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** (Applicable to India) means the medical and / or **Hospitalisation** treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6) **AYUSH Day Care Centre** (Applicable to India) 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 authorised representative.

7) **AYUSH Hospital** (Applicable to India) 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 recognised 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 recognised 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** authorised 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-authorisation is approved.

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

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

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

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

i. Internal Congenital Anomaly

Congenital Anomaly which is not in the visible and accessible

parts of the body.

ii. **External Congenital Anomaly**

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

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

16) **Cumulative Bonus (or No Claim Bonus)** means any increase or addition in Sum Insured granted by the Insurer without an associated increase in premium.

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

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

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

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

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

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

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

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

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

23) **Domiciliary Hospitalisation** (Applicable to India Cover) 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.

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

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

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

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

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

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

27) **Hospitalisation** 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).**

28) **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

29) **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.**

30) **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.

31) **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.

32) **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.

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

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

35) **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.

36) **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.

37) **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

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

39) **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognised modes of communication.

40) **OPD Treatment** (Applicable to India Cover) 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.**

41) **Post Hospitalisation 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** hospitalisation was required and

ii. The **In-patient hospitalisation** claim for such **Hospitalisation** is admissible by the **Company**

42) **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.

43) **Pre-existing Disease** (PED) 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.

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

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

ii. The **In-patient hospitalisation** claim for such **Hospitalisation** is admissible by the Company

45) **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

46) **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.**

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

48) **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

49) **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.

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

51) **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.**

52) **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.**

53) **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) **Abroad,** for the purpose of this policy, means geographies located outside the boundaries of the Republic of India.

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

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

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

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

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

7) **City/Country of Treatment** means the city/country where the **Insured Person** is availing the treatment on the basis of pre-requisite approval (where applicable) obtained from the **Company.**

8) **Child** means Insured Person's 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.

9) **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.**

10) **Companion** (Applicable to Global Cover) means **Insured Person's** family member/ relative who is above 18 years of age and who is travelling with the **Insured Person** on an identical itinerary with the sole purpose of accompanying the **Insured Person** during the **Insured person's** treatment abroad.

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

12) **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.

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

14) **Empaneled Service Provider** means any organisation or institution appointed by the **Company** for providing services to the **Insured Person** for an insurable event under this **Policy** and as mentioned in the **Policy Schedule.** The updated list of Empaneled Service Providers (along with complete contact details) shall be available on **Company's** website.

15) **Family** means as mentioned 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.

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

17) **Hospital** (Applicable to Global Cover) means any institution legally established and operated for **In-Patient Care** and **Day Care** treatment of illness and/or injuries of persons, for which a charge is made that the Insured Person(s) is legally obligated to pay in the absence of insurance; and which has been registered, accredited or licensed as a Hospital with the local authorities in the state or country in which it operates; and which complies with all minimum criteria as under:

i. Provides such care and treatment(s) in medical, diagnostic, or surgical facilities on its premises, or those prearranged for its use

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

iii. Has qualified nursing staff under its employment round the clock,

iv. Has qualified Medical Practitioner(s) in charge round the clock,

v. Has a fully equipped operation theatre of its own where surgical procedures are carried out,

vi. Maintains daily records of patients and makes these accessible to the insurance company's authorised personnel.

Hospital does not mean:

i. A Convalescent, nursing, or rest home or facility, or a

home for the aged; rejuvenation or health resort

ii. A place mainly providing Custodial, Educational, or Rehabilitative Care; or a facility mainly used for the treatment(s) of drug addicts or alcoholics.

18) **Hospital** (Applicable to India Cover) 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 authorised personnel.

Hospital does not mean:

i. A Convalescent, nursing, or rest home or facility, or a home for the aged; rejuvenation or health resort

ii. A place mainly providing Custodial, Educational, or Rehabilitative Care; or a facility mainly used for the treatment(s) of drug addicts or alcoholics.

19) **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.**

20) **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.

21) **Medical Practitioner** (Applicable to Global Cover) means a person who is qualified to practice medicine or is a Surgeon or an Anesthetist and has a valid license issued by the appropriate authority in the current City/Country of Treatment.

A Medical Practitioner shall not include a practitioner of Complementary and Alternative Medicine (CAM). CAM includes, but is not limited to the below areas of medicine:

- Traditional alternative medicine: like Acupuncture, Ayurveda, Homeopathy, Naturopathy, Chinese or Oriental medicine, Herbal medicine
- Manual manipulation: like Chiropractic and osteopathic medicine, Massage, Body movement therapies, Tai chi, Yoga
- Energy therapies: like Electromagnetic therapy, Magnetic Field Therapy, Reiki, Qigong, Therapeutic ("Healing") Touch
- Mind and Sensory healing: like Meditation, Biofeedback, Hypnosis, Art, dance and music, Visualisation and guided imagery
- The registered practitioner should not be the Policyholder/ Insured or their close family member.

22) **Medical Practitioner/Physician** (Applicable to India Cover) 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.

23) **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 characterised by sub normality of intelligence.

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

25) **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.

26) **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.

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

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

29) **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.

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

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

32) **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.**

33) **Preliminary Medical Certificate** means written approval, issued by the **Company** which includes confirmation of cover under the **Policy** prior to services being performed in the indicated Hospital, outside of India, for any treatment, services, supplies or prescription relating to a Claim.

34) **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.

35) **Place of Residence** means the city that the Insured is normally residing in currently, and declared it in the residential address of the Insured as stated in the **Policy Schedule.** The policy can be issued to Indian citizens residing in India. The policy is not available to NRIs, OCIs, PIOs or foreign nationals residing in India for employment.

36) **Qualified Nurse** means a person who holds a valid registration from the Nursing Council or equivalent authority in the city of treatment.

37) **Second Opinion** means an additional medical opinion obtained from a **Medical Practitioner** solely on the **Policyholder's** or **Insured Person's** express request.

38) **Sum Insured** means the maximum, total and cumulative liability of the **Company** to pay the claims made under the **Policy** in respect of the **Insured Person** (on Individual basis) or all Insured Persons together (on Floater basis) during the **Policy Year.** The Sum Insured shall be the total of the following and in this order:

i. For 3.1 Global Cover:
   a. Global Sum Insured

ii. For 3.2 India Cover (if opted):
   a. India Base Sum Insured
   b. Benefit 3.2.15 No Claim Bonus (if applicable)
   c. Benefit 3.2.16 Inflation Protection
   d. Benefit 3.2.17 Unlimited Reinstatement (if applicable)

39) **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.

40) **Specialist** means an allopathic Medical Practitioner with post graduate medical qualification in broad specialties of 3 year duration in case of degree course and 2 year duration in case of Diploma course after MBBS.

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

2.3 Specified Illnesses

For the purpose of this Policy, the Specified Illness shall mean the Illnesses, medical events or Surgical Procedures/Treatments as specifically defined below:

1) **Primary Treatment for Cancer**

Cancer means a malignant tumor characterised by the uncontrolled growth and spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

Primary Treatment for Cancer refers to treatment of Any newly diagnosed Cancer which is diagnosed to be at Stage II or above (as defined by AJCC cancer staging manual) and primary treatment of up to 2 confirmed relapses. Relapse will be preceded by a phase where Insured will be declared to be apparently free of disease which will be after Insured has completed standard protocol based treatment for that Cancer.

Primary treatment is defined as curative surgery and immediate chemo and radiotherapy.

The following are excluded:

a. Diagnostic procedures; preparatory pre surgical radio and chemotherapy; ongoing cycles of radio or chemo therapy and long term pain, and management taken in India.
b. All tumors which are histologically described as carcinoma in situ, benign, premalignant, 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.
c. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
d. Malignant melanoma that has not caused invasion beyond the epidermis;
e. 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
f. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below
g. Chronic lymphocytic leukaemia less than RAI stage 2
h. Lymphoma less than Ann Arbor stage 2.
i. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
j. 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;

2) **Neurosurgery (including Keyhole surgery)**

Neurosurgery (including Keyhole surgery refers to the actual undergoing of surgery to the brain or the spinal cord under general anesthesia for treatment of conditions resulting from illness or injury. This Policy covers Neurosurgery for following cases:

a. Brain tumors (benign or malignant)
b. Brain artery aneurysms

c. Brain arteriovenous malformations

d. Spinal cord tumors (benign or malignant)

The presence of the neurological condition must be confirmed by imaging studies such as CT scan, Magnetic Resonance Imaging (MRI), Computerised Tomography, or other reliable imaging techniques.

The condition must be confirmed by a medical practitioner holding relevant specialisation as exhibiting (or in the absence of the suggested neurosurgery, be expected to result in):

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days OR

ii. Significant and permanent functional neurological impairment with objective evidence of motor or sensory dysfunction that has persisted for a continuous period of at least 90 consecutive days

Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolisations, thrombolysis and stereotactic biopsy are all excluded.

