit supersedes the existing Benefit no-3.2.2 Extra Sum Insured.

3.7.3 CHANGE IN ROOM RENT LIMITS

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

3.7.4 REDUCTION IN PRE-EXISTING WAITING PERIOD

Under this option, the **Company** shall reduce the 36 months **Waiting Period** for **Pre-Existing Diseases** as mentioned in Clause 4.1.1, to 24 or 12 months (as opted). Such reduction, if allowed, shall be expressly mentioned in the **Policy Schedule**.

3.7.5 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** has to exceed the annual **Aggregate Deductible** as mentioned in the **Policy Schedule**.

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

iii. The annual **Aggregate Deductible** shall not be applicable on Benefit-3.1.1.3-Accomodation Bonus, Benefit-3.3.1 Accidental Death Cover, Benefit -3.4.1-Waiver of Premium, Benefit 3.5.3 Loyalty Cover, Benefit-3.6 .1 Wellness Services, Benefit 3.7.7 Hospital Cash(if opted) ,Benefit-3.7.8.4 Convalescence Cover, Benefit-3.7.9.1 Health Check Up, Benefit-3.7.9.2 Vaccination Cover, Benefit-3.7.11.2 Companion Cover, Benefit-3.7.11.3 Child Care Cover.

3.7.6 REMOVAL OF CO-PAYMENT

Under this option, the **Company** shall waive off the **Co-Payment** condition mentioned in Clause-6.2 **Co-Payment** Sub-section (i). Such waiver, if allowed, shall be expressly mentioned in the **Policy Schedule**.

3.7.7 HOSPITAL CASH

Under this option, the **Company** shall compensate the **Insured Person**, as per the following:

3.7.7.1 IN-PATIENT CASH

If the **Company** has accepted and paid a claim under Benefit-3.1.1.1 **In-Patient Treatment**, then the **Company** shall pay the **Insured Person** an amount equal to the Daily Cash amount specified in the **Policy Schedule** per day of **Hospitalization**, provided,

i. The Daily Cash amount shall be payable for each 24 hours of continuous and completed Hospitalization as **In-Patient**.

ii. The amount under this benefit shall be payable maximum up to 30 days in a Policy Year.

iii. Time Deductible: If the Hospitalization is for less than a continuous and consecutive period of 72 hours, no amount shall be payable under this benefit. If the Hospitalization extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of Hospitalization.

iv. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the **Policy**.

3.7.7.2 ICU CASH

If the Company has accepted and paid a claim under Benefit - 3.1.1.1 In-Patient Treatment where the **Insured Person** is admitted in an **Intensive Care Unit (ICU)** of a **Hospital** on the written advice of a **Medical Practitioner**, then the **Company** shall pay the **Insured Person** additional 100% of Daily Cash amount as specified in the **Policy Schedule** per day of **ICU Hospitalization** provided,

i. The additional Daily Cash amount shall be payable for each 24 hours of continuous and completed **ICU In-Patient Hospitalization**

ii. In a given **Policy Year**, the amount under this benefit shall be payable for a maximum of 15 days

iii. Time Deductible: If the Hospitalization is for less than a continuous and consecutive period of 72 hours, no amount shall be payable under this benefit. If the Hospitalization extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of Hospitalization

iv. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the **Policy**.

3.7.8 CONVENIENCE COVER

3.7.8.1 CHANGE IN PRE-POST HOSPITALIZATION LIMIT

Under this benefit, the **Policyholder** shall be allowed to change the coverage period for Benefit - 3.1.5 **Pre-Hospitalization** to 90 days, and that for Benefit - 3.1.6 **Post-Hospitalization** to 180 days, if so requested by the **Policyholder** and explicitly accepted by the **Company**. The agreed **Pre-Hospitalization** and **Post-Hospitalization** limits shall beexpressly mentioned in the **Policy Schedule.**

3.7.8.2 AIR AMBULANCE

The **Company** shall indemnify the **Policyholder/Insured Person** upto an amount specified in the **Policy Schedule,** for the expenses incurred on availing Air Ambulance services during the **Policy Year**, provided that:

i. The **Company** has accepted the Inpatient Hospitalization claim under Benefit 3.**1.1.1 In Patient Treatment.**

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

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

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

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

vi. This benefit can be availed once in a **Policy Year**.

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

3.7.8.3 RADIO TAXI

The **Company** shall indemnify the **Policyholder/Insured Person** up to the amount specified in the **Policy Schedule**, per **Hospitalization**, for the expenses incurred on availing registered Radio cab operator services, provided that:

i. The **Company** has accepted the Hospitalization claim under Benefit- 3.1.1.Hospitalization Expenses

ii. The coverage includes the cost of the transportation of the **Insured Person** for whom claim has been accepted under Benefit- 3.1.1. Hospitalization Expenses to the nearest Hospital and/or from Hospital to home.

3.7.8.4 CONVALESCENCE COVER

The **Company** shall pay a lump sum amount as specified in the **Policy Schedule**, if during the **Policy Year**, the **Insured Person** suffers an **Illness** or **Injury** for which **Insured Person** is **Hospitalized** for a minimum period of 7 continuous and consecutive days, provided that:

i. The Company has accepted Inpatient Hospitalization Claim under Benefit - 3.1.1.1 In Patient Treatment.

ii. This benefit is payable once in a **Policy Year**.

iii. The Convalescence Cover shall be available on individual basis for individual policies and on floater basis for floater policies.

iv. The payment under this benefit will be over and above the payment made under Benefit-3.1.1.1 **In-Patient Treatment**.

3.7.9 PREVENTIVE CARE COVER

3.7.9.1 HEALTH CHECK UP

At the end of every **Policy Year**, the **Company** shall provide expenses for the listed diagnostic or preventive medical tests with respect to the **Insured Persons** in the **Policy**. This benefit is subject to following:

i. The total amount payable towards medical tests in a given **Policy Year** shall be limited to Rs 3000.

ii. In case of a Floater Policy, the medical check-up limit mentioned above shall be available on Floater basis.

iii. The amount claimed under this Benefit shall not reduce the **Base Sum Insured** and **Cumulative Bonus** under the **Policy**.

iv. The **Insured Person** can undergo one or more of the listed medical tests anytime within a period of four months of becoming eligible.

v. The benefit shall be available on Cashless basis and arranged with **Company's** Empaneled Service Providers. Where the test(s) cannot be arranged with an Empaneled Service Provider the **Company** may provide Reimbursement facility on approval basis.

vi. Utilizing this benefit alone shall not be considered as claim under the **Policy**.

vii. The benefit shall only be applicable to those **Insured Persons** who were insured under the **Policy** in the expiring **Policy Year**.

Following are the list of medical tests:

Organ/ Disease Specific	**Tests**
Heart	ECG,2D Echo, TMT, Lipid Profile
Liver	Liver Profile, Sonography Abdomen
Kidney	Kidney Profile, Sonography Abdomen
Lungs	Chest X-Ray, PFT
Eyes	Vision Test, Colour Vision Test, Eye Dilation Test, Intraocular Pressure Measurement
Female Specific	PAP Smear, Sonography Abdomen and Pelvis, Mammography
Thyroid Gland	Thyroid Function Test
ENT	ENT check Up, Audiometry Test
Dental	OPG Dental (X Ray)
Diabetes	Blood Sugar (PP/Fasting),HbA1c
General	CBC,C-Reactive Protein, Urine Routine, Serum Electrolytes (Calcium, Potassium, Sodium, Phosphorus, Chloride), Vitamin D, Vitamin B-12

3.7.9.2 VACCINATION COVER

At the end of every **Policy Year**, the **Company** shall provide expenses for the listed vaccines with respect to the **Insured Persons** in the **Policy**. This benefit is subject to following:

i. The total amount payable under this benefit in a given **Policy**

Year shall be limited to the amount specified in the **Policy Schedule.**

ii. In case of a Floater Policy, the vaccination limit specified in **Policy Schedule** shall be available on Floater basis.

iii. The amount claimed under this Benefit shall not reduce the Base **Sum Insured** and **Cumulative Bonus** under the **Policy**.

iv. Expenses related to doctor, nurses or any incidental expenses shall not be payable.

v. The benefit shall be available on Cashless basis and arranged with **Company's** Empaneled Service Providers. Where the vaccination cannot be arranged with an Empaneled Service Provider the **Company** may provide Reimbursement basis facility on approval basis.

vi. Utilizing this benefit alone shall not be considered as claim under the **Policy**.

vii. The benefit shall only be applicable to those **Insured Persons** who were insured under the **Policy** in the expiring **Policy Year**.

