RELIANCE HEALTH GAIN POLICY - PROSPECTUS

1. Eligibility Criteria

i. Policy can be availed by persons between the age of 18 years and 65 years, as Proposer, except for Sum Insured 3 lacs where there is no restriction on maximum entry age. Dependent children (i.e. naturally or legally adopted and financially dependent on the Proposer) can be covered from 91 days to 25 years of age.

ii. Policy can be availed for self and the following family members

a. Legally wedded spouse

b. Parents and Parents-in-law

c. Brothers, Sisters, Grand Parents, Grand Children, Daughter in law and Son-in-law

d. Dependent Children (i.e. natural or legally adopted) between the age of 3 months to 25 years.

Note:

- Brothers, Sisters, Grand Parents, Grand Children, Daughter in law and Son-in-law are allowed to be covered only in an Individual Policy on Individual S.I basis.
- If the child above 18 years of age is financially independent, the child will be ported to an Individual Policy having a separate Sum Insured and treated as an 'Adult'

iii. Age means "Age as on last birthday" as on the date of first Policy issuance or at renewal. If any age changes during proposal stage, then "age" at submission of proposal from would be considered for premium calculation.

iv. This Policy can be issued to an individual and/or a family.

v. There is no maximum cover ceasing age on continuous renewals.

vi. **Individual Policy:** A maximum of 8 member can be covered in a single individual policy on individual sum insured basis. The family includes, Self, Spouse, Son, Daughter, Father, Mother, Father-in-law, Mother-in-law, Brothers, Sisters, Grand Parents, Grand Children, Daughter in law and Son-in-law.

vii. **Floater Policy**: In case of Family Floater, one family will share a single Sum Insured as per Plan opted.

Plus: A maximum of 8 members can be covered in a single-family floater policy with a maximum of 2 Adults (Self+ Spouse) and 6 children.

Power:A maximum of 10 members can be covered in a single-family floater policy with a maximum of 4 Adults (Self+ Spouse + one set of dependent Parents or Parents in law) and 6 children

Prime: A maximum of 12 members can be covered in a single-family floater policy with a maximum of 6 Adults (Self+ Spouse + set of dependent Parents +set of Parents in law) and 6 children.

2. Policy Plans and Sum Insured

The Product offers 3 plans: Plan Plus, Plan Power and Plan Prime

All the plans offer different Sum Insured Options which are mentioned below.

	Plus	Power	Prime
New Business Base Sum Insured (in lakhs)	3, 5	10, 15, 20	25, 30, 50, 100
Renewal Business/ Call Option Base Sum Insured (in lakhs)	3, 5, 6, 9	10, 12, 15, 18 ,20,24	25, 30, 36,40,48,50,60,72,80,100

3. Policy Period

The Policy can be purchased for 1 year, 2 years or 3 years.

4. Coverages

4.1 Hospitalization Covers

4.1.1 Hospitalization Expenses

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

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

i. Room Rent
ii. Nursing expense
iii. Intensive care Unit (ICU) charges,
iv. Medical Practitioner(s) fees,
v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances expenses,
vi. Medicines, drugs and Consumables expenses
vii. Diagnostic procedures expenses
viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure, unless specifically excluded.

4.1.1.1 In-Patient Treatment

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

4.1.1.2 Day Care Treatment

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

4.1.1.3 Accommodation Bonus

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

i. Plan Plus & Power: Twin sharing Room or below
ii. Plan Prime: Single Private Air Conditioned Room or below

Provided that:

i. The above mentioned fixed daily amount shall be payable for each continuous and completed 24 hours of such Hospitalization
ii. The daily amount mentioned above shall not be payable for the number of completed days the Insured Person is admitted into an ICU Room.
iii. If the Policyholder has opted Benefit - 4.7.3 Change in Room Rent Limits under this Policy, then daily amount mentioned above shall not be payable for the category of Room selected under optional Benefit - 4.7.3 Change in Room Rent Limits
iv. The **Company** has accepted the claim under Benefit - 4.1.1.1. In-Patient Treatment