Coverage shall not include Brain artery aneurysms and Brain arteriovenous malformations if they have already resulted in brain hemorrhage (IC Bleed).

3) **Organ Donor Transplant**

The actual undergoing of Surgical transplant of one of the following human organs: heart, lung, liver, kidney, pancreas from a living human donor due to irreversible end-stage failure of the organ.

The following are excluded:

a. Any transplant that involves Stem Cells treatment or Stem-cell transplants.

b. Procedures where only islets of langerhans are transplanted.

c. Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.

d. Any transplant when the transplant is conducted as a self-transplant.

e. Any transplant when the Insured is a donor for a third-party.

f. The transplant made possible by the purchase of required organs from a donor.

g. Any transplant and connected procedure(s) which does not fall under the scope of lawful transplantation as laid out under "The Transplantation Of Human Organs And Tissues Act (India), 1994" and amendments thereof, and under the relevant organ transplantation laws in the Country of Treatment.

4) **Coronary Artery Bypass Graft (CABG)Surgery**

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 CABG surgery must be determined by a cardiologist as being medically necessary.

The following are excluded:

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

b. CABG following or in connection to heart transplantation.

c. Diagnostic angiography or investigation procedures without subsequent CABG are excluded.

5) **Open Heart Valve Replacement or Repair**

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 realisation of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

6) **Bone Marrow Transplant**

Human Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured using haematopoietic stem cells originating from:

a. The Insured (Autologous bone marrow transplant); or

b. From a living compatible donor (allogeneic bone marrow transplant).

The following are excluded:

a. Other stem-cell transplants

b. Any transplant when the Insured is a donor for a third-party.

c. Any transplants from a deceased donor.

d. The transplant made possible by the purchase of required organs from a donor

e. Any transplant and connected procedure(s) which does not fall under the scope of lawful transplantation as laid out under "The Transplantation Of Human Organs And Tissues Act (India), 1994" and amendments thereof, and under the relevant organ transplantation laws in the Country of Treatment.

7) **Pulmonary Artery Graft Surgery**

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Pulmonary Artery through surgical opening of the chest or abdomen.

Pulmonary artery graft surgery benefit covers Surgery to the Pulmonary artery wherein part of it is removed and replaced with a graft.

8) **Aorta Graft Surgery**

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of Aorta shall mean the thoracic and abdominal aorta but not its branches.

The following are excluded:

a. Surgery performed using only minimally invasive or intra arterial techniques.

b. Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures.

Aorta graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

9) **Skin Grafting Surgery for Major Burns**

The actual undergoing of skin transplantation due to accidental major burns suffered during the Policy Period where major burns are as defined below.

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 standardised, clinically accepted, body surface area charts covering 20% of the body surface area.

10) **Joint Replacement / Reconstruction (Hip, Knee, Shoulder)**

The actual undergoing of Surgical Replacement or Reconstruction of the following joints. The Company covers Replacement / Reconstruction for following cases:

Knee:

a. Complete tears of Anterior cruciate ligament (ACL), posterior cruciate ligament (PCL), and medial collateral ligament (MCL)
b. Severe Arthritis, including rheumatoid, post-traumatic, psoriatic, and osteoarthritis
c. Osteonecrosis/Avascular bone necrosis (damages/death of bone tissue to lack of blood supply to joint)
d. Torn cartilage

Hip:

a. Hip Fractures/Trauma
b. Severe Arthritis, including rheumatoid, post-traumatic, psoriatic, and osteoarthritis
c. Osteonecrosis, a condition caused by inadequate blood supply to the ball of the hip joint

Shoulder:

a. Serious Shoulder injury like broken bone, fractures
b. Severe Arthritis
c. Complete rotator cuff tears
d. Osteonecrosis, a condition caused by inadequate blood supply to the bones of the shoulder joint

The following specific conditions are applicable:

a. Expenses related to Replacement/ Reconstruction of abovementioned joints shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy with the Company. However, the mentioned Waiting Period shall not be applicable where replacement or reconstruction is necessitated due to an Accident which has occurred during the Policy Period.
b. The replacement/reconstruction of joint should be medically necessary to restore the normal function of the body part.

The following are excluded:

a. Reconstruction or replacement following any failed prior knee/hip/shoulder surgery (including failed or re-torn rotator cuff repairs, recurrent dislocations after surgical shoulder stabilisation, etc.) except if claim for such prior treatment is approved under this Policy and the Policy is continuously renewed with the Company.
b. Occupational Hazard: Expenses incurred in connection with Illness or Injury resulting due to participation in one's occupation, including professional and semi-professional sports.

11) **Reconstructive Surgery**

The actual undergoing of Reconstructive surgery to restore the normal function of below mentioned reconstruction.

a. Breast Reconstruction: Applicable where female Insured Person has undergone mastectomy.
b. Facial Reconstruction: Covered where Insured has suffered from
   - Tumor, or
   - Chronic disease like temporomandibular joint (TMJ) with failed conservative treatment, or
   - Injury from an Accident occurred during the Policy Period which has resulted in damage to nerves, glands, muscles or bone, causing loss of function.
c. Trauma Reconstruction of the Limbs: Refers to surgical re-attachment of body parts and transfer of tissues to preserve life and limb. Covered only where the Insured has suffered bodily Injury from an Accident occurred during the Policy Period where bone and tendon are exposed.

The following specific conditions are applicable:

a. Limb shall include the following: hand, foot, leg above the ankle and the arm above the wrist.
b. The reconstruction is medically necessary to restore the normal function of the body part.
c. Any reconstruction using Limbs (or parts thereof) from a donor, whether deceased or live, shall be excluded.
d. Subject to terms and conditions, Reconstructive Surgery for Knee, Hip and Shoulder shall be covered under Section-3 Scope of Cover, sub point 10) of this Policy.

The following are excluded:

a. Breast Reconstruction where mastectomy was carried out
   - As preventive measure or
   - Outside of Policy Period or
   - Within waiting period
b. Reconstruction in connection with any Pre-Existing Disease
c. Any Infections (Deep tissue infections etc), Burns, nerve compression, paralysis ,arthritis , reconstruction due to wear and tear of joints or muscles, and congenital defects.
d. Occupational Hazard: Expenses incurred in connection with Illness or Injury resulting due to participation in one's occupation, including professional and semi-professional sports.

12) **Gene Therapy**

The actual undergoing of Treatment towards the following therapies:

Sr. No.	Illness	Drug or Treatment
1.	Large B-cell Lymphoma Lymphoma (blood cell cancer)	• BREYANZI by Juno Therapeutics, Inc. • KYMRIAH (tisagenlecleucel) by Novartis Pharmaceuticals Corporation • YESCARTA (axicabtagene ciloleucel) by Kite Pharma, Inc.
2.	Mantle cell Lymphoma (blood cell cancer)	• TECARTUS (brexucabtagene autoleucel) by Kite Pharma, Inc.
3.	Multiple myeloma (bone cancer)	• ABECMA (idecabtagene vicleucel) by Celgene Corporation • CARVYKTI (ciltacabtagene autoleucel) Janssen Biotech, Inc.

4.	Severe Hemophilia	• Roctavian by BioMarin
5.	Disorders affecting the hematopoietic (blood forming) system	• ALLOCORD (HPC, Cord Blood) by SSM Cardinal Glennon Children's Medical Center • CLEVECORD (HPC Cord Blood) by Cleveland Cord Blood Center • Ducord, HPC Cord Blood by Duke University School of Medicine • HEMACORD (HPC, cord blood) by New York Blood Center • HPC, Cord Blood by Clinimmune Labs, University of Colorado Cord Blood Bank • HPC, Cord Blood - Bloodworks by Bloodworks • HPC, Cord Blood - LifeSouth by LifeSouth Community Blood Centers, Inc. • HPC, Cord Blood - MD Anderson Cord Blood Bank by MD Anderson Cord Blood Bank
6.	Spinal Muscular Atrophy (genetic muscle condition):	• ZOLGENSMA (onasemnogene abeparvovec-xioi) by Novartis Gene Therapies, Inc.
7.	Biallelic RPE65 mutation associated Leber congenital amaurosis (vision)	• LUXTURNA by Spark Therapeutics, Inc.

The following specific conditions are applicable to Gene Therapy:

a. Patients who have received at least two other kinds of treatment regimens that have not worked or have stopped working are eligible for claim for Gene Therapy

b. The therapy shall be applicable for In-Patient Treatment only.

c. The coverage under Gene Therapy shall be limited to

- For Global Cover: 50% of Global Sum Insured or USD 5 lakhs (whichever is lower), with a Lifetime limit of 100% of Global Sum Insured.
- For India Cover: 50% of India Base Sum Insured with a Lifetime limit of 100% of India Base Sum Insured.

d. Expenses related to Gene Therapy shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with the **Company.**

e. The drug and treatment must have completed clinical trials and hold valid marketing approval/authorisation from the regulatory authority in the Country of Treatment. Treatment in the following countries is covered under this Policy: USA, UK, Germany, Switzerland, France. The List of covered Treatments under Gene Therapy shall be subject to revision basis changes in the approval status of the treatment in these countries. Treatment in other countries may be allowed by the Company on case-to-case basis.