List of vaccines covered:

a. Diphtheria, Tetanus, Pertussis

b. Varicella Vaccine

c. Combined Measles, Mumps and Rubella (MMR)Vaccine

d. Influenza

e. Pneumonia

f. Typhoid

g. Hepatitis B

h. Hepatitis A

i. Haemophiles influenzae type b Vaccine (Hib)

j. Human Papillomavirus Vaccine (HPV)

i. Anti-Rabies

3.7.10 SMART COVERS

3.7.10.1 CHANGE IN MODERN TREATMENT LIMITS

Under this benefit, the **Policyholder** shall be allowed to change the coverage limit under Plans Plus and power for Benefit 3.1.4 Modern Treatment from 50% of **Base Sum Insured** to 100% of **Base Sum Insured** and if so requested by the **Policyholder** and explicitly accepted by the **Company**. The agreed coverage limit for Modern Treatment shall be expressly mentioned in the **Policy Schedule**.

3.7.10.2 VISION CORRECTION

The **Company** shall indemnify the **Policyholder/Insured Person** up to an amount specified in the **Policy Schedule** for the **Medical Expenses** incurred during the **Policy Year**, for undergoing medically necessary treatment under Benefit 3.1.1 Hospitalization Expenses for correction of eyesight due to refractive error on the written advice of the **Medical Practitioner**, provided that:

i. The refractive error must be equal to or above-6.0/+6.0 dioptresat the time of taking the treatment

ii. This benefit shall become available only after the expiry of 24 months from the date of inception of the **Insured Person's** first **Policy** with the **Company**.

iii. The **Company** has accepted claim under Benefit 3.1.1 Hospitalization Expenses.

iv. The treatment carried out for the cosmetic reasons shall not be covered

v. Pre-Hospitalization and Post-Hospitalization expenses shall not be covered

vi. This benefit waives the Standard Exclusion clause no-4.1.15 Refractive Error (Code: Excl 15)to the extent mentioned under point (i) above.

3.7.10.3 SECOND OPINION

The **Company** shall the indemnify the cost incurred for availing second medical opinion from a **Medical Practitioner** within India, if the **Insured Person**, during the **Policy Year** is diagnosed with any of the listed **Critical Illnesses** provided that:

i. The benefit shall be provided on reimbursement basis.

ii. By seeking the Second Opinion under this benefit the **Insured Person** is not prohibited or advised against visiting or consulting with any other independent **Medical Practitioner** or commencing or continuing any treatment advised by another **Medical Practitioner**.

iii. The **Insured Person** is free to choose whether to avail Second opinion and if availed under this benefit, then whether or not to act on it.

iv. The Second opinion shall be only for medical reason and not be valid for medico-legal purposes.

v. The **Company** does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any **Medical Practitioner** or in any expert opinion or for any consequences of actions taken or not taken in reliance thereon.

vi. This benefit can be availed once in a Policy Year.

vii. Utilizing this benefit alone shall not be considered as claim under the **Policy**.

viii. For the purpose of this Cover, Critical Illnesses shall include:

I. CANCER OF SPECIFIED SEVERITY

a. A malignant tumour characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

b. The following are excluded —

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM

Classification) or below;

- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- All tumors in the presence of HIV infection

II. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

a. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

III. MAJOR ORGAN /BONE MARROW TRANSPLANT

a. The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner

b. The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

IV. COMA OF SPECIFIED SEVERITY

a. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

b. The condition has to be confirmed by a Specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

V. SURGERY OF AORTA

a. The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneurysms)
- Angiography (an x-ray of the blood vessels)

VI. BENIGN BRAIN TUMOR

a. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

b. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

c. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, and tumors of skull bones, and tumors of the spinal cord.

VII. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

a. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner

VIII. END STAGE LUNG FAILURE

a. End stage lung disease, causing chronic respiratory failure, as confirmed by a physician and evidenced by all of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
- Dyspnea at rest.

IX. END STAGE LIVER FAILURE

a. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

X. STROKE RESULTING IN PERMANENT SYMPTOMS

a. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

b. The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain

- Vascular disease affecting only the eye or optic nerve or vestibular

XI. PERMANENT PARALYSIS OF LIMBS

a. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

XII. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

a. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

b. Other causes of neurological damage such as SLE and HIV are excluded.

XIII. BLINDNESS

a. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

b. The Blindness is evidenced by:

- Corrected visual acuity being 3/60 or less in both eyes or ;
- The field of vision being less than 10 degrees in both eyes.

c. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

XIV. THIRD DEGREE BURNS

a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

XV. BACTERIAL MENINGITIS

a. Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

3.7.11 FAMILY CARE COVER

3.7.11.1 HOME CARE TREATMENT

The **Company** shall indemnify the **Policyholder/Insured Person** for the **Medical Expenses**, incurred during the **Policy Year**, 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 period of treatment 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. No amount shall be payable towards **Medical Expenses** incurred outside the period of treatment.

v. The benefit can be availed for maximum 15 days, per **Insured Person**, during the **Policy Year**

vi. The following treatments or illnesses shall be covered under **Home Care Treatment**:

a. Chemotherapy excluding any supporting medication

b. Dialysis

c. Gastroenteritis: Severe Gastroenteritis with dehydration level >=10%

d. Bronchopneumonia supported by radiological evidence

e. Lower Respiratory tract infection supported by radiological (X-ray) evidence

f. Non-alcoholic Pancreatitis

g. Dengue with platelet count less than 1 lakh and supported by positive Dengue Antigen report

h. Hepatitis supported by positive diagnosis through blood reports

3.7.11.2 COMPANION COVER

The **Company** shall pay the **Policyholder/Insured Person** a fixed daily amount, as specified in the **Policy Schedule** towards the expenses of a **Companion** during the **Inpatient Treatment** of the **Insured Person**, provided that:

i. The Company has accepted **In-Patient Hospitalization Claim** under Benefit 3.1.1.1 **In Patient Treatment**.

ii. The daily amount shall be payable for each 24 hours of continuous and completed In-patient **Hospitalization** of the **Insured Person**.

iii. The amount under this benefit shall be payable maximum up to 30 days in a Policy Year.

iv. The amount shall be payable towards expenses incurred by the Companion towards accommodation, transportation, food or any other miscellaneous expenses.

v. For a claim to be payable under this cover, the Companion/ **Insured Person** shall submit at minimum, the receipts of paid accommodation availed by the Companion to assist the **Insured Person** during **Hospitalization**.

vi. Time Deductible: If the **Hospitalization** is for less than a continuous and consecutive period of 72 hours, no amount shall be payable under this benefit. If the **Hospitalization** extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of **Hospitalization**

vii. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the Policy.

viii. The **Company** has accepted **In-Patient Hospitalization Claim**

under Benefit **3.1.1.1 In Patient Treatment**.