4.1.2 Domestic Road Ambulance

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

i. Company has accepted the In-Patient Hospitalization claim under Benefit 4.1.1.1 In Patient Treatment.
ii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital in case of an emergency Life Threatening Medical condition, or from one Hospital to another Hospital which is prepared to admit the Insured Person and provide the necessary medical services.
iii. Such Life threatening Medical Condition is certified by the Medical Practitioner
iv. The transportation from one Hospital to another Hospital has been prescribed by a Medical Practitioner and is medically necessary.
v. The coverage is extended to provide upto an amount specified in the Policy Schedule for intercity transportation (beyond 100km in distance) 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 has been prescribed by a Medical Practitioner and is medically necessary.

4.1.3 Domiciliary Hospitalization

The Company shall indemnify the Policyholder/Insured Personup to an amount specified in the Policy Schedule,for the Medical Expenses incurred for Domiciliary Hospitalization during the Policy Year, provided that the conditionfor 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. Diarrhoea 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

xii. Arthritis, Gout and Rheumatism.

4.1.4 Modern Treatment

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

i. Uterine Artery Embolization and HIFU

ii. Balloon Sinuplasty

iii. Deep Brain Stimulation

iv. Oral Chemotherapy

v. Immunotherapy-Monoclonal Antibody to be given as injection

vi. Intra Vitreal injections

vii. Robotic surgeries

viii. Stereotactic radio surgeries

ix. BronchicalThermoplasty

x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)

xi. IONM- (Intra Operative Neutro Monitoring)

xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Benefits 4.1.1, 4.1.3, 4.1.5, 4.1.6 and 4.1.7

4.1.5 Pre-Hospitalization

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

i. Such Medical Expenses are incurred in respect of the same condition for which the Insured Person has taken Hospitalization, and

ii. The Company has accepted the claim for these Hospitalization expenses under any one of the following 4.1.1, 4.1.3, 4.1.4

4.1.6 Post-Hospitalization

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

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

ii. The Company has accepted the claim for these Hospitalization expenses under any one of the following sections: 4.1.1, 4.1.3, 4.1.4

4.1.7 Organ Donor Expenses

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

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

ii. The Company has accepted In-Patient Hospitalization Claim under Benefit 4.1.1.1 In Patient Treatment.

iii. The Company shall not pay the donor's Pre and Post Hospitalization Expenses

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

4.2 Extra Cover

4.2.1 Reinstatement of Base Sum Insured

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

i. For a claim to be admissible under Re-instated Sum Insured it should be admissible under the Sections 4.1 Hospitalization Covers

ii. The limits of claims in aggregate under Re-instated Sum Insured during a Policy Year shall be as per follows:

a. Up to 100% of Base Sum Insured

- For subsequent claims for unrelated illness or injury.;

b. Upto 20% of Base Sum Insured

- For subsequent claim which has arisen out of or is a consequence of or its related to or is a complication of an illness/injury for which a claim has already been admitted under the current or any previous Policy in relation to an Insured Person

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

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

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

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

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

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

4.2.2 Extra Sum Insured

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

i. For a claim to be admissible under this benefit it should be admissible under the Section- 4.1 Hospitalization Covers

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

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

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

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

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

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

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

4.3 Personal Accident Cover

4.3.1 Accidental Death Cover

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

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

Exclusions applicable to Benefit - 4.3.1 Accidental Death Cover

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

i. Any pre-existing injury or physical condition

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

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

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

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

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

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

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

ix. Results from pregnancy or child-birth

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

4.4 Critical Illness Cover

4.4.1 Waiver of Premium

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

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

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

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

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

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

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

i. **Cancer of specified severity**

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

The following are excluded —

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

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

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

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

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

f. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

i. All tumors in the presence of HIV infection.