Note: i. The **Company** may revise the list of covered drugs and therapies basis changes in authorisation status, and new therapies may be added in line with future approvals as appropriate. Please refer the Company website for the latest list of covered Gene Therapies.

ii. Performance-based payout: The **Company** reserves the right to negotiate to pay the claim (cost of treatment) in instalments conditional upon the patient's performance in the months following the treatment meeting certain criteria, as per terms agreed with the Hospital or drug provider before start of treatment.

SECTION-3 SCOPE OF COVER

The Company hereby agrees that the Reliance Health Global is subject to the terms, conditions and exclusions contained or expressed herein.

3.1 **Global Cover (Applicable outside India)**

If any of the **Insured Person** is diagnosed or suffers from an Illness or injury that requires **Medically Necessary In-Patient Treatment,** outside India during the **Policy Period,** then the **Company** shall indemnify the **Insured Person** for the following expenses incurred by the **Insured Person,** up to the **Global Sum Insured,** subject to the terms, conditions and exclusions mentioned under this **Policy.**

Specific Conditions related to Benefit- 3.1 Global Cover (Applicable outside India)

i. This benefit covers only treatment which is planned and scheduled in advance and taken outside India. Pre-requisite authorisation is must to be obtained from the **Company** or **Empaneled Service Provider**

ii. The symptoms of Illness first occur or manifest in India, within the **Policy Period** and after completion of 90 days from inception of the first **Policy** with the **Company.**

iii. The Illness must be diagnosed by a **Medical Practitioner** in India during the **Policy Year.**

iv. The benefit will be available only on Cashless basis and arranged with **Company's Empaneled Service Providers.** The **Company** may provide **Reimbursement** facility only on case-to-case basis.

v. The **Company** shall provide benefits 3.1.1 to 3.1.8 only on obtaining certification from the treating **Medical Practitioner** that the Insured is fit to travel.

Note: The list of the covered Illnesses and covers available shall be as specified under the Plans chosen by the Proposer and detailed in Section Annexure-I Coverage Summary.

3.1.1 **In-Patient Treatment**

The **Company** shall indemnify the **Insured Person** for the **Medical Expenses** incurred during the **Policy Year,** if the **Insured Person** undergoes **Hospitalisation** for **In-Patient Treatment** towards a covered **Illness or injury** on the written advice of a **Medical Practitioner.**

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

ii. **Room Rent**

iii. Nursing expense

iv. Intensive care Unit (ICU) charges,

v. Medical Practitioner(s) fees,

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

vii. Medicines, drugs and Consumables expenses

viii. Diagnostic procedures expenses

ix. The cost of prosthetic and other devices or equipment if implanted internally during a covered Surgical Procedure,

unless specifically excluded.

x. Transfer and Transportation by Road or Air Ambulances where their use is indicated and prescribed by the **Medical Practitioner** and pre-approved by the **Company** or **Company's Empaneled Service Provider.**

xi. For services provided to a living donor during the process of removal of an organ to be transplanted to the Insured, arising from:

a. The investigation procedure for the location of potential donors.

b. Hospital services provided to the donor, including accommodation in a Hospital room, ward or section, meals, general nursing services, regular services provided by Hospital staff, laboratory tests and use of equipment and other Hospital facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);

c. For Surgery and medical services for the removal of a donor's organ or tissue to be transplanted to the Insured.

For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the Insured. Cover will only be provided for expenses incurred from the date of issue of the Preliminary Medical Certificate.

3.1.2 **Pre and Post-Operative Day Care Treatment**

The **Company** shall indemnify the **Insured Person** for the **Medical Expenses** incurred during the **Policy Year,** if the **Insured Person** undergoes a pre or post-Operative **Day Care Treatment** in connection with the **In-Patient Treatment** approved by the **Company.**

3.1.3 **Pre-Hospitalisation**

The **Company** shall indemnify the **Insured Person** for the **Pre-Hospitalisation Medical Expenses** for consultations, investigations and prescription medicines incurred from the date of arrival in the **City of Treatment** upto 15 days or to the date of start of pre-approved **In-Patient Treatment** whichever is earlier.

3.1.4 **Post- Hospitalisation**

The **Company** shall indemnify the **Insured Person** for the **Post-Hospitalisation Medical Expenses** for consultations, investigations and prescription medicines incurred up to 30 days immediately after the **Insured Person** was discharged from Hospital after taking the **In-Patient Treatment**

3.1.5 **Rehabilitation**

The **Company** shall pay up to an amount as per the plan opted and specified in the **Policy Schedule** to the **Insured Person** towards In-patient Rehabilitation treatment Abroad, in connection with an **Injury** sustained during the **Policy Period,** that combines therapies such as physical, occupational and speech therapy provided that:

a) it is carried out by a **Medical Practitioner** specialised in rehabilitation; and

b) it is carried out in a licensed rehabilitation Hospital or unit;

c) it is scheduled in advance and taken outside India. Pre-requisite authorisation is must to be obtained from the **Company** or **Empaneled Service Provider**

d) The **Company** has accepted an Inpatient Hospitalisation claim under benefit 3.1.1 for the Insured under Inpatient Treatment and rehabilitation starts within 14 days of discharge from Hospital following acute medical and/or surgical treatment

e) The treatment could not be carried out on an out-patient basis.

3.1.6 **Travel Expenses**

The **Company** shall indemnify the **Insured Person** as per the plan opted towards the travel expenses incurred by the **Insured Person,** one accompanying Companion and the living donor (only in the case of transplant) for the treatment of **Insured Person,** provided that:

i. The sole reason for travel is receiving treatment for which the **Company** has accepted **In-Patient Hospitalisation** claim under Benefit 3.1.1 In-Patient Treatment

ii. This benefit covers the travel cost to the City of Treatment. This includes road or rail transportation from **Insured's Place of Residence** to the designated airport, Economy class air ticket to the city of treatment and onwards transportation from airport to the **Hospital** or the place of accommodation in the **City of Treatment.**

iii. This benefit also covers the travel cost of returning to **Insured's Place of Residence** in India. This includes the transportation from the **Hospital** or place of accommodation in the **City of Treatment** to the nearest Airport, Economy class air ticket to the **Insured's Place of Residence** and onwards transportation to **Insured's Place of Residence.** The **Company's Empaneled Service Provider** will provide the such expense for a return date based on the completion of the treatment and the certification from the treating **Medical Practitioner** that the Insured is fit to travel.

iv. In case the **Insured Person** requests to reschedule the travel dates towards which the **Company's Empaneled Service Provider** has already made the arrangements then the difference in travel cost and other related cost shall be borne by the Insured Person unless the changes have been necessary from the medical point of view and the **Company** has accepted the same. The benefit will be available on **Cashless** basis, unless otherwise agreed by the **Company** and shall be arranged by the **Company's Empaneled Service Provider**

3.1.7 **Accommodation Expenses**

The **Company** shall indemnify the **Insured Person** as per the plan opted towards the expenses incurred by the **Insured Person,** one accompanying Companion and the living donor (only in the case of transplant) on availing the accommodation in the **City of Treatment,** provided that:

i. The accommodation is availed in connection with receiving treatment for which the **Company** has accepted **In-Patient Hospitalisation** claim under Benefit 3.1.1 In-Patient Treatment

ii. The **Insured Person** or accompanying **Companion** and the living donor (only in the case of transplant) does not own a residence in the **City of Treatment.**

iii. The benefit will be available only on **Cashless basis,** unless otherwise agreed by the **Company** and shall be arranged by the **Company's Empaneled Service Provider**

iv. The **Company's Empaneled Service Provider** shall be responsible for deciding the accommodation booking dates based on the approved treatment schedule. These dates will be informed to the **Insured Person** to allow for sufficient time for the **Insured** to make all the necessary personal arrangements.

v. The **Company's Empaneled Service Provider** shall also provide an agreed return date based on the completion of the treatment and the certification from the treating **Medical Practitioner** that the Insured is fit to travel.

vi. In case the **Insured Person** requests to reschedule the travel dates towards which the **Company's Empaneled Service Provider** has already made the arrangements then cost of organizing and providing new accommodation arrangements and other related cost shall be borne by the **Insured Person** unless the changes have been necessary from the medical point of view and the **Company** has accepted the same.

vii. The **Company's Empaneled Service Provider** shall arrange upon request, a reasonable accommodation for the **Insured Person,** accompanying **Companion** and the living donor (only in the case of transplant) which will be limited to one double room or twin bedroom (or two rooms only in case where **Companion** and living donor both require accommodation) in a three or four-star hotel or any other alternative equivalent accommodation (Service apartment, guest house, house on rent by online marketplace). The choice of accommodation will be subject to availability and based on the proximity to the hospital or treating medical practitioner being within a radius of 10 km.

viii. The **Company's Empaneled Service Provider** shall take all due care while booking a reasonable accommodation, but the **Company** shall not be responsible for the quality of services or deficiency of services that may occur in particular accommodation. The accommodation shall be available for maximum 60 days or until the return date ascertained by the **Company's Empaneled Service Provider,** whichever is earlier.

ix. The expenses towards meals, laundry, toiletries, upgrades to the higher room or any other miscellaneous expenses or incidental costs shall not be covered under this benefit.