3.7.11.3 CHILD CARE COVER

The **Company** shall pay the **Policyholder/Insured Person** a fixed daily amount specified in the **Policy Schedule** towards the childcare expenses of an **Insured Child**, if the **Insured Person** (Self or Spouse) during the **Policy Year**, suffers an **Illness** or **Injury** for which **Insured Person** is **Hospitalized**, provided that:

i. The benefit shall be payable toward any one dependent child covered under the **Policy** and aged up to 12 years.

ii. The amount under this benefit shall be payable maximum up to 30 days in a **Policy Year**.

iii. Time Deductible: If the **Hospitalization** is for less than a continuous and consecutive period of 72 hours, no amount shall be payable under this benefit. If the **Hospitalization** extends beyond a continuous and consecutive period of 72 hours, the payment under this benefit shall be made from the first day of **Hospitalization**

iv. Time Deductible shall be applicable on each and every **In-Patient Treatment** claim reported under the Policy.

v. The **Company** has accepted **In-Patient Hospitalization Claim** under Benefit **3.1.1.1 In Patient Treatment**.

vi. The amount payable under this benefit shall be over and above the amount payable under Benefit **3.1.1.1 In Patient Treatment**.

SECTION-4 EXCLUSIONS

The **Company** shall not be liable to make any payment under the **Policy**, in respect of any expenses incurred in connection with or in respect of the following:

4.1. STANDARD EXCLUSIONS

4.1.1. PRE-EXISTING DISEASES (CODE- EXCL 01)

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

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

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

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

4.1.2. SPECIFIC WAITING PERIOD (CODE- EXCL 02)

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

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

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

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

v. If the **Insured Person** is continuously covered without any Break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage. 24 months waiting period:

Organ / Organ System	Illness /Diagnosis ((irrespective of treatment being medical or surgical)	Surgeries / Surgical Procedure (irrespective of any Illness / diagnosis)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps, including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed uterus	• Hysterectomy unless necessitated by malignancy
Orthopaedic	• Non-infective arthritis • Gout and rheumatism • Osteoporosis • Ligament, tendon and meniscal tear • Prolapsed intervertebral disk	• Joint replacement surgery
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/ fistula in anus, haemorrhoids, pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), ulcer and erosion of stomach and duodenum • Cirrhosis (however alcoholic	• Cholecystectomy • Surgery of hernia

	cirrhosis is permanently excluded) • Perineal and perianal abscess • Rectal prolapse	
Urogenital	• Calculus diseases of urogenital system including kidney, ureter, bladder stones • Benign hyperplasia of prostate • Varicocele	• Surgery on prostate unless necessitated by malignancy • Surgery for hydrocele/ rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Surgery for correction of eye sight due to refractive error above dioptre 7.5 (-6/+6 dioptre if Optional Benefit-3.7.10 Smart Covers has been opted under the Policy)
Others	• Congenital internal disease	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems / organs whether or not described above)	• Benign tumors of non-infectious etiology Such as cysts, nodules, polyps, lumps or growth.	• Nil

4.1.3. FIRST THIRTY DAYS WAITING PERIOD (CODE- EXCL03)

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

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

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

4.1.4. INVESTIGATION & EVALUATION (CODE: EXCL04)

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

ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded except under the Benefit 3.7.1.4 Health Check Up.

4.1.5. 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:

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

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

4.1.6. OBESITY/ WEIGHT CONTROL (CODE: EXCL06):

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

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

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

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

iv. Body Mass Index (BMI);

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

o Obesity-related cardiomyopathy

o Coronary heart disease

o Severe Sleep Apnea

o Uncontrolled Type 2 Diabetes

4.1.7. CHANGE-OF-GENDER TREATMENTS (CODE: EXCL 07):

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

4.1.8. COSMETIC OR PLASTIC SURGERY (CODE: EXCL 08):

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

4.1.9. HAZARDOUS OR ADVENTURE SPORTS (CODE: EXCL 09):

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

4.1.10. BREACH OF LAW (CODE: EXCL 10):

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

4.1.11. EXCLUDED PROVIDERS (CODE: EXCL 11):

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

4.1.12. SUBSTANCE ABUSE AND ALCOHOL (CODE: EXCL12):

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

4.1.13. WELLNESS AND REJUVENATION (CODE: EXCL13):

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

4.1.14. DIETARY SUPPLEMENTS & SUBSTANCES (CODE: EXCL14):

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

4.1.15. REFRACTIVE ERROR (CODE: EXCL 15):

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

4.1.16. UNPROVEN TREATMENTS-CODE (CODE: EXCL 16)

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

4.1.17. STERILITY AND INFERTILITY (CODE: EXCL17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

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

iii. Gestational Surrogacy

iv. Reversal of sterilization

4.1.18. MATERNITY EXPENSES (CODE - EXCL 18)

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

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy Period.**

4.2. SPECIFIC EXCLUSIONS

4.2.1. 15 DAYS WAITING PERIOD FOR COVID-19:

i. Any Expenses related to the treatment of Covid-19 within 15 days from the first Policy commencement date shall be excluded.

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

iii. The within referred Waiting Period is made applicable to the enhanced **Base Sum Insured** in the event of granting higher **Base Sum Insured** subsequently.

4.2.2. 24 MONTHS WAITING PERIOD FOR VISION CORRECTION

i. Any Expenses related to the treatment of Vision Correction within 24 months 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 **Base Sum Insured** in the event of granting higher **Base Sum Insured** subsequently.

4.2.3. Treatment outside Discipline: Treatment taken from anyone not falling within the scope of definition of **Medical Practitioner** or from a **Medical Practitioner** who is practicing outside the discipline for which he is licensed or any kind of self-medication

4.2.4. Hearing Aids and spectacles: Any charges incurred on hearing aids, cost of spectacles, contact lenses, routine eye and ear examinations.

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

4.2.6. Sleep Apnea: Any treatment related to sleep apnea, general debility and convalescence.

4.2.7. External Congenital Anomaly: Treatment of External Congenital Anomaly.

4.2.8. Artificial Life support equipment's: Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

4.2.9. Non-payable items: Expenses against items mentioned in "**Annexure A- List I**" shall not be payable. This exclusion shall be waived off, if Optional Benefit - 3.7.1.3"Consumable Cover" has been opted under the **Policy**.

4.2.10. Outpatient Treatment: Treatment which has been done on an outpatient basis without any associated **Hospitalization**.

4.2.11. Overseas Treatment: Treatment received outside India.

4.2.12. Self-injury: Any intentional self-inflicted Injury, suicide or attempted suicide.

4.2.13. Documentation charges: Any charges incurred to procure any medical certificate, treatment/Illness related documents pertaining to any period of Hospitalization/Illness.

4.2.14. Charges other than Reasonable & Customary Charges: Any Medical Expenses which are not **Reasonable and Customary Charges**

4.2.15. RMO charges and Service charge: Expenses related to any kind of RMO charges, service charge where nursing charges are also charged, night charges levied by the Hospital under whatever head.

4.2.16. 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:

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

b. 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.

c. 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.

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

4.3. PERMANENT EXCLUSIONS

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) that otherwise would have resulted in rejection of insurance coverage under this **Policy** to such **Insured Person**. The list of such diseases/ conditions or treatments are enclosed as an Annexure-F

SECTION-5 GENERAL TERMS AND CLAUSES

5.1. STANDARD GENERAL TERMS AND CLAUSES

5.1.1. DISCLOSURE OF INFORMATION

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

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

5.1.2. CONDITION PRECEDENT TO ADMISSION OF LIABILITY

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

5.1.3. CLAIM SETTLEMENT (PROVISION FOR PENAL INTEREST)

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

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

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

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank 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)

5.1.4. COMPLETE DISCHARGE

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

5.1.5. 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.