ii. **Open chest Coronary Artery Bypass Graft (CABG)**

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

The following are excluded:

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

iii. **Stroke resulting in permanent symptoms**

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

The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

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

iv. **Multiple Sclerosis with persisting symptoms**

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

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

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

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

4.5 Renewal Benefits

4.5.1 Cumulative Bonus

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

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

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

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

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

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

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

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

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

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

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

xi. Cumulative Bonus shall decrease to the extent(in-part or whole) of Cumulative Bonus amount utilized for settlement of claim.

xii. The accrued Cumulative Bonus will be carried forward to the renewed Policy. This shall apply even if the Policyholder avails the Benefit -4.5.2 (Call Option for Enhancement of Base Sum Insured)

xiii. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit 4.1 Hospitalization Covers.

4.5.2 Call Option for Enhancement of Base Sum Insured

At the end of four consecutive and continuous Policy Years, if no claim has been made under Benefit - 4.1 - Hospitalization Covers and Benefit - 4.4 Critical Illness Cover in respect of any of the Insured Persons in the Policy, the Company shall provide the Policyholder, the Call option for enhancement of Base Sum Insured by an amount equal to the accumulated Cumulative Bonus. If the Policyholder chooses to exercise this option, and make appropriate payment for such option, the Base Sum Insured of the renewed Policy shall be the sum total of:

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

This is subject to the following:

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

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

iii. The call option shall cease to be available:

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

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

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

v. Under a Floater Policy the Call option shall be available only if all the Insured Person(s) who are to be insured under the enhanced Base Sum Insured were also continuously covered in the immediate preceding 4 Policy Years, and had no claim under any of the benefits listed in Benefit -4.1-Hospitalization Covers and Benefit -4.4 Critical Illness Cover during this period and continue to be insured under the subsequent Policy Year. However, if a new member is to be added at the time of renewal, the Company may cover that particular member under the renewed Policy subject to receipt of appropriate premium, underwriting and applicability of Waiting Periods as defined under clause 5.1.1, 5.1.2 & 5.1.3 and 5.2.1 of the Policy.

vi. Under an Individual Policy the Call option shall be available only if the Insured Person(s) who is to be insured under the enhanced Base Sum Insured was also continuously covered in the immediate preceding 4 Policy Years and had no claim under any of the benefits listed in Benefit - 4.1 - Hospitalization Covers and Benefit - 4.4 Critical Illness Cover during this period and continues to be insured in the subsequent Policy Year.

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

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

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

x. If the Policyholder chooses to forgo this option then the same would be available at time of next renewal, provided that the Policy was in force for four consecutive and continuous years immediately preceding such renewal and no claim has been made under Benefit 4.1 Hospitalization Covers and Benefit - 4.4 Critical Illness Cover during this period.

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

xii. On exercising of the Call option, Insured Person will be offered continuity of coverage to the extent of the full amount of the enhanced Sum Insured, in terms of Waiting Period with respect to Pre-Existing Diseases and time bound exclusions as specified in Section-5 of this Policy.

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

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

4.5.3 Loyalty Cover

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

Year-wise availability of Sum Insured for Loyalty Cover ('Earned' Loyalty Cover Sum Insured)				
Policy Year	**Accidental Death and Permanent Total Disability**	**Critical Illness**	**Hospital Cash**	**Leave Compensation Benefit**
Year 2	10% of Base Sum Insured			
Year 3	20% of Base Sum Insured	10% of Base Sum Insured		
Year 4	30% of Base Sum Insured	20% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	
Year 5	40% of Base Sum Insured	30% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Rs. 1000 per day
Year 6	50% of Base Sum Insured	40% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Rs. 1000 per day
Year 7 onward	50% of Base Sum Insured	50% of Base Sum Insured	Daily Cash amount (Plan wise) of: Plus: Rs. 1000, Power: Rs. 2000, Prime: Rs. 3000	Rs. 1000 per day
Maximum limit	50% of Base Sum Insured or 25 lakhs, whichever is lower	50% of Base Sum Insured or 25 lakhs, whichever is lower	30 days of payment	30 days of payment