3.1.8 **Repatriation of Mortal Remains**

In the event of the death of the **Insured Person** while taking treatment **Abroad** during the **Policy Period,** the **Company** shall pay up to an amount specified in the **Policy Schedule** towards the cost of transporting the mortal remains of such **Insured Person** back to the Republic of India OR, up to an equivalent amount for a local burial or cremation in the **City of Treatment** where the death occurred, provided:

i. The **Company** has accepted **In-Patient Hospitalisation** claim under Benefit 3.1.1 In-Patient Treatment.

ii. Any miscellaneous expenses or incidental costs shall not be covered under this benefit.

3.1.9 **Second Opinion**

The Company shall arrange for a Second Medical opinion for the Insured Person through Company's or Empanelled Service Provider's panel of Medical Practitioner outside India (through digital mode) or in India (digital or physical mode), if the Insured Person, during the Policy Year is diagnosed with any of the listed Specified Illness in this Policy, provided that:

i. The benefit shall be provided on Cashless 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.

3.1.10 **Visa Charges and Documentation**

The Company shall indemnify the Insured Person as per the plan opted up to an amount specified in the Policy Schedule towards expenses incurred towards Visa application and processing fees.

The Company or Empanelled Service Provider shall also arrange to provide the information or details for a Visa Documentation of the Insured Person for overseas travel for the purpose of availing the treatment, which is pre-approved by the Company, during the Policy Year, provided that:

i. The Company's Empaneled Service Provider shall also provide the address, telephone number and hours of opening of the appropriate consulate and embassy worldwide, nearest to the Insured Person.

ii. The Company does not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country.

iii. The Company does not assume any liability towards any actual or alleged errors in the information provided by the Company or Empaneled Service Provider, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.

iv. Under this benefit, the Company is providing the Visa charges and information concerning visa documentation to the Insured Person and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Company's part.

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

3.1.11 **Assistance Services**

The Insured Person is entitled to avail the following assistance services as per plan opted, during the Policy Year provided that Company has accepted In-Patient Hospitalisation claim under Benefit 3.1.1 In-Patient Treatment. Insured Person can avail such services by contacting Empaneled Service Provider, details for which is specified on the Policy Schedule.

3.1.11.1 **Translation services**

The Company shall indemnify the Insured Person towards the translation services rendered by the Insured Person, during the Policy Year provided the sole reason to avail such service is to understand the line of treatment carried out abroad by the treating Medical Practitioner.

3.1.11.2 **Transmission of urgent messages**

The Empaneled Service Provider shall provide assistance to the Insured Person, towards the Transmission of urgent messages rendered by the Insured Person during the Policy

Year provided the Empaneled Service Provider will transmit urgent (personal) messages on behalf of or to an Insured Person in the event of an emergency during the Insured Person's travel Abroad.

3.1.11.3 **Lost Passport Assistance**

The Empaneled Service Provider shall provide assistance to the Insured Person, towards the loss of passport by the Insured Person during the Policy Year provided if an Insured Person lose his/her passport, the Empaneled Service Provider will help them make alternative arrangements.

3.1.11.4 **Consular Referral**

The Assistance Service Provider shall provide assistance to the Insured Person, towards the consular referral during the Policy Year provided wherever possible Empaneled Service Provider will provide an Insured Person with the details of the representative of the relevant consulate, government agencies that can help Insured with travel Emergencies.

3.1.11.5 **Arrangement of Radio Taxi or Chauffer services**

The Empaneled Service Provider shall provide assistance to the Insured Person towards the arrangement of Radio Taxi or Chauffer services during treatment Abroad during the Policy Year.

3.1.11.6 **Emergency cash assistance**

The Company shall provide an assistance service in case the Insured requires emergency cash, during a Policy Period arising out of the incidents like theft, burglary, robbery, mugging, dacoity, fraud Illness or Injury the Insured Person requires Emergency cash including Money transfer charges(if any), Empaneled Service Provider will advise the Insured representative on how to obtain additional funds.

For the purpose of this benefit, Emergency shall mean a situation wherein the Insured losses all or a substantial amount of his / her travel funds such that there is a detrimental effect on his / her travel plans. The onus of providing adequate proof of emergency in such case lies with the Insured.

Note to 3.1.11 Assistance Services:

i. It is entirely for the 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

ii. In case the Services are availed, the Insured Person will be required to provide the details as sought by the Empaneled Service Provider in order to establish authenticity and validity prior to availing such services.

iii. The onus of providing adequate proof of emergency in such case lies with the Insured.

iv. The Company assumes no responsibility for any advice or legal counsel given by the professional or attorney arranged by the Empaneled Service Provider

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 the translator or in any expert opinion or for any consequences of actions taken or not taken in reliance thereon.

3.2 **India Cover (Optional)**

3.2.1 **Hospitalisation Expenses**

If any of the Insured Person is diagnosed with any Illness or suffers any Injury that requires Hospitalisation, (including Hospitalisation 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.

ix. All consumable items, which are listed in Annexure A-List I, 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.

3.2.1.1 **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 Hospitalisation for In-Patient Treatment, on the written advice of a Medical Practitioner.

3.2.1.2 **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.

3.2.2 **Domestic Road Ambulance**

The Company shall indemnify the Policyholder/Insured Person up to the amount specified in the Policy Schedule, per Hospitalisation, 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 Hospitalisation claim under Benefit 3.2.1.1 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).

3.2.3 **Air Ambulance**

The Company shall indemnify the Policyholder/Insured Person up to 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 Hospitalisation claim under Benefit 3.2.1.1 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. Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.

3.2.4 **Domiciliary Hospitalisation**

The Company shall indemnify the Policyholder/Insured Person up to an amount specified in the Policy Schedule, for the Medical Expenses incurred for Domiciliary Hospitalisation 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

3.2.5 **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 Embolisation 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. Vaporisation 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 3.2.1, 3.2.4, 3.2.6, 3.2.7 and 3.2.8

3.2.6 **Pre-Hospitalisation**

The Company shall indemnify the Policyholder/Insured Person for the Medical Expenses incurred in the 90 days immediately before the Insured Person was Hospitalised, provided that:

i. Such Medical Expenses are incurred in respect of the same condition for which the Insured Person has taken Hospitalisation, and
ii. The Company has accepted the claim for these Hospitalisation expenses under any one of the following Benefits: 3.2.1, 3.2.4 and 3.2.5

3.2.7 **Post-Hospitalisation**

The Company shall indemnify the Policyholder/Insured Person for the Medical Expenses incurred in the 180 days (as specified in the Policy Schedule) immediately after the Insured Person was discharged post Hospitalisation, provided that:

i. Such costs are incurred in respect of the same condition for which the Insured Person has taken Hospitalisation, and
ii. The Company has accepted the claim for these Hospitalisation expenses under any one of the following Benefits: 3.2.1, 3.2.4 and 3.2.5

3.2.8 **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 Hospitalisation Claim under Benefit 3.2.1.1 In-Patient Treatment
iii. The Company shall not pay the donor's Pre and Post Hospitalisation Expenses
iv. 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).

3.2.9 **Rehabilitation**

The Company shall pay up to an amount specified in the

Policy Schedule to the Insured Person towards In-patient Rehabilitation treatment in India, in connection with an Injury sustained during the Policy Period, that combines therapies such as physical, occupational and speech therapy provided that:

a) It is carried out by a Medical Practitioner specialised in rehabilitation; and

b) It is carried out in a licensed rehabilitation Hospital or unit;

c) The Company has accepted an Inpatient Hospitalisation under benefit 3.2.1 claim for the Insured under In Patient Hospitalisation Treatment and rehabilitation starts within 14 days of discharge from Hospital following acute medical and/or surgical treatment

d) The treatment could not be carried out on an out-patient basis.

3.2.10 **Home Care Treatment**

The Company shall indemnify the Policyholder/Insured Person as per the plan opted 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

3.2.11 **Medical Equipment**

The Company shall pay the Reasonable and Customary expenses incurred by the Insured Person as per the plan opted up to limits specified in the Schedule, for procuring listed medical equipment or devices as medical aid, during the Policy Year.

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

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

This would be payable in the following cases:

Severe arthritis, foot or leg injury, nervous system injury, paralysis, a heart condition that makes it dangerous for the patient to strain to get in or out of bed. Any other condition that satisfies the Medical Practitioner's certification condition may be considered by the Company basis the merits of the case.