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

5.1.6. 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.

5.1.7. CANCELLATION

i. The **Policyholder** may cancel this policy by giving 7 days' written notice and in such an event, the **Company** shall refund premium for the unexpired **Policy Periodas** detailed below:

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

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

Calculation of Pro-Rata refund:

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

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

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

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

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

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.

5.1.8. MIGRATION

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

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

5.1.9. 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).

5.1.10. RENEWAL OF POLICY

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

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

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

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

v. 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.

vi. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

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

5.1.11. WITHDRAWAL OF POLICY

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

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

5.1.12. MORATORIUM PERIOD

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

5.1.13. 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. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly / half-yearly / annual instalments) is available on

the premium due date, to pay the premium.

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

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

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

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

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

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

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

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

5.1.15. 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

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

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

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

5.1.16. NOMINATION

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

5.1.17. REDRESSAL OF GRIEVANCE

In case of any grievance the Insured Person may contact the Company through

Website: www. Relianceada.com

Toll free: 1800-3009

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

E-mail: rgicl.services@relianceada.com

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

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, Winway Building 2nd &3rd Floor,11/12 Block No-4,Old no-67,South Takoganj,Indore(M.P)-452001.Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

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

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

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

Krishe Block, Krishe Sapphire, Madhapur

Hyderabad – 500 081

Grievance Redressal officer
email ID: rgicl.headgrievances@relian ceada.com

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

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

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

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

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

5.2. SPECIFIC TERMS AND CLAUSES

5.2.1. MATERIAL CHANGE

The **Policyholder/Insured Person** shall immediately notify the **Company** in writing of any material change in the risk at his own expense and the **Company** may adjust the scope of cover and/or premium, if necessary, accordingly.

5.2.2. RECORDS TO BE MAINTAINED

The **Policyholder/ Insured Person** shall keep an accurate record containing all relevant medical records until final adjustment (if any) and resolution of all **Claims** under this **Policy** and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the **Company** may require under this **Policy** .

5.2.3. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in

relation to the **Policyholder/ Insured Person** which is in possession of the **Company** and not specifically informed by the **Policyholder / Insured Person** shall not be held to bind or prejudicially affect the **Company** notwithstanding subsequent acceptance of any premium.

5.2.4. POLICY DISPUTES

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this **Policy** shall be determined by the Indian Courts and subject to Indian law.

5.2.5. LIMITATION PERIOD

In no case whatsoever the **Company** shall be liable for any **Claim** under this **Policy**, if the requirement of Clause 6.1 above are not complied with, unless the **Claim** is the subject of pending action; it being expressly agreed and declared that if the **Company** shall disclaim liability for any **Claim** hereunder and such **Claim** shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the **Claim** shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable.

5.2.6. ALTERATIONS IN THE POLICY

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

5.2.7. ENDORSEMENTS (MID TERM ADDITION/DELETION OF INSURED PERSONS)

i. **Mid-Term Addition of Family**: Mid-term addition of **Family members** shall be allowed in the event of following:

a) Newborn baby covered from 90 days

b) Spouse in the event of marriage.

ii. **Mid Term Deletion** of **Policyholder/Family**: Midterm deletion of **Policyholder** or his/her **Family** members shall be allowed on pro-rata basis only in the event of Death of the Insured **Person** or his/her **Family** members subject to no claim has been made against the deleted person.

iii. The **Company** may at any time terminate coverage to the **Policyholder** or his/her **Family** members on grounds as specified in Clause 5.1.1 Disclosure to information norm, by giving 15 days' notice and by sending an endorsement to Policyholder's address shown in the **Policy Schedule** without refund of premium.

5.2.9. COMMUNICATION

Any communication meant for the **Company** must be in writing(by physical or digital mode) and be delivered to its address shown in the **Policy Schedule**. Any communication meant for the **Policyholder** will be sent by the **Company** to his last known address or the address as shown in the **Policy Schedule**.

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

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

5.2.10. OVERRIDING EFFECT OF POLICY SCHEDULE

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

SECTION-6 OTHER TERMS AND CONDITION

6.1. CLAIMS INTIMATION, ASSESSMENT AND MANAGEMENT

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

6.1.1. CLAIMS INTIMATION

In the event of any Disease or **Illness/ Injury** or occurrence of any other contingency which has resulted in a **Claim** or may result in a **Claim** covered under the Policy, the **Policyholder/ Insured Person**, must notify the **TPA/Company** either at the call center or in writing immediately, in the event of :

i. Planned Hospitalization, the **Policyholder /Insured Person** will intimate such admission at least 48 hours prior to the planned date of admission.

ii. **Emergency Hospitalization**, the **Policyholder /Insured Person** will intimate such admission within 24 hours of such admission.

The following details are to be provided to the **TPA/Company** at the time of intimation of Claim:

a. Policy Number

b. Name of the **Policyholder**

c. Name of the Insured Person in whose relation the Claim is being lodged.

d. Nature of Illness / Injury

e. Name and address of the attending **Medical Practitioner and Hospital**

f. Date of Admission to **Hospital** or proposed date of admission to **Hospital** for Planned Hospitalization

g. Any other information as requested by the **Company**.

6.1.2. CLAIMS PROCEDURE

i. **CASHLESS:**

Cashless facility is available only at a **Network Hospital** and shall be available for Benefits-3.1.1 (Hospitalization Expenses) and 3.1.4 (Modern Treatment), unless specified otherwise. The **Insured Person** can avail **Cashless** facility at the time of admission into any **Network Hospital**, by presenting the health card as provided by the **TPA/ Company** with this **Policy**, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the **Company**).

To avail **Cashless** facility, the following procedure must be followed

by the **Policyholder/ Insured Person**:

a. Pre-authorization: Prior to **Hospitalization**, the **Policyholder/ Insured Person** must call the call center of the **TPA/Company** and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned **Hospitalization** and in case of an Emergency situation, within 24 hours of **Hospitalization**.

b. The **TPA/Company** will process the **Policyholder's/ Insured Person's** request for authorization after having obtained accurate and complete information for the Illness/ Injury for which **Cashless** facility for **Hospitalization** is sought by the **Policyholder/ Insured Person** and the **Company** will confirm such **Cashless** authorization / rejection in writing or by other means.

c. If the procedure above is followed and the **Policyholder's/ Insured Person's** request for **Cashless** facility is authorized, the **Policyholder/ Insured Perso**n will not be required to pay for the **Hospitalization Expenses** which are covered under this Policy and fall within the **Company's** liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the **Network Hospital**.

d. The **Company/TPA** (On behalf of **Company**) reserves the right to review each Claim for **Hospitalization Expenses** and coverage will be determined according to the terms and conditions of this **Policy**. The **Policyholder/ Insured Person** shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), directly with the **Hospital**.

e. Cashless facility for **Hospitalization** Expenses shall be limited exclusively to **Medical Expenses** incurred for treatment undertaken in a **Network Hospital** for Illness or Injury which are covered under the **Policy**.

f. There can be instances where the **TPA/Company** may deny **Cashless** facility for **Hospitalization** due to insufficient **Sum Insured** or insufficient information to determine admissibility in which case the **Policyholder/ Insured Person** may be required to pay for the treatment and submit the Claim for reimbursement to the **TPA/Company** which will be considered subject to the Policy Terms &Conditions.

g. The **Policyholder/ Insured Person** shall be required to submit the documents as mentioned in Clause 6.1.4: Claim Documents, with the Network Hospital.