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

4.5.3.1 Accidental Death

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

4.5.3.2 Permanent Total Disability

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

I. The total and irrecoverable loss of:

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

OR

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

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

Conditions applicable to Accidental Death and Permanent Total Disability

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

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

iii. The Exclusions applicable to Benefit-4.3.1 Accidental Death Cover shall also be applicable on Benefit-4.5.3.1 Accidental Death and Benefit-4.5.3.2 Permanent Total Disability benefits.

4.5.3.3 Critical Illness

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

i. The Critical Illness has been diagnosed for the first time

ii. Such diagnosis is made during the Policy Year

iii. The Insured Person survives the 30 days Survival Period

iv. This benefit is claimable once in the lifetime of the Policyholder

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

"Critical Illness" means disease / illness / surgery limited to the following and as defined under Section 4.4 Critical Illness Cover:

a. Cancer of specified severity

b. Open chest Coronary Artery Bypass Graft (CABG)

c. Stroke resulting in permanent symptoms

d. Multiple Sclerosis with persisting symptoms

4.5.3.4 Hospital Cash

i. **In-Patient Cash**

If the Company has accepted and paid a claim under Benefit-4.1.1.1 In-Patient Treatment, then the Company shall pay the Policyholder an amount equal to the Daily Cash amount specified in the Policy Schedule per day of Hospitalization, provided,

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

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

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

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

ii. **ICU Cash**

If the Company has accepted and paid a claim under Benefit-4.1.1.1 In-Patient Treatment where the Policyholder is admitted in an Intensive Care Unit (ICU) of a Hospital on the written advice of a Medical Practitioner, then the Company shall pay the Policyholder additional 100% of Daily Cash amount as specified in the Policy Schedule per day of ICU Hospitalization provided,

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

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

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

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

4.5.3.5 Leave Compensation Benefit

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

i. The Company has accepted the claim under Benefit - 4.1.1.1 In-Patient Treatment

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

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

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

Exclusions related to Leave Compensation Benefit

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

Conditions Applicable to Benefit 4.5.3 - Loyalty Cover

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

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

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

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

4.6 Value Added Covers

4.6.1 Wellness Services

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

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

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

Specific Conditions applicable to this Benefit:

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

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

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

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

4.6.2 Claim Service Guarantee

i. **Cashless Intimation**

If the Insured Person notifies a request for Cashless facility for Benefit 4.1.1 Hospitalization Expenses as per Section-6.1, along with

complete set of documents & information then the Company will respond within 6 business hours of receipt of such information with either

a. Approval; or
b. Rejection; or
c. Query seeking further information.

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

a) For delay beyond 6 business hours and up to 12 hours– 1% of Delayed Claim Amount. For delay beyond 12 hours additional 1% for every additional delay of 6 business hours. The total liability under this clause shall be subject to a maximum of 6% of Delayed Claim Amount.

ii. **Reimbursement Intimation**

The Company shall process the Claimfor Benefit 4.1.1 Hospitalization Expenses within 21 days of the actual receipt of complete information and all documents as specified in Section 7 ("Claims Intimation, Assessment and Management")

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

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

Specific Conditions applicable to this benefit

- Delayed Claim Amount for the purposes of this benefit shall mean the minimum of authorization request amount, authorization amount issued, final claim amount or balance Sum Insured.
- The Company shall not be liable to pay under above mentioned point i) and ii) in case of any force majeure, natural event or manmade disturbances which impedes the Company's ability to make a decision or to communicate such decision to the Policyholder/Insured Person.
- Any amount paid under i) and ii) will not affect the Base Sum Insured as specified in the Policy Schedule. The Company's maximum liability to make payment under this benefit shall not exceed the amount specified in above point i) and ii)
- The payment under this benefit is over and above that payable under Standard General Terms and Clauses, Clause-8Claim Settlement (provision for Penal Interest).