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

Provided that,

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

ii. This benefit shall be available through Company's Network Providers (For details refer Company's website:

www.reliancegenera.co.in). In case the listed equipment is not available with the Network Provider, the Company may admit a claim for purchase of listed equipment through non-network provider on pre-authorisation basis.

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

iv. Each item under Durable Medical Equipment can be claimed once per Policy in three continuous and consecutive Policy Years with the Company.

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

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

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

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

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

iii. Corrective splints (To support broken bone)

iv. Compression stockings

v. Cervical Collar

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

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

*Must be supported by Medical Prescription from Ophthalmologist

Provided that,

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

ii. Each item under Small Medical Equipment can be claimed once per Policy in three continuous and consecutive Policy Years with the Company.

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

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

3.2.12 **OPD Cover**

3.2.12.1 **Out-patient Treatment**

The Company will cover Reasonable and Customary charges incurred by the Insured Person as per the plan opted for the following up to the limits specified in the Coverage Summary/ Policy Schedule, during the Policy Year.

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

The benefit is subject to following:

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

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

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

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

v. Any unutilised OPD limit shall not be carried forward to next Policy Year.

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

vii. The benefit will be available only on Cashless basis and arranged with Company's Empaneled Service Providers/ Network Provider.

viii. The amount claimed under this Benefit is over and above the India Base Sum Insured

ix. Out-patient Dental Treatment expenses shall not be covered

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

xi. Any medical equipment such as spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt shall not be covered under this benefit.

xii. The Company shall not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner (including Diagnostics and Pharmacy services).

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

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

3.2.12.2 **Physiotherapy Benefit**

The Company shall pay expenses incurred towards professional physiotherapy sessions prescribed by the treating Medical Practitioner taken on Outpatient basis for Illness/Injury contracted during the Policy Period, maximum up to the limit specified in the Policy Schedule, provided that,

i. Such costs are incurred in respect of the same injury for which the Insured Person has taken Hospitalisation, and

ii. The treatment should be carried out by a registered physiotherapist in a Hospital or a clinic as defined under the Policy

iii. The Company has accepted the claim for these Hospitalisation expenses under any one of the following Benefits- 3.2.1.1 In-Patient Treatment or 3.2.1.2 Day Care Treatment

iv. A maximum of twelve sessions of physiotherapy with a registered Physiotherapist shall be covered, up to the limit specified in the Policy Schedule.

3.2.12.3 **Dental Cover**

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

i. Dental Consultation:

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

ii. Dental Treatment/Surgery:

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

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

iii. Periodontics

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

Exclusions:

i. Dental surgery under Dental Cover does not cover surgical treatment that relates to dental implants.

ii. Dental Prostheses, dental implants, orthodontics are not covered under Dental Cover.

iii. Expenses related to the Dental cover within 30 days from the first Policy year shall not be payable

3.2.13 **Health Check Up**

At the end of every two Policy Years, the Company shall provide expenses for the listed diagnostic or preventive medical tests with respect to the Insured Persons as per the plan opted 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 10000.

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 India Base Sum Insured, No Claim Bonus and Inflation Protection 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

3.2.14 **Second Opinion**

The Company shall arrange for a Second Medical opinion for the Insured Person through Company's or Empanelled Service Provider's panel of Medical Practitioner in India, if the Insured Person, during the Policy Year is diagnosed with any of the listed Specified Illness opted in this Policy, provided that:

i. The benefit shall be provided on Cashless 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 up to amount specified in the Policy Schedule.

3.2.15 **No Claim Bonus**

The Company shall provide 25% of the India Base Sum Insured as No Claim 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 No Claim Bonus, including the one credited under Portability if any, shall not exceed 100% of the of India Base Sum Insured available in this renewed Policy.

ii. The No Claim 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 India Base Sum Insured.

iii. In relation to a Floater, the No Claim Bonus, shall be available on Floater basis. The No Claim 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 No Claim 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 No Claim 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 No Claim Bonus.

vi. If the Policyholder opts to reduce the India Base Sum Insured at the time of Renewal, the applicable No Claim Bonus shall be reduced in the same proportion to the India 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 No Claim Bonus awarded basis the expiring Policy Year shall be withdrawn.

viii. Entire No Claim Bonus will be lost if Policy is not continued / renewed on or before expiry of Grace Period.

ix. No Claim 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 No Claim Bonus shall be decreased by 25% of the India Base Sum Insured in the subsequent year. However, the reduction in No Claim Bonus shall not reduce the India Base Sum Insured.

xi. No Claim Bonus shall decrease to the extent (in-part or whole) of No Claim Bonus amount utilised for settlement of claim.

xii. The accrued No Claim Bonus will be carried forward to the renewed Policy.

xiii. For a claim to be admissible under No Claim Bonus it should be admissible under the Benefit 3.2.1 Hospitalisation Covers.

3.2.16 **Inflation Protection**

The Company shall provide 8% of the India Base Sum Insured as Inflation Protection at the end of each completed and continuous Policy Year. This benefit is subject to the following:

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

ii. The Inflation Protection 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 India Base Sum Insured.

iii. In relation to a Floater, the Inflation Protection, shall be available on Floater basis. The Inflation Protection which accrued during Policy Year will only be available to those Insured Person(s) who were insured in 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 Inflation Protection 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 Inflation Protection 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 Inflation Protection.

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

vii. Entire Inflation Protection will be lost if Policy is not continued / renewed on or before expiry of Grace Period.

viii. Inflation Protection shall be applicable on an annual basis subject to continuation of the Policy.

ix. The accrued, unutilised portion of the Inflation Protection will be carried forward to the renewed Policy.

x. For a claim to be admissible under Inflation Protection it should be admissible under the Benefit 3.2.1 Hospitalisation Covers.

3.2.17 **Unlimited Reinstatement**

The Company shall reinstate the India 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 India Base Sum Insured shall be reinstated to full extent immediately after settlement of a claim under Benefit-3.2.1 Hospitalisation Covers and such reinstated part shall become part of Reinstated Sum Insured

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

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

b. Unlimited utilisation 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 utilised only after the India Base Sum Insured, Inflation Protection, No Claim Bonus (if applicable) and Inflation Protection 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 India Base Sum Insured

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

viii. While calculating No Claim Bonus, Unlimited Re-instatement of India Base Sum Insured shall not be considered.

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

x. Under the Policy, this benefit can be utilised in following sequence:

a. India Base Sum Insured

b. No Claim Bonus (if applicable)

c. Inflation Protection

d. Unlimited Reinstatement (if applicable)

3.2.18 **Assistance Services**

The Insured Person is entitled for following assistance services, during the Policy Year. Insured Person can avail such services by contacting Empaneled Service Provider, details for which are specified on the Policy Schedule.

3.2.18.1 **Tele-consultation**

The Insured Person shall have the option of seeking medical advice from a Medical Practitioner through the telephonic or online mode.

3.2.18.2 **Booking of health checkups**

The Assistance Service Provider shall provide assistance to the Insured Person towards the booking of health checkups at home during the Policy Year.

3.2.18.3 **Arrangement of Nurse at home**

The Assistance Service Provider shall provide assistance to the Insured Person towards the arrangement of nurse at home during the Policy Year.

3.2.18.4 **Emergency helpline**

Insured Person can dial dedicated Emergency helpline number mentioned in company's website for various information towards emergency services like nearest hospital, clinic, diagnostic center, blood bank, ambulance etc.

Note: i. It is entirely for the 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

ii. In case the Services are availed, the Insured Person will be required to provide the details as sought by the Empaneled Service Provider in order to establish authenticity and validity prior to availing such services.

iii. The onus of providing adequate proof of emergency in such case lies with the Insured.

iv. The Company assumes no responsibility for any advice or legal counsel given by the professional or attorney arranged by the Empaneled Service Provider

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 the translator or in any expert opinion or for any consequences of actions taken or not taken in reliance thereon.

3.3 **Optional Covers**

3.3.1 **Waiver of Co-Payment**

Under this option, the Company shall waive off the Co-Payment condition mentioned in Clause-6.13 Co-Payment. Such waiver, if allowed,

- shall be expressly mentioned in the Policy Schedule
- shall not be applicable to 3.2.12.4 Dental Cover

3.3.2 **Voluntary Co-Payment**

Under this option, the Company shall provide a discount in the premium, if the Policyholder opts a Co-payment under the Policy. The agreed limits of Co-Payment shall be expressly mentioned in the Policy Schedule. This benefit is subject to following:

i. Co-Payment shall be applicable on each and every claim admissible and payable under the Policy.

ii. Voluntary Co-Payment shall be applicable over and above the Co-Payment specified in Clause 6.9 of this document

iii. The Co-Payment shall be applicable to all the covers mentioned under Global and India Cover (if opted), however shall not be applicable on Benefit no: 3.1.11 "Assistance Services" and 3.2.18 "Assistance Services".