Note: Under **Cashless** facility, the **TPA/Company** may authorize upon the **Policyholder's / Insured Person's** request for direct settlement of admissible **Claim** as per agreed charges & terms and conditions between Network Hospital and the **TPA/Company**. In such cases, the **TPA/Company** will directly settle all eligible amounts as per the Policy Terms &Conditions with the **Network** Hospital to the extent the **Claim** is covered under the **Policy**.

The **Company**, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for **Cashless** services available under the **Policy**. Before availing the Cashless service, the **Policyholder / Insured Person** is required to check the applicable list of **Network** Hospital on the Company's website.

ii. **RE-IMBURSEMENT:**

In case of any **Claim** under the Benefits, where **Cashless facility** is not availed, the list of documents as mentioned in Clause 6.1.4: Claim Documents shall be provided by the **Policyholder/Insured Person**, immediately but not later than 15 days of discharge from the **Hospital**, at the **Policyholder's/ Insured Person's** expense to avail the **Claim**.

Note- For reimbursement claim under Benefit-3.1.4 Domiciliary Hospitalization, Benefit-3.1.6 Post Hospitalization and Benefit-3.7.11.1 Home Care Treatment the above mentioned condition of" not later than 15 days of discharge from the Hospital" shall stands modified as under:

a. Benefit-3.1.4 Domiciliary Hospitalization "not later than 15 days of completion of Domiciliary Hospitalization "

b. Benefit-3.1.6 Post Hospitalization "not later than 15 days of completion of Post hospitalization period "

c. Benefit-3.7.11.1 Home Care Treatment ""not later than 15 days of completion of Home Care Treatment.

6.1.3. RESPONSIBILITY OF POLICYHOLDER/ INSURED PERSON

i. Forthwith intimate / file / submit a **Claim** in accordance with Clause 6.1 of this **Policy**.

ii. If so requested by the **TPA/Company**, the **Insured Person** will have to submit himself for a medical examination by the **Company's** nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the **Company**.

iii. The **Policyholder/ Insured Person** is required to check the applicable list of **Network** Hospitalization the **TPA/ Company's** website or call center before availing the **Cashless** services.

iv. On occurrence of an event which will lead to a **Claim** under this **Policy**, the **Policyholder/ Insured Person** shall:

a. Allow the **Medical Practitioner** or any of the **Company's** representatives to inspect the medical and **Hospitalization** records, investigate the facts and examine the **Insured Person**.

b. Assist and not hinder or prevent the **Company's** representatives in pursuance of their duties for ascertaining the admissibility of the **Claim** under the **Policy**.

c. If the **Policyholder / Insured** Person does not comply with the provisions of these conditions all benefits under this **Policy** shall be forfeited at the **Company's** option.

6.1.4. CLAIM DOCUMENTS

The **Policyholder / Insured Person** shall submit to the **TPA/Company/ Network Hospital** (as applicable) the following documents for or in support of the Claim:

Benefit No.	Covers	List of Claim Documents
Benefit-3.1	**Hospitalization Cover:** Hospitalization Expenses, Domestic Road Ambulance, Domiciliary Hospitalization, Modern Treatment, Pre and Post Hospitalization, Organ Donor E	
	Hospitalization Cover: Hospitalization Expenses, Domestic Road Ambulance, Domiciliary Hospitalization, Modern Treatment, Pre and Post Hospitalization, Organ Donor Expenses	i. Duly completed and signed Claim Form, in original ii. Medical Practitioner's referral letter advising Hospitalization iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner v. Original bills from pharmacy / chemists vi. Original pathological / diagnostic test reports and payment receipts vii. Indoor case papers viii. Ambulance receipt and bill ix. First Information Report/ Final Police Report, if applicable x. Post mortem report, if available
Benefit-3.2	**Extra Cover:** Reinstatement of Base Sum Insured and Extra Sum Insured	i. Same Documents as mentioned for Benefit - 3.1 - Hospitalization Cover are required
Benefit-3.3	**Personal Accident Cover:** Accidental Death Cover	i. Duly completed and signed Claim Form, in original ii. Death certificate(In case of Death Claim) iii. Disability Certificate(In case of Disability Claim) iv. Post mortem report if available and applicable v. First Information Report/ Final Police Report, if applicable vi. Identity proof of Nominee or Original Succession Certificate/ Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased. vii. Any other document as required by the Company to assess the Claim
Benefit-3.4	**Critical Illness Cover:** Waiver of Premium	i. Same Documents as mentioned for Benefit -3.1 - Hospitalization Cover are required
Benefit-3.5	**Renewal Benefits:** Cumulative Bonus, Call Option for Enhancement of Base Sum Insured and Loyalty Cover	i. Same Documents as mentioned for Benefit- 3.1 - Hospitalization Cover are required ii. Documents as mentioned for Benefit: 3.3 (Personal Accident Cover) iii. Proof of employment
Benefit-3.6	**Value Added Covers:** Wellness Services, Claim Service Guarantee, Policy Service Guarantee	As per case, if required
	Benefit-3.7-Optional Covers	
Benefit-3.7.1	**Enhanced covers:** Guaranteed Cumulative Bonus, Unlimited Reinstatement of Base Sum Insured, Consumable Cover	i. Same Documents as mentioned for Benefit - 3.1 - Hospitalization Cover are required
Benefit-3.7.2	Double Cover	i. Same Documents as mentioned for Benefit- 3.1 - Hospitalization Cover are required
Benefit-3.7.3	Change in Room Rent limits	i. Same Documents as mentioned for Benefit -3.1 - Hospitalization Cover are required
Benefit-3.7.4	Reduction in Pre-Existing Waiting Period	i. Same Documents as mentioned for Benefit -3.1 - Hospitalization Cover are required
Benefit-3.7.5	Voluntary Aggregate Deductible	i. Same Documents as mentioned for Benefit -3.1 - Hospitalization Cover are required
Benefit-3.7.6	Removal of Co-Payment	i. Same Documents as mentioned for Benefit -3.1 - Hospitalization Cover are required
Benefit-3.7.7	Hospital Cash	i. Same Documents as mentioned for Benefit - 3.1 - Hospitalization Cover are required

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Benefit-3.7.8	**Convenience Cover:** Change in Pre-Post Hospitalization, Air Ambulance, Radio Taxi, Convalescence Cover	i. Same Documents as mentioned for Benefit - 3.1 - Hospitalization Cover are required. ii. Radio Taxi bill and receipt
Benefit-3.7.9	**Preventive Cover:** Health Checkup and Vaccination	i. Duly completed and signed Claim Form, in original ii. Health Check up bills and Receipts iii. Vaccination bills and Receipts
Benefit-3.7.10	**Smart Cover:** Change in Modern Treatment, Vision Correction, Second Opinion	i. Same Documents as mentioned for Benefit - 3.1 - Hospitalization Cover are required
Benefit-3.7.11	**Family Care Cover:** Home Care Treatment, Companion and Child Cover	i. Same Documents as mentioned for Benefit-3.1-Hospitalization Cover are required ii. Companion's accommodation bills and receipts
Note - The Company may call for any other documents as required by the Company to assess the Claim.		

When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/ reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

NOTE :

i. **Claim** once paid under one Benefit cannot be paid again under any other Benefit.

ii. All invoices / bills should be in Insured Person's name.