4.6.3 Policy Service Guarantee

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

4.7 Optional Covers

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

4.7.1 Enhanced Covers

4.7.1.1 Guaranteed Cumulative Bonus

This cover is an extension to Benefit no-4.5.1 Cumulative Bonus. The Company shall provide 33.33 % (one third) of the Base Sum Insured at the end of each completed and continuous Policy Year, provided that no Claim has been made in the expiring Policy Year.

All the conditions and provisions stated under Benefit no-4.5.1 Cumulative Bonus shall also be applicable on this benefit,except for clause ix which shall stand modified as below:

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

4.7.1.2 Unlimited Reinstatement of Base Sum Insured

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

i. The Base Sum Insured shall be reinstated to full extent immediately after settlement of a claim under Benefit-4.1 Hospitalization Covers and such reinstated part shall become part of Reinstated Sum Insured

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

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

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

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

completely exhausted.

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

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

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

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

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

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

x. This benefit supersedes the existing Benefit no - 4.2.1 Reinstatement of Base Sum Insured.

4.7.1.3 Consumable Cover

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

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

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

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

4.7.2 Double Cover

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

i. The benefit shall be available only if the Company has accepted the claim under Benefit - 4.1 Hospitalization Covers.

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

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

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

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

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

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

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

ix. This benefit supersedes the existing Benefit no-4.2.2 Extra Sum Insured

4.7.3 Change in Room Rent Limits

Under this option, the Policyholder shall be allowed to opt the Room Rent category (as specified in the Coverage Summary) for hospitalizations allowable under Section 4 of this Policy, if so requested by the Policyholder and explicitly accepted by the Company. The agreed Room Rent category shall be expressly mentioned in the Policy Schedule.

4.7.4 Reduction in Pre-Existing Waiting Period

Under this option, the Company shall reduce the 36 months Waiting Period for Pre-Existing Diseases as mentioned in Clause 5.1.1, to 24 or 12 months (as opted). Such reduction, if allowed, shall be expressly mentioned in the Policy Schedule.

4.7.5 Voluntary Aggregate Deductible

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

The Benefit is subject to following:

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

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

iii. The annual Aggregate Deductible shall not be applicable on Benefit - 4.1.1.3 - Accomodation Bonus, Benefit - 4.3.1 Accidental Death Cover, Benefit - 4.4.1 - Waiver of Premium, Benefit 4.5.3 Loyalty Cover, Benefit - 4.6.1 Wellness Services, Benefit 4.7.7 Hospital Cash (if opted), Benefit - 4.7.8.4 Convalescence Cover, Benefit - 4.7.9.1 Health Check Up, Benefit - 4.7.9.2 Vaccination Cover, Benefit - 4.7.11.2 Companion Cover, Benefit-4.7.11.3 Child Care Cover

4.7.6 Removal of Co-Payment

Under this option, the Company shall waive off the Co-Payment condition mentioned in Clause 21 - Co-Payment. Such waiver, if allowed, shall be expressly mentioned in the Policy Schedule.

4.7.7 Hospital Cash

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

4.7.7.1 In-Patient Cash

If the Company has accepted and paid a claim under Benefit-4.1.1.1 In-Patient Treatment, then the Company shall pay the Insured Person an amount equal to the Daily Cash amount specified in the Policy Schedule per day of Hospitalization, provided,

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

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

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

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

4.7.7.3 ICU Cash

If the Company has accepted and paid a claim under Benefit-4.1.1.1 In-Patient Treatment where the Insured Person is admitted in an Intensive Care Unit (ICU) of a Hospital on the written advice of a Medical Practitioner, then the Company shall pay the Insured Person additional 100% of Daily Cash amount as specified in the Policy Schedule per day of ICU Hospitalization provided,

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

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

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

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

4.7.8 Convenience Cover

4.7.8.1 Change in Pre-Post Hospitalization limit

Under this benefit, the Policyholder shall be allowed to change the coverage period for Benefit 4.1.5 Pre-Hospitalization to 90 days, and that for Benefit 4.1.6 Post-Hospitalization to 180 days, if so requested by the Policyholder and explicitly accepted by the Company. The agreed Pre-Hospitalization and Post-Hospitalization limits shall be expressly mentioned in the Policy Schedule.