3.3.3 **Change in Pre-Existing Waiting Period**

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

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 Disease Waiting Period (Code:Excl01)**

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

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

iii. If 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 a Pre-Existing Disease subject to the same being declared at the time of application and accepted by the Company.

4.1.2. **Specific waiting period (Code:Excl02)**

i. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months (as specified below) of continuous coverage after the date of inception of the first Policy with the Company. This exclusion shall not be applicable for

claims arising due to an Accident.

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

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

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

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

vi. List of specific diseases/procedures in respect of which waiting period (24 months) is imposed is mentioned below:

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

vii. List of specific diseases/procedures in respect of which waiting period of 24/ 36 months is imposed is mentioned below:

Treatments as described under Scope of Cover	**Specific Waiting Period**
Joint Replacement / Reconstruction (Hip, Knee, Shoulder) (for India Cover if opted)	24 months
Joint Replacement / Reconstruction (Hip, Knee, Shoulder) (for Global Cover)	36 months
Gene Therapy	36 months

4.1.3. **Investigation & Evaluation (Code: Excl04)**

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

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

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

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

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

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

4.1.5. **Obesity/ Weight Control (Code: Excl06):**

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

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

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

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

v. 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:

vi. Obesity-related cardiomyopathy

vii. Coronary heart disease

viii. Severe Sleep Apnea

ix. Uncontrolled Type2 Diabetes

4.1.6. **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.

4.1.7. **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.

4.1.8. **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.

4.1.9. **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.

4.1.10. **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. (For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

4.1.11. **Substance Abuse and Alcohol (Code: Excl12):**

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

4.1.12. **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.

4.1.13. **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 hospitalisation claim or day care procedure.

4.1.14. **Refractive Error (Code: Excl 15):**

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

4.1.15. **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.

4.1.16. **Sterility and Infertility (Code: Excl17)**

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilisation

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

iii. Gestational Surrogacy

iv. Reversal of sterilisation

4.1.17. **Maternity Expenses (Code - Excl 18)**

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) 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 (Applicable-to both 3.1 Global Cover and 3.2 India Cover)**

4.2.1. **Organ Donor Expenses:** Any expenses related to Organ Donor in relation to harvesting of an Organ, except where specifically mentioned as covered under this Policy.

4.2.2. **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

4.2.3. **Gene Therapy:** Any type of Gene Therapy except to the extent specifically covered under Specified Illnesses, sub-point 12 of this Policy.

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, except to the extent specified under 3.2.11 Medical Equipment.

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. **Outpatient Treatment:** Treatment which has been done on an outpatient basis except to the extent covered under 3.2.12 OPD Cover

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

4.2.11. **Documentation charges:** Any charges incurred to procure any medical certificate, treatment/Illness related documents

pertaining to any period of Hospitalisation/Illness.

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

4.2.13. **Convalescence or Rehabilitation:** Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition") basis except to the extent covered under Benefit -3.1.5 "Rehabilitation" and 3.2.9 "Rehabilitation"

4.2.14. **Dental Treatments:** Dental Treatments of any kind, unless requiring Hospitalisation necessitated due to illness or injury, or except to the extent covered under Benefit- 3.2.12 "OPD Cover", subject to the conditions contained therein.

4.2.15. **Unprescribed Drugs or treatments:** Any drugs or treatments which are not supported by a prescription.

4.2.16. **Hormonal therapies**

i. Growth hormonal therapy

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

4.2.17. Peritoneal dialysis: Charges related to peritoneal dialysis, including supplies.

4.2.18. Non-Medically Necessary Treatment: Any treatment or part of a treatment that is not Medically Necessary Treatment

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

4.2.20. Treatment by a family member: Treatment rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

4.2.21. Vaccination and immunisation: Vaccination including inoculation and immunisation, except in case of post-bite treatment

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

4.2.23. 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 synthesised toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.2.24. **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. **Specific Exclusions (Applicable to 3.1 Global Cover)**

4.3.1. **Initial 90 days Waiting Period:**

i. Expenses related to the treatment of any Illness within 90 days from 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 apply if the Insured Person has continuous coverage for more than twelve months.

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

4.3.2. **Alternative Treatments**

Alternative Treatment or any other non-allopathic treatment

4.3.3. **Countries outside Geographical Scope:** Any treatment outside of the geographical scope specified as being covered in the Policy Schedule.

4.3.4. Non-payable items: Expenses against items mentioned in "Annexure A- List I" shall not be payable.

4.3.5. Sanction Clause: Any Claim or benefit hereunder to the extent that the provision of such cover, payment of such Claim, or provision of such benefit would expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of India, the European Union, United Kingdom or United States of America.

4.3.6. **Treatment taken in India:** Treatment received in India.

4.4. **Specific Exclusions (Applicable to 3.2 India Cover)**

4.4.1. **Initial 30 days Waiting Period:**

i. Expenses related to the treatment of any Illness within 30 days from 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 apply if the Insured Person has continuous coverage for more than twelve months.

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

4.4.2. Medical supplies: Medical supplies including elastic stockings, diabetic test strips, and similar products, except to the extent covered under Benefit- 3.2.11 "Medical Equipment", subject to the conditions contained therein.

4.4.3. Prosthetic and other devices: Prosthetic and other devices which are self-detachable/ removable without surgery involving anaesthesia. This exclusion shall not apply to the extent covered under the Benefit- 3.2.11 "Medical Equipment", subject to the conditions contained therein.

4.4.4. Treatment taken Abroad: Treatment received outside India.

4.4.5. 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.

4.5. **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 Period as detailed below:

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

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

Calculation of Pro-Rata refund:

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

For e.g. If Policy Premium for 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. **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. Coverage is not available during the grace period, except in case where the premium is paid in instalment

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

5.1.9. **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 No Claim Bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

5.1.10. **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.

5.1.11. **Premium Payment in Instalments (wherever applicable)**

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Lumpsum, 3 EMIs (Equated Monthly instalments) , 6 EMIs or 9 EMIs, as mentioned in the Policy Schedule, 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.

5.1.12. **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.

5.1.13. **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;

5.1.14. **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.

5.1.15. **Redressal of Grievances**

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

Website: www. Relianceada.com

Dedicated Senior Citizen helpline: 022-33834185 (paid)

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, Winway Building 2nd and 3rd Floor, 11/12 Block No - 4, Old No - 67, South Tukoganj, Indore (M.P) - 452001. Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

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@relianceada.com

(For updated details of grievance officer, kindly refer the link. https://reliancegeneral.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.gov. in/

5.1.16. **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)

5.1.17. **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 30 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).

5.2. **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 6.1above 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 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.

5.2.8. **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 authorised 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.

5.2.9. **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

5.2.10. **Geography**

This Policy is applicable solely to an Insured Person who is an Indian citizen residing in India as per applicable Indian law. In the event of a change in this status, the same should be informed to the Company and the Company shall cancel the Policy with refund of premium paid for the remaining Policy Period according to the scale mentioned in 5.1.7 Cancellation provided that no claims have been made.

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 realisation 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 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:

6.2. **Claims Intimation**

In the event of occurrence or discovery of an Illness or Injury which has resulted in a Claim or may result in a Claim covered under the Policy, the Policyholder/ Insured Person, must notify the Company or Empaneled Service Provider immediately.

The following details are to be provided to the Empaneled Service Provider/Company at the time of intimation of Claim:

i. Policy Number

ii. Name of the Policyholder

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

iv. Nature of Illness/Injury and the treatment or Surgery required

v. Name and address of the attending Medical Practitioner and Hospital

vi. On diagnosis of an Illness or Injury, the Insured Person must submit following documents

a. First Consultation from treating Medical Practitioner in India

b. Final Diagnosis Paper

c. All investigation reports supporting documents.

d. Consent Form to collect documents from various source.

e. Any other relevant documents to ascertain eligibility of claim.

6.3. **Claims Procedure (Applicable to 3.1 Global Cover)**

i. **Cashless:**

Cashless facility is available only at a Network Hospital/ Empaneled Services Provider

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

a. Pre-authorisation for Planned Treatment

1. On the basis of documents submitted and Insured Person's medical condition the Empaneled Service Provider will identify 3 Hospitals from their network abroad with relevant specialisations. The Insured Person may choose one of the Hospitals/ treatments centres out of the 3 choices given by the Empaneled Service Provider.
2. Medical Reports and all other information are shared with the chosen Hospital/ Treatment Centre
3. After the receipt of all medical information, a detailed Medical Opinion from the selected Hospital/treatment centre would be delivered to Insured at the earliest.
4. Once satisfied, the Insured Person must notify the Company of the willingness to take the treatment abroad.
5. On receipt of the Insured Person's confirmation of his/her decision to receive treatment abroad and after receipt of Visa the Company/Empaneled Service Provider will organize the necessary logistical, travel, accommodation and medical arrangements for the correct admission of the Insured Person and will issue a Preliminary Medical Certificate valid only for that Hospital.