6.1.5. PROPORTIONATE DEDUCTIONS

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

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

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

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

a. Cost of Pharmacy and Consumables

b. Cost of Implants and Medical Devices

c. 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. **Base Sum Insured**

b. Benefit- 3.2.2- Extra Sum Insured or Benefit-3.7.2-Double Cover (whichever is applicable)

c. Benefit-3.5.1-Cumulative bonus

d. Benefit-3.6.3-Policy Service Guaranteed Sum Insured (if applicable)

e. Benefit-3.2.1 Reinstated Sum Insured or Benefit-3.7.1.2 Unlimited Reinstatement of Base Sum (whichever is applicable)

Proportionate Deduction is subject to the following:

i. Apart from the **Associate Medical Expenses**, no other expenses will be proportionately reduced

ii. If the given **Hospital** do not follow differential billing or if there are items in the claim for which the **Hospital** do not follow differential billing, the **Insurer** shall not be proportionately reducing the **Claims**. This shall be applied in case of admissions in Government Hospitals and the **Network Hospitals** of the **Insurer**.

iii. **ICU** charges shall not be proportionately reduced in all cases.

6.1.6. Payment Terms

i. This **Policy** covers medical treatment taken within India, and payments under this **Policy** shall be made in Indian Rupees within India.

ii. **Claims** shall not be admissible under this **Policy** unless the **TPA/Company** has been provided with the complete documentation / information which the **Company** has requested to establish its liability for the **Claim**, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.

iii. The **Company** shall not indemnify the **Policyholder / Insured Person** for any period of Hospitalization of less than 24 hours except for the **Day Care Treatment**

iv. The claims payable under all benefits are limited to **Total Liability**, defined under this Policy.

v. The **Sum Insured** of the **Insured Person** shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the **Sum Insured** for the **unexpired Policy Year**. This clause shall not be applicable to the Benefit 3.7.1.2 Unlimited Reinstated Sum Insured in case Benefit 3.7.1 Enhanced Covers is opted.

vi. For **Cashless Claims**, the payment shall be made to the **Network Hospital** whose discharge would be complete and final.

vii. For the **Reimbursement Claims**, the **Company** will pay the **Policyholder/Insured Person**. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.

viii. The Company will only be liable to pay for such Benefits for which the **Policyholder/ Insured Person** has specifically claimed in the **Claim Form**.

6.2. Co-Payment

The Policyholder/Insured Person shall bear a Co-Payment of 20% on the Assessed Claim Amount, if at the time of inception of the first Policy with the Company, the age of the Insured Person (or eldest Insured Person in case of Family Floater Policy) is 61 years and above.

In case of an Individual Policy, the above-mentioned Co-Payment shall be applicable on each and every claim incurred by that particular Insured Person whose age at the time of inception of the first Policy is >=61 years.

For Floater Policy, the Co-Payment shall be applicable on each and every claim incurred under the Policy during the Policy Year.

If the Parents are covered in a floater policy and the age of Parents at the time of entering into the Policy is >=61 years then the Co-Payment shall be applicable on both the Parents' claim and not on other Insured Persons.

If the Proposer (who is also an Insured Person) or his or her spouse at the time of entering into the Policy is >=61 years then Co-Payment shall be applicable on each and every claim of all Insured Persons under the Policy.

The Co-Payment shall not be applicable on Benefit 3.1.1.3 - Accomodation Bonus, Benefit - 3.3.1 Accidental Death Cover, Benefit - 3.4.1 - Waiver of Premium, Benefit 3.5.3 Loyalty Cover, Benefit - 3.6 .1 Wellness Services, Benefit 3.7.7 Hospital Cash (if opted), Benefit - 3.7.8.4 Convalescence Cover, Benefit-3.7.9.1 Health Check Up, Benefit - 3.7.9.2 Vaccination Cover, Benefit - 3.7.11.2 Companion Cover, Benefit - 3.7.11.3 Child Care Cover.

ii. **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.

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, Co-Payment mentioned in above Clause-6.2 (i) (if applicable) ,shall apply over and above the Zone wise Co-Payment.

Annexure-I Coverage Summary

Policy Period		1, 2 years and 3 years				
Plan Type		There are 3 plans Plus, Power and Prime				
New Business Base Sum Insured (in lakhs)		Plus: 3,5 Power: 10,15,20 Prime: 25,30,50,100				
Renewal Business/ Call Option Base Sum Insured (in lakhs)		Plus: 3,5, 6,9 Power: 10,12,15,18,20,24, Prime: 25,30,36, 40,48,50,60,72,80,100				
Room Category		For Plus and Power: Single Private Air-Conditioned Room For Prime : Actuals				
Benefit No.	**Covers**	**Limits for Plus**	**Limits for Power**	**Limits for Prime**	**Basis of Payment**	**Pre-Requisite for Claim**
Benefit 3.1 :- Hospitalization Cover:						
3.1.1	Hospitalization Expenses: 3.1.1.1 - In Patient Treatment 3.1.1.2 - Day Care Treatment 3.1.1.3 - Accomodation Bonus	Upto the Sum Insured **Accommodation Bonus:** Additional fixed daily amount of Rs 1000(Payable, only if applicable)	Upto the Sum Insured Accommodation Bonus: Additional fixed daily amount of Rs 1000(Payable, only if applicable)	Upto the Sum Insured Accommodation Bonus: Additional fixed daily amount of Rs 1000(Payable, only if applicable)	Indemnity	Not applicable 3.1.1.1 - In Patient Treatment (applicable for Accommodation Bonus)
3.1.2	Domestic Road Ambulance	upto 1500 per hospitalization Intercity Ambulance cost (beyond 100km): upto Rs 20000 per hospitalization	upto 3000 per hospitalization Intercity Ambulance cost (beyond 100km): upto Rs 20000 per hospitalization	Actuals (including Intercity ambulance cost: beyond 100km)	Indemnity	3.1.1.1 - In Patient Treatment
3.1.3	Domiciliary Hospitalization	Within the Sum Insured			Indemnity	Not applicable
3.1.4	Modern Treatment	upto 50% of Base Sum Insured		upto 100% of Base Sum Insured	Indemnity	3.1.1 - Hospitalization Expenses or 3.1.3 - Domiciliary Hospitalization

3.1.5	Pre Hospitalization	upto 60 days, within the Sum Insured		Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization or 3.1.4 - Modern Treatment
3.1.6	Post Hospitalization	upto 60 days, within the Sum Insured	upto 90 days, within the Sum Insured	Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization or 3.1.4 - Modern Treatment
3.1.7	Organ Donor Expenses	Upto 50% of Base Sum Insured, subject to maximum of Rs 5 lakhs	Upto 50% of Base Sum Insured, subject to maximum of Rs 10 lakhs	Indemnity	3.1.1.1 - In Patient Treatment
Benefit -3.2: Extra Cover					
3.2.1	Reinstatement of Base Sum Insured	On subsequent claim, one reinstatement up to 100% of Base Sum Insured for unrelated illness/injury, sub-limit of 20% of Base Sum Insured for related illness/injury		Indemnity	3.1 - Hospitalization Cover
3.2.2	Extra Sum Insured	Additional,20% of Base Sum Insured on same claim, in single Hospitalization		Indemnity	3.1 - Hospitalization Cover
Benefit-3.3-Personal Accident Cover					
3.3.1	Accidental Death Cover	Not Applicable	5% of Base Sum Insured subject to minimum of Rs 1lakh	Benefit	Not applicable
Benefit-3.4-Critical Illness Cover					
3.4.1	Waiver of Premium	Not Applicable	Waives off renewal Policy Premium on diagnosis of listed Critical Illness	Not Applicable	Not applicable
Benefit-3.5-Renewal Benefits					
3.5.1	Cumulative Bonus	33.33% increase in Base Sum Insured for every claim free Policy Year, max upto 100% of Base Sum Insured and 33.33% decrease for every claim year		Indemnity	3.1 - Hospitalization Cover
3.5.2	Call Option for Enhancement of Base Sum Insured	After 4 continuous and consecutive claim free Policy Years, if Policyholder avails this benefit then enhanced Sum Insured is sum of expiring Policy's Base Sum Insured and accumulated Cumulative Bonus		Indemnity	3.1 - Hospitalization Cover
3.5.3	Loyalty Cover	Refer Benefit-3.5.3 Loyalty Cover		Benefit and Indemnity	3.1.1.1 - In Patient Treatment(applicable for Hospital Cash and Leave Compensation benefit)
Benefit -3.6-Value Added Covers					
3.6.1	Wellness Services	This is Service in which Insured Person can seek Medical advice through telephonic or online mode		Not Applicable	Not applicable
3.6.2	Claim Service Guarantee	Cashless Claim - 1% of Delayed Claim Amount(for delay beyond 6 hours to 12 hours),additional 1% for every additional delay of 6 business hours		Indemnity	3.1.1 Hospitalization Expenses
		Reimbursement Claim-1% of Delayed Claim Amount (for delay beyond 21 days to upto 42 days),additional 1% for every additional delay of 6 business hours Maximum limit - 6% of Delayed Claim Amount			