4.7.8.2 Air Ambulance

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

i. The Company has accepted the In-Patient Hospitalization claim under Benefit 4.1.1.1 In Patient Treatment.

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

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

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

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

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

vii. Such Air Ambulance should have been duly licensed to operate as such by the Competent Authorities of the Government.

4.7.8.3 Radio Taxi

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

i. The Company has accepted the Hospitalization claim under Benefit- 4.1.1.Hospitalization Expenses

ii. The coverage includes the cost of the transportation of the Insured Person for whom claim has been accepted under Benefit-4.1.1. Hospitalization Expenses to the nearest Hospital and/or from Hospital to home.

4.7.8.4 Convalescence Cover

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

i. The Company has accepted In-Patient Hospitalization Claim under Benefit- 4.1.1.1 In Patient Treatment.

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

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

iv. The payment under this benefit will be over and above the payment made under Benefit-4.1.1.1 In-Patient Treatment

4.7.9 Preventive Care Cover

4.7.9.1 Health Check Up

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

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

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

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

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

v. The benefit shall be available on Cashless basis and arranged with Company's Empanelled Service Providers. Where the test(s) cannot be arranged with an Empanelled 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

4.7.9.2 Vaccination Cover

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

i. The total amount payable under this benefit in a given Policy Year shall be limited to the amount specified in the Policy Schedule.

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

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

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

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

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

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

List of vaccines covered:

- Diphtheria,Tetanus, Pertussis
- Varicella Vaccine
- Combined Measles, Mumps and Rubella (MMR)Vaccine
- Influenza
- Pneumonia

- Typhoid
- Hepatitis B
- Hepatitis A
- Haemophiles influenzae type b Vaccine (Hib)
- Human Papillomavirus Vaccine (HPV)
- Anti-Rabies

4.7.10 Smart Covers

4.7.10.1 Change in Modern Treatment Limits

Under this benefit, the Policyholder shall be allowed to change the coverage limit under Plan-Plus and Power for Benefit 4.1.4 Modern Treatment from 50% of Base Sum Insured to 100% of Base Sum Insured and if so requested by the Policy holder and explicitly accepted by the Company. The agreed coverage limit for Modern Treatment shall be expressly mentioned in the Policy Schedule.

4.7.10.2 Vision Correction

The Company shall indemnify the Policyholder/Insured Person up to an amount specified in the Policy Schedule for the Medical Expensesincurred during the Policy Year, for undergoing medically necessary treatment under Benefit 4.1.1 Hospitalization Expenses for correction of eyesight due to refractive error on the written advice of the Medical Practitioner, provided that:

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

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

iii. The Company has accepted claim under Benefit 4.1.1Hospitalization Expenses.

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

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

vi. This benefit waives the Standard Exclusion clause no-6.1.12 Refractive Error (Code: Excl 15) to the extent mentioned under point (i) above.

4.7.10.3 Second Opinion

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

i. The benefit shall be provided on reimbursement basis.