6. Once the treatment is completed, Empaneled Service Provider will arrange the travel back to India.

Note: a. The Company will provide coverage only in the indicated Hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one specified in the Preliminary Medical Certificate will not be covered.

b. Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.

c. In the event that the Insured Person does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate, the Company on the request of Insured shall reinitiate the process of Pre-Authorisation for Planned Treatment based on the health condition of the Insured Person at that time.

d. The entire claim procedure is on Cashless basis as this Policy is meant to cover Planned Treatment outside India and does not cover emergencies occurring while the Insured is overseas.

e. Under Cashless facility, the Empaneled Service Provider/ 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 Empaneled Service Provider / Company. In such cases, the Empaneled Service Provider /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.

f. 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 Hospitals with the Empaneled Service Providers or with the Company.

ii. **Re-imbursement:**

In case of any Claim under the Benefits 3.1.3, 3.1.4, 3.1.10, 3.1.11 where Cashless facility is not availed, the list of documents as mentioned in Clause -6.8 Claim Documents (Applicable to 3.1 Global Cover) shall be provided by the Insured Person, immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

6.4. **Claims Procedure (Applicable to 3.2 India Cover)**

i. **Cashless:**

Cashless facility is available only at a Network Hospital and shall be available for Benefits-3.2.1 (Hospitalisation Expenses) and 3.2.5 (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-authorisation: Prior to Hospitalisation, the Policyholder/ Insured Person must call the call center of the TPA/Company and request authorisation by way of submission of a completed Pre-authorisation form at least 48 hours before a planned Hospitalisation and in case of an Emergency situation, within 24 hours of Hospitalisation.

b. The TPA/Company will process the Policyholder's/ Insured Person's request for authorisation after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalisation is sought by the Policyholder/ Insured Person and the Company will confirm such Cashless authorisation / 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 authorised, the Policyholder/ Insured Person will not be required to pay for the Hospitalisation Expenses which are covered under this Policy and fall within the Company's liability (within the authorised 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 Hospitalisation 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 Hospitalisation 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 Hospitalisation 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 6.9: 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 6.9: Claim Documents (Applicable to 3.2 India

Cover) 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-3.2.4 Domiciliary Hospitalisation, Benefit-3.2.7 Post Hospitalisation and Benefit-3.2.10 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-3.2.4 Domiciliary Hospitalisation "not later than 15 days of completion of Domiciliary Hospitalisation "

b. Benefit-3.2.7 Post Hospitalisation "not later than 15 days of completion of Post hospitalisation period "

c. Benefit-3.2.10 Home Care Treatment ""not later than 15 days of completion of Home Care Treatment.

6.5. **Exceptions to provision of Services**

The Company shall strive to provide all the above-listed services in the best possible manner. However, in the exceptional unforeseen circumstance where the Company is unable to book or provide services falling under the Scope of Cover within the specified timelines due to either unavailability or inaccessibility of the service, the Company shall, on a case-to-case basis, allow one or more of the following:

i. Provide alternative treatment option OR

ii. Provide the next-best available service (e.g. in case of Travel or Accommodation) OR

iii. Allow the Policyholder to avail the insured services on their own accord and provide reimbursement for the same, within the limits of the Policy.

To qualify as an exception, the Insured must have informed the Company or the Empaneled Service Providers in writing and obtained an authorisation, prior to availing external service and must provide necessary documents justifying the event and the actual costs to be incurred.

6.6. **Responsibility of Policyholder/ Insured Person**

i. Forthwith intimate / file / submit a Claim in accordance with Clause 6.2 of this Policy.

ii. If so requested by the Empaneled Service Provider/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 Hospitalisation the TPA/ Company's website or call centre 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 Hospitalisation 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.

6.7. **Steps to be taken if Insured Person is not Responding to the treatment (applicable to 3.1 Global Cover)**

In the event that the Insured Person is not responding to the treatment, Empaneled Service Provider will notify the Company and once it is medically justified to look at options regarding the Insured Person, Empaneled Service Provider will coordinate all aspects of the repatriation, together with authorisation from the Company.

i. Should the Insured Person be fit to fly and able to travel back to India, but not on their own, the options will be explored which is the best medically justified means of travel -

- On a commercial airline with a medical escort - determined again in the severity of the Insured Person's condition - a nurse escort, a doctor and nurse escort, etc.
- On a stretcher on a commercial airline (which are limited in availability)
- On an Air Ambulance equipped to manage the requirements of the Insured Person.

ii. Should the Insured Person be on life support with no chance of recovery, with the recommendations of the treating doctor a meeting with the Company, Empaneled Service Provider and Companion are required urgently to weigh up options, which include switching off the equipment/keeping the Insured Person alive or looking at other options to get the Insured Person back to the Place of Residence in India.

Should the decision be to switch off the equipment, then full authority from the Companion is required. Empaneled Service Provider will coordinate all the logistics, including the Repatriation of the Mortal Remains, whether the Companion elect to have the remains cremated in the City of Treatment, then have the ashes repatriated, or should the option be to repatriate the actual remains to the Insured Person's Place of Residence in India. These decisions will be made together with Companion and Empaneled Service Provider.

The charges for any of the mentioned above will be covered in the Policy under the Global Sum Insured.

6.8. **Claim Documents (Applicable to Global Cover)**

The Policyholder / Insured Person shall submit to the Empaneled Service Provider /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		
	Hospitalisation Cover: • In-Patient Treatment • Pre and Post-Operative Day Care Treatment • Pre& Post Hospitalisation • Rehabilitation	i. Duly completed and signed Claim Form, in original ii. Certificate from the treating Medical Practitioner that the Insured is fit to travel. iii. Photo ID & Age Proof. iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner v. Original invoices of implant stickers for all implants used during surgeries

	• Travel Expenses • Accommodation Expenses • Repatriation of Mortal Remains • Second Opinion • Visa Documentation • Assistance Services	vi. Original bills from pharmacy / chemist vii. Original pathological / imaging/ diagnostic test reports and payment receipts vii. Original pathological / imaging/ diagnostic test reports and payment receipts viii. Indoor case papers ix. Ambulance receipt and bill x. First Information Report/ Final Police Report, if applicable xi. Postmortem report, if available xii. All previous consultation papers indicating history and treatment details for current ailment. xiii. Copy of Death Summary and copy of Death Certificate (in death claims only). xiv. A valid ticket / proof of travel (such as Airline boarding pass) to the location the Insured Person is traveling as a bona fide passenger xv. Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided (if applicable) xvi. Copy of Visa xvii. Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation. xviii. Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided(if applicable) xix. Documentary proof for expenses incurred towards disposal of the mortal remains(if applicable) xx. Translator Service 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.

6.9. **Claim Documents (Applicable to India Cover)**

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 - 3.2	**Hospitalisation Cover:** Hospitalisation Expenses, Domestic Road Ambulance, Air Ambulance, Domiciliary Hospitalisation, Modern Treatment, Pre and Post Hospitalisation, Organ Donor Expenses, Rehabilitation, Home Care Treatment, Medical Equipment, OPD Cover, Health Check up, Second Opinion	i. Duly completed and signed Claim Form, in original ii. Medical Practitioner's referral letter advising Hospitalisation 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 xi. Health Check up bills and Receipts

6.10. **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 Hospitalisation 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 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 Hospitalisation Medical Expenses as mentioned in Benefit-3.1.1 Hospitalisation Expenses or 3.2.1 Hospitalisation 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 Limit	Rent 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 Co-pay	
G	=	Ground up claim amount	-
	(-)	Deductions for Policy Deductibles and Limits*	-
H	=	Payable claim amount	-

*The Final Claim amount for 3.2 India Cover would be deducted, in the following progressive order, from:

i. India Base Sum Insured (If India Cover opted)
ii. Benefit 3.2.15 No Claim Bonus (if applicable)
iii. Benefit 3.2.16 Inflation Protection
iv. Benefit 3.2.17 Unlimited Reinstatement (if 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.

6.11. **Payment Terms (Applicable to Global Cover)**

i. The payments under this Policy shall be made in USD. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts settled in other currency into USD for calculation of claim payments under this Policy. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.
ii. Claims shall not be admissible under this Policy unless the Company's Empaneled Service Provider/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 Hospitalisation of less than 24 hours.
iv. The claims payable under all benefits are limited to Global Sum Insured, defined under this Policy.
v. The Global 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 Global Sum Insured for the unexpired Policy Year.
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 or to the Legal Heir 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.

6.12. **Payment Terms (Applicable to India Cover)**

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 Hospitalisation of less than 24 hours except for the Day Care Treatment
iv. The claims payable under all benefits are limited to India Base Sum Insured, defined under this Policy.
v. The India Base 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 India Sum Insured for the unexpired Policy Year. This clause shall not be applicable to the Benefit 3.2.17 Unlimited Reinstatement

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.

6.13. **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 be applicable to all the covers mentioned under Global and India Cover (if opted), however shall not be applicable on Benefit no: 3.1.11 "Assistance Services" and 3.2.18 "Assistance Services".

ANNEXURE-I COVERAGE SUMMARY

Coverage Summary for Global Cover (Applicable outside India)

Coverage Basis	Individual Basis and Floater Basis				
Global Sum Insured (USD per annum)	1.5 Lakh	2.5 Lakh	5 Lakh	7.5 Lakh	10 Lakh
Lifetime limit	2 times of Annual Sum Insured				
Plans	**Elite**	**Elite+**	**Royal**	**Royal+**	
Scope of Cover	For Specific Illness/Treatment listed below		All Illnesses Including Specified Illnesses		

Specific Illness/Treatment	Sub-limits
Cancer Treatment	None
Coronary Artery by-pass Surgery (CABG)	None
Heart Valve Replacement or Repair	None
Neurosurgery	None
Donor Organ Transplant Bone Marrow Transplant	None
Aorta Graft Surgery	None
Pulmonary Artery Graft Surgery	None
Skin Grafting Surgery for Major Burns	None
Joint Replacement / Reconstruction (Hip, Knee, Shoulder)	None
Reconstructive Surgery	None
Gene Therapy	50% of Sum Insured or USD 5 lakhs (whichever is lower), Lifetime limit: 100% of Global SI

(For Gene Therapy: Sublimit of 50% of Global SI, Lifetime limit: 100% of Global SI)

Benefit no.	Cover Name	Limits	Elite	Elite+	Royal	Royal+
3.1.1	In-Patient Treatment Including ambulance and organ donor expenses	Up to the S.I	✓	✓	✓	✓
3.1.2	Pre and Post-Operative Day Care Treatment	Within S.I	✓	✓	✓	✓
3.1.3	Pre-Hospitalisation	From the date of arrival in the City of Treatment up to 15 days or to the date of start of pre-approved In-Patient Treatment whichever is earlier. (Within S.I)	✓	✓	✓	✓
3.1.4	Post-Hospitalisation	30 days, (Within S.I)	✓	✓	✓	✓
3.1.5	Rehabilitation (Accident only)	USD 2300, Within S.I		✓		✓
3.1.6	Travel Expenses	For Worldwide including US/Canada: Up to USD 7000 total (for insured, companion and living donor) For Worldwide excluding US/Canada: Up to USD 3500 total (for insured, companion and living donor) (Within S.I)		✓		✓
3.1.7	Accommodation Expenses	For Worldwide including US/ Canada: Up to USD 350 per day For Worldwide excluding US/ Canada: Up to USD 250 per day; Within S.I, max up to 60 days		✓		✓
3.1.8	Repatriation of Mortal Remains	Up to USD 15000, Within S.I	✓	✓	✓	✓
3.1.9	Second Opinion	Within S.I	✓	✓	✓	✓
3.1.10	Visa Charges and Documentation	Within S.I		✓		✓
3.1.11	Assistance Services • Translation services • Transmission of urgent messages • Lost Passport Assistance • Consular Referral • Arrangement of Radio Taxi or Chauffer services • Emergency cash assistance	No Limit		✓		✓

The maximum liability of the Company towards all claims under the Policy put together shall be limited to the Sum Insured.

Coverage Summary for India Cover (Optional)					
India Base Sum Insured corresponding to Global Sum Insured:					
Global Sum Insured (USD per annum)	1.5 Lakh	2.5 Lakh	5 Lakh	7.5 Lakh	10 Lakh
India Base Sum Insured (INR per annum)	1.5 Cr.	2.5 Cr.	4.5 Cr.	6.5 Cr.	Unlimited*
India Scope of Cover: All Illnesses Including Specified Illnesses (For Gene Therapy: Sublimit of 50% of India Base Sum Insured, Lifetime limit: 100% of India Base Sum Insured)					

*Floater option shall not be available where Unlimited India Base Sum Insured is Opted

Benefit no.	Cover Name	Limits	India – Basic	India - Comprehensive
3.2.1	In-Patient Treatment (incl. Consumables)	Up to SI, Actuals (Any Room category)	✓	✓
3.2.2	Day Care Treatment (incl. Consumables)	Within S.I, Actuals (Any Room category)	✓	✓
3.2.3	Domestic Road Ambulance	Within S.I	✓	✓

Reliance Health Global. UIN No.: IRDAN103RP0001V01202324.

3.2.4	Air Ambulance	Within S.I	✓	✓
3.2.5	Domiciliary Hospitalisation	Within S.I	✓	✓
3.2.6	Modern Treatment	Within S.I	✓	✓
3.2.7	Pre-Hospitalisation	90 Days, Within S.I	✓	✓
3.2.8	Post-Hospitalisation	180 Days, Within S.I	✓	✓
3.2.9	Organ Donor Expenses	Within S.I	✓	✓
3.2.10	Rehabilitation	INR 50,000, Within S.I		✓
3.2.11	Home Care Treatment (with round the clock, doctor visit)	INR 25 lakhs, max 15 days in a policy year (Within S.I)		✓
3.2.12	Medical Equipment • Durable Medical Equipment (wheel chairs, CPM machine, Oxygen concentrators, patient lifts, artificial limbs, etc.) • Small Medical Equipment (spectacles, medical splints, cervical collar, Nebulizer etc.)	DME: INR 5 lakhs SME: INR 2 lakhs; (Within S.I)		✓
3.2.13	OPD for • Generalist consultation, specialist consultation, prescribed diagnostic test and pharmacy • Physiotherapy Benefit • Dental Cover	INR 50000		✓
3.2.14	Health Check-Up	Up to INR 10000, every 2 years, starting at the beginning of year 2.		✓
3.2.15	Second Opinion	INR 5000, Within S.I	✓	✓
3.2.16	No Claim Bonus*	25% increase in India Base Sum Insured for every claim free Policy Year, max up to 100% of India Base Sum Insured and 25% decrease for every claim year	✓	✓
3.2.17	Inflation Protection*	8% increase in India Base Sum Insured at the end of each Policy Year, max up to 100% of India Base Sum, irrespective of claim made in a particular year.	✓	✓
3.2.18	Unlimited Reinstatement*	On subsequent claim, Unlimited reinstatement of India Base Sum Insured on related or unrelated illness or injury.	✓	✓
3.2.19	Assistance Services • Tele-consultation • Booking of health checkups • Arrangement of Nurse at home • Emergency helpline	No Limit	✓	✓

*Not applicable for unlimited India Base Sum Insured

OPTIONAL COVERS* (Applicable outside Global and India)		
3.3.1	Waiver 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
3.3.2	Voluntary Co-payment	10%/20% on the Assessed Claim Amount
3.3.3	Change in Pre-Existing Waiting Period	This benefit changes the Pre-Existing Waiting Period from 36 months to 12, 24 months
*Additional premium or discounts shall apply		

Reliance Health Global. UIN No.: IRDAN103RP0001V01202324.

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	NEBULIZER 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

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

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

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

THE CONTACT DETAILS OF INSURANCE OMBUDSMAN OFFICES ARE AS BELOW

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 IRDA 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 **Policy** in the case where such Diseases 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, Unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
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 (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(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 Osteonecrosis

16.	**Cystic Fibrosis of the Lungs**	E84.0 Cystic fibrosis with pulmonary manifestations
17.	**Bronchopulmonary dysplasia**	P27 Chronic respiratory disease originating in the perinatal period, Q33 Congenital malformations of lung
18.	**Chronic lower respiratory diseases**	J40-J47 Chronic lower respiratory diseases
19.	**Pulmonary heart disease including pulmonary hypertension**	I27 Other pulmonary heart diseases
20.	**Lymphangioleiomyomatosis**	J84.81 lymphangioleiomyomatosis
21.	**Chronic total occlusion of coronary artery**	I25. 82 Chronic total occlusion of coronary artery
22.	**Rheumatoid arthritis**	M05 Rheumatoid arthritis with rheumatoid factor, M06 Other Rheumatoid arthritis, M08 Juvenile rheumatoid arthritis, M45 rheumatoid arthritis of spine
23.	**Recurrent dislocation, Joint derangements**	M22.0 Recurrent dislocation of patella, M22.1 Recurrent subluxation of patella, M23 Internal derangement of knee, M24.3 Pathological dislocation and subluxation of joint, not elsewhere classified, M24.4 Recurrent dislocation of joint, M43.3 Recurrent atlantoaxial dislocation with myelopathy, M43.4 Other recurrent atlantoaxial dislocation, M43.5 Other recurrent vertebral dislocation
24.	**Spinal Muscular Atrophy**	G12 Spinal muscular atrophy and related syndromes
25.	**Biallelic RPE65 mutation, Leber congenital amaurosis**	H35.5 Hereditary retinal dystrophy