3.6.3	Policy Service Guarantee	10000	20000	20000	Indemnity	Not applicable
Benefit - 3.7 - Optional Covers*						
Benefit - 3.7.1 - Enhanced covers						
3.7.1.1	Guaranteed Cumulative Bonus	This benefit waives off the condition of decrease in Cumulative Bonus in case of a claim in immediate previous Policy Year			Indemnity	3.1 - Hospitalization Cover
3.7.1.2	Unlimited Reinstatement of Base Sum Insured	On subsequent claim, Unlimited reinstatement of Base Sum Insured on unrelated illness or injury, sub-limit of 100% of Base Sum Insured for related illness/injury. This benefit supersedes Benefit no-3.2.1-Reinstatement of Base Sum Insured			Indemnity	3.1 - Hospitalization Cover
3.7.1.3	Consumable Cover	Within Sum Insured			Indemnity	3.1 - Hospitalization Cover, 3.2- Extra Cover, 3.5 - Renewal Benefits, 3.7.1 - Enhanced Covers (if applicable), 3.7.2 - Double Cover, 3.7.10-Smart Covers
3.7.2	Double Cover	Additional,100% of Base Sum Insured for Same claim. This benefit supersedes-Benefit no-3.2.2 Extra Sum Insured			Indemnity	3.1 - Hospitalization Cover
3.7.3	Change in Room Rent limits	Category of Room capped to: Twin sharing	Category of Room upgrade to : Actuals OR Category of Room capped to: Twin sharing	Category of Room capped to: Single Private A.C room	Indemnity	3.1.1 Hospitalization Expenses
3.7.4	Reduction in Pre-Existing Waiting Period	This benefit reduces the Pre-Existing Waiting Period to 24 months or 12 months			Not Applicable	3.1 - Hospitalization Cover
3.7.5	Voluntary Aggregate Deductible	Options are:10000,25000,50000,100000			Indemnity	3.1 - Hospitalization Cover
3.7.6	Removal of Co-Payment	This benefit waives off the Co-Payment condition of 20% on the Assessed Claim Amount, applicable on Policies where the Insured age, first time entering into the Policy is >=61 years			Indemnity	3.1 - Hospitalization Cover
3.7.7	Hospital Cash	Daily Cash options:1000,1500,2000,2500 max up to 30 days for In Patient Hospitalization and 15 days for ICU Hospitalization Minimum Hospitalization of 72 hours			Benefit	3.1.1.1 - In Patient Treatment
Benefit 3.7.8 - Convenience Cover						
3.7.8.1	Change in Pre-Post Hospitalization limit	Pre-Hospitalization-90 days Post Hospitalization-180 days			Indemnity	3.1.1 - Hospitalization Expenses, 3.1.3 - Domiciliary Hospitalization or 3.1.4 - Modern Treatment

3.7.8.2	Air Ambulance	7.5% of Base Sum Insured or Rs 5 Lakhs whichever is higher		Indemnity	3.1.1.1 - In Patient Treatment
3.7.8.3	Radio Taxi	1000 per Hospitalization		Indemnity	3.1.1.1 - In Patient Treatment
3.7.8.4	Convalescence Cover	10000	25000	Benefit	3.1.1.1 - In Patient Treatment
Benefit 3.7.9 - Preventive Care Cover					
3.7.9.1	Health Checkup	3000 (Annual)		Indemnity	Not applicable
3.7.9.2	Vaccination Cover	2000 (Annual)	3500 (Annual)	Indemnity	Not applicable
Benefit - 3.7.10 - Smart Cover					
3.7.10.1	Change in Modern Treatment limits	100% of Base Sum Insured	Not Applicable	Indemnity	3.1.1 - Hospitalization Expenses or 3.1.3 - Domiciliary Hospitalization
3.7.10.2	Vision Correction	50000	100000	Indemnity	3.1.1 - Hospitalization Expenses
3.7.10.3	Second Opinion	3000	5000	Indemnity	Not applicable
Benefit - 3.7.11 - Family Care Cover					
3.7.11.1	Home Care Treatment	Within Sum Insured		Indemnity	Not applicable
3.7.11.2	Companion Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours		Benefit	3.1.1.1 - In Patient Treatment
3.7.11.3	Child Care Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours		Benefit	3.1.1.1 - In Patient Treatment

*Optional Covers are available for Sum Insured Rs 5 lakhs and above except for Benefit no.3.7.3 Change in Room Rent Limits and Benefit no-3.7.5 Voluntary Aggregate Deductible.

Note - The maximum liability of the Company to pay the claims under this Policy is limited to **Total Liability** defined under the **Policy**.

Illustration for Benefit- Reinstatement/Unlimited Reinstatement of Base Sum Insured

Illustration 1 - Reinstatement of Base Sum Insured - Inbuilt Cover

Double Cover: Not Opted (Applicable: In-built Extra Sum Insured (20% of Base Sum Insured)
Enhanced cover: Not Opted (Unlimited Reinstatement of Base Sum Insured not applicable)

	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	**Base Sum Insured**	**Extra Sum Insured**	**Accumulated Cumulative Bonus**	**Policy Service Guarantee**	**Reinstatement of Base Sum Insured**	**Treatment taken for Disease / Injury / Illness**	**Assessed Hospitalization amount**	**Base Sum Insured**	**Extra Sum Insured**	**Accumulated Cumulative Bonus**	**Service Guarantee**	**Reinstatement of Base Sum Insured**	**Claim Amount Payable**
Claim 1	6,00,000	1,20,000	2,00,000	-	-	CABG	5,00,000	5,00,000	-	-	-	-	5,00,000
Claim 2	1,00,000	1,20,000	2,00,000	-	-	Stroke	4,50,000	1,00,000	1,20,000	2,00,000	-	-	4,20,000
Claim 3	-	-	-	-	6,00,000	Accident	8,00,000	-	-	-	-	6,00,000	6,00,000
Claim 4	-	-	-	-	-	Accident (related injury)	4,50,000	-	-	-	-	-	-
Claim 5	-	-	-	-	-	Hospitalization due to Pneoumonia	2,00,000	-	-	-	-	-	-

In the above scenario, Total Hospitalization Amount is Rs 24,00,000 and the claim out go us Rs 15,20,000. Policyholder has to pay Rs 8,80,000 from his pocket and for future claims in the same Policy Year, Policyholder has zero Sum Insured balance