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

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

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

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

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

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

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

i. **Cancer of specified severity**

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

b. The following are excluded —

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

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

ii. **Open Heart Replacement or Repair of Heart Valves**

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

iii. **Major Organ /Bone Marrow Transplant**

a. The actual undergoing of a transplant of:

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

b. The following are excluded:

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

iv. **Coma of specified severity**

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

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

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

v. **Surgery of Aorta**

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

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

vi. **Benign Brain Tumor**

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

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

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

c. The following conditions are excluded:

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

vii. **Kidney Failure Requiring Regular Dialysis**

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

viii. **End Stage Lung Failure**

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

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

ix. **End Stage Liver Failure**

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

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

x. **Stroke resulting in permanent symptoms**

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

b. The following are excluded:

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

Vascular disease affecting only the eye or optic nerve or vestibular

xi. **Permanent Paralysis of Limbs**

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

xii. **Multiple Sclerosis with persisting symptoms**

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

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

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

xiii. **Blindness**

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

b. The Blindness is evidenced by:

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

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

xiv. **Third Degree Burns**

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

xv. **Bacterial Meningitis**

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

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

Bacterial Meningitis in the presence of HIV infection is excluded.

4.7.11 Family Care Cover

4.7.11.1 Home Care Treatment

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

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

ii. The benefit can be availed onreimbursement 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

4.7.11.2 Companion Cover

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

i. The Company has accepted In-Patient Hospitalization Claim under Benefit 4.1.1.1 In Patient Treatment.

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

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

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

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

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

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

viii. The Company has accepted In-Patient Hospitalization Claim under Benefit 4.1.1.1 In Patient Treatment.

4.7.11.3 Child Care Cover

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

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

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

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

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

v. The Company has accepted In-Patient Hospitalization Claim under Benefit 4.1.1.1 In Patient Treatment.

vi. The amount payable under this benefit shall be over and above the amount payable under Benefit 4.1.1.1 In Patient Treatment

5. Waiting Period

5.1 Pre-Existing Diseases (Code- Excl 01)

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

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

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

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

5.2 Specific Waiting Period (Code- Excl 02)

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

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

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

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

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

24 months waiting period:

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

Eye	• Cataract • Retinal detachment • Glaucoma	• Surgery for correction of eye sight due to refractive error above dioptre 7.5(otherwise • -6/+6 dioptre if Optional Benefit-4.7.10 Smart Covers has been opted under the Policy)
Others	• Congenital internal disease	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/ organs whether or not described above)	• Benign tumors of non-infectious etiology Such as cysts, nodules, polyps, lumps or growth.	• Nil

5.3 First Thirty Days Waiting Period (Code- Excl 03)

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

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

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

5.4 15 Days Waiting Period for Covid-19

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

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

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

5.5 24 months Waiting Period for Vision Correction

i. Any Expenses related to the treatment of Vision Correction within 24 months from the first Policy commencement date shall be excluded.

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

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

6. Exclusions

6.1 Standard 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, except to the extent specifically mentioned as covered under Section 4 of this document:

6.1.1 Investigation & Evaluation (Code: Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes

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

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

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

a. 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.

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

6.1.3 Obesity/ Weight Control (Code:Excl06):

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

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

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

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

d. Body Mass Index (BMI);

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

o Obesity-related cardiomyopathy

- o Coronary heart disease
- o Severe Sleep Apnea
- o Uncontrolled Type 2 Diabetes

6.1.4 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

6.1.5 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

6.1.6 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.

6.1.7 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

6.1.8 Excluded Providers (Code: Excl 11):

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

6.1.9 Substance Abuse and Alcohol (Code: Excl12):

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

6.1.10 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.

6.1.11 Dietary Supplements & Substances (Code: Excl14):

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

6.1.12 Refractive Error (Code: Excl 15):

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

6.1.13 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.

6.1.14 Sterility and Infertility (Code: Excl 17):

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

6.1.15 Maternity Expenses (Code - Excl 18)

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

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

6.2 Specific Exclusions

6.2.1 **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

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

6.2.3 **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.

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

6.2.5 **External Congenital Anomaly**:Treatment of External Congenital Anomaly.

6.2.6 **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.

6.2.7 **Non-payable items**: Expenses against items mentioned in "Annexure A- List I"shall not be payable. This exclusion shall be waived off, if Optional Benefit-4.7.1.3"Consumable Cover" has been opted under the Policy.

6.2.8 **Outpatient Treatment**: Treatment which has been done on an outpatient basis without anyassociated Hospitalization, unless specified otherwise.

6.2.9 **Overseas Treatment**:Treatment received outside India.

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

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

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

6.2.13 **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.

6.2.14 **Nuclear Attack**:Nuclear, Chemical or Biological attack/ weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this Clause

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

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

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

6.2.15 **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.

7. Claims Intimation, Assessment and Management

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

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

7.1 Claims Intimation

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

- Planned Hospitalization,the Policyholder /Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization, the Policyholder /Insured Person will intimate such admission within 24 hours of such admission.

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

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

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

vi. Date of Admissionto Hospitalor proposed date of admission to Hospital for Planned Hospitalization

vii. Any other information as requested by the Company

7.2 Claims Procedure

i. **Cashless:**

Cashless facility is available only at a Network Hospitaland shall be available for Benefits - 4.1.1 (Hospitalization Expenses) and 4.1.4

(Modern Treatment), unless specified otherwise. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

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

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

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

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

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

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

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

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 7.4: Claim Documents, with the Network Hospital.

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

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

ii. **Re-imbursement:**

In case of any Claim under the Benefits, where Cashless facility is not availed, the list of documents as mentioned in Clause 7.4: Claim Documents shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

Note - For reimbursement claim under Benefit - 4.1.3 Domiciliary Hospitalization, Benefit - 4.1.6 Post Hospitalization and Benefit - 4.7.11.1 Home Care Treatment above mentioned condition of "not later than 15 days of discharge from the Hospital" shall stands modified as under:

a. Benefit - 4.1.3 Domiciliary Hospitalization "not later than 15 days of completion of Domiciliary Hospitalization"

b. Benefit - 4.1.6 Post Hospitalization "not later than 15 days of completion of Post hospitalization period"

c. Benefit - 4.7.11.1 Home Care Treatment "not later than 15 days of completion of Home Care Treatment.

7.3 Responsibility of Policyholder/ Insured Person

i. Forthwith intimate / file / submit a Claim in accordance with Clause 7.1 of this Policy.

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

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

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

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

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

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

7.4 Claim Documents

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

Benefit No.	Covers	List of Claim Documents
Benefit-4.1	**Hospitalization Cover**: Hospitalization Expenses, Domestic Road Ambulance, Domiciliary Hospitalization, Modern Treatment, Pre and Post Hospitalization, Organ Donor Expenses	i. Duly completed and signed Claim Form, in original ii. Medical Practitioner's referral letter advising Hospitalization iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner v. Original bills from pharmacy / chemists vi. Original pathological / diagnostic test reports and payment receipts vii. Indoor case papers viii. Ambulance receipt and bill ix. First Information Report/ Final Police Report, if applicable x. Post mortem report, if available
Benefit -4.2	**Extra Cover**: Reinstatement of Base Sum Insured and Extra Sum Insured	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.3	**Personal Accident Cover**: Accidental Death Cover	i. Duly completed and signed Claim Form, in original ii. Death certificate(In case of Death Claim) iii. Disability Certificate(In case of Disability Claim) iv. Post mortem report if available and applicable v.First Information Report/ Final Police Report, if applicable vi.Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased. vii. Any other document as required by the Company to assess the Claim
Benefit -4.4	**Critical Illness Cover**: Waiver of Premium	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.5	**Renewal Benefits**: Cumulative Bonus, Call Option for Enhancement of Base Sum Insured and Loyalty Cover	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required ii. Documents as mentioned for Benefit: 4.3(Personal Accident Cover) iii. Income proof with break-up specifying basic salary
Benefit -4.6	**Value Added Covers**: Wellness Services, Claim Service Guarantee, Policy Service Guarantee	i.Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7-Optional Covers		
Benefit -4.7.1	**Enhanced