Illustration 2 - Reinstatement of Base Sum Insured - inbuilt Cover													
Double Cover: Opted (100% on same claim) Enhanced Covers: Not Opted (Unlimited Reinstatement of Base Sum Insured not applicable)													
	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	Base Sum Insured	Double Cover	Accumulated Cumulative Bonus	Policy Service Guarantee	Reinstatement of Base Sum Insured	Treatment taken for Disease / Injury / Illness	Assessed Hospitalization amount	Base Sum Insured	Double Cover	Accumulated Cumulative Bonus	Service Guarantee	Reinstatement of Base Sum Insured	Claim Amount Payable
Claim 1	6,00,000	6,00,000	2,00,000	-	-	CABG	5,00,000	5,00,000	-	-	-	-	5,00,000
Claim 2	1,00,000	6,00,000	2,00,000	-	-	Stroke	4,50,000	1,00,000	3,50,000	-	-	-	4,50,000
Claim 3	-	-	2,00,000	-	6,00,000	Accident	8,00,000	-	-	2,00,000	-	6,00,000	8,00,000
Claim 4	-	-	-	-	-	Accident (related Injury)	4,50,000	-	-	-	-	1,20,000	1,20,000
Claim 5	-	-	-	-	-	Hospitalization due to Pneoumonia	2,00,000	-	-	-	-	-	-
In the above scenario, Total Hospitalization Amount is 2,40,000 and the claim outgo is Rs 17,50,000. Policyholder has paid 6,50,000 from his pocket and for future claims in the same Policy Year, Policyholder has zero Sum Insured balance.													

Illustration for Guaranteed Cumulative Bonus

Illustration on application of Cumulative Bonus (Base policy) and Guaranteed Cumulative Bonus (Optional cover)					
Particulars	**Limits**	**Case 1- Claim of 2 lakhs incurred during the year**		**Case 2- Claim of 6 lakhs incurred during year**	
Guaranteed Cumulative Bonus (Opted / Not Opted)		Not Opted	Opted	Not Opted	Opted
Base Sum Insured	500000	Utilised by 2 lakhs	Utilised by 2 lakhs	Fully utilised	Fully utilised
Cumulative Bonus	500000	333,333	500,000	233,333	400,000

In Case 1 (Claim amount less than Base Sum Insured): The customer gets reduced CB of 3.33 lakhs if Guaranteed Cumulative Bonus has not been opted and gets Rs 5 lakhs as CB if Guaranteed Cumulative Bonus has been opted

In Case 2(Claim amount more than Base Sum Insured): The customer gets reduced CB of 2.33 lakhs if Guaranteed Cumulative Bonus has not been opted and gets Rs 4 lakhs as CB if Guaranteed Cumulative Bonus has been opted(as CB reduced to the extent of utilization of CB amount for the payment of claim above Base Sum Insured)

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 RGI under each deductible option:

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

Illustration for Accommodation Bonus

The illustration below explains the working of Accommodation Bonus

Customer has opted Plan" Power" for Sum Insured Rs 5 lakhs, as per the Plan, the customer is eligible to avail the treatment in a room category up to Single private A.C Room.

Case	Room Category	No. of hospital days	Inpatient Claim Payable*	Accommodation Bonus Payable
1	Single Pvt. A.C room	5	As per Inpatient Claim Assessment	Zero
2	Twin Sharing A.C Room	5	As per Inpatient Claim Assessment	1000*5=5000
3	General Ward	5	As per Inpatient Claim Assessment	1000*5=5000

*This would not have impact on Accommodation Bonus payable amount.
In the above example, the Accommodation Bonus gets triggered only on the basis of opting Room Category lower than single Private A.C Room.

Illustration 3 - Unlimited Reinstatement of Base Sum Insured

Double Cover: Not Opted (Applicable: inbuilt Extra Sum Insured (20% of Base Sum Insured))

Enhanced Covers: Opted (Unlimited Reinstatement of Base Sum Insured is applicable)

	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	Base Sum Insured	Extra Cover	Accumulated Cumulative Bonus	Policy Service Guarantee	Unlimited Reinstatement	Treatment taken for Disease / Injury / Illness	Assessed Hospitalization amount	Base Sum Insured	Extra Cover	Accumulated Cumulative Bonus	Service Guarantee	Reinstatement	Claim Amount Payable
Claim 1	6,00,000	1,20,000	2,00,000	-	-	CABG	5,00,000	5,00,000	-	-	-	-	5,00,000
Claim 2	1,00,000	1,20,000	2,00,000	-	5,00,000	Stroke	4,50,000	1,00,000	1,20,000	2,00,000	-	30,000	4,50,000
Claim 3	-	-	-	-	6,00,000	Accident	8,00,000	-	-	-	-	6,00,000	6,00,000
Claim 4	-	-	-	-	6,00,000	Accident (related injury))	4,50,000	-	-	-	-	4,50,000	4,50,000
Claim 5	-	-	-	-	6,00,000	Hospitalization due to Pneoumonia	2,00,000	-	-	-	-	2,00,000	2,00,000

In the above scenario, Total Hospitalization Amount is 24,00,000 and the claim out go is Rs 22,00,000. Policyholder has to pay 2,00,000 from his pocket and for future claims in the same Policy Year, Policyholder has Sum Insured balance of Rs 1,50,000 on related illness or injury(since 4,50,000 has be paid) and unlimited Sum Insured for unrelated illness or injury.

Illustration 4 - Unlimited Reinstatement of Base Sum Insured

Double Cover: Opted (100% on same claim)

Enhanced Covers: Opted (Unlimited Reinstatement of Base Sum Insured is applicable)

	Sum Insured Available					Claim details		Sum Insured Utilization					
Claim	Base Sum Insured	Double Cover	Accumulated Cumulative Bonus	Policy Service Guarantee	Unlimited Reinstatement	Treatment taken for Disease /Injury / Illness	Assessed Hospitalization amount	Base Sum Insured	Double Cover	Accumulated Cumulative Bonus	Service Guarantee	Reinstatement	Claim Amount Payable
Claim 1	6,00,000	6,00,000	2,00,000	-	-	CABG	5,00,000	5,00,000	-	-	-	-	5,00,000
Claim 2	1,00,000	6,00,000	2,00,000	-	5,00,000	Stroke	4,50,000	1,00,000	3,50,000	-	-	-	4,50,000
Claim 3	-	-	2,00,000	-	6,00,000	Accident	8,00,000	-	-	2,00,000	-	6,00,000	8,00,000
Claim 4	-	-	-	-	6,00,000	Accident (related injury))	4,50,000	-	-	-	-	4,50,000	4,50,000
Claim 5	-	-	-	-	6,00,000	Hospitalization due to Pneoumonia	2,00,000	-	-	-	-	2,00,000	2,00,000

In the above scenario, Total Hospitalization Amount is 24,00,000 and the claim out go is Rs 24,00,000. Policyholder has to pay nothing from his pocket and for future claims in the same Policy Year, Policyholder has Sum Insured balance of Rs 1,50,000 on related inlless or injury(since 4,50,000 has been paid) and unlimited Sum Insured for unrelated illness or injury

ANNEXURE-A- ATTACHED TO POLICY WORDINGS

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)

10	LEGGING S
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPY ES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZE R KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPE CIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT,RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT

28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

Annexure-B

OMBUDSMAN OFFICE

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

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

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

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

Annexure-F

Below mentioned Diseases maybe permanently excluded under the Policyin the case where suchDiseases are Pre-Existing at the time of first proposal of this Product with the Company

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue •D00-D09 In situ neoplasms •D10-D36 Benign neoplasms, except benign neuroendocrine tumours •D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes •D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.

5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease,
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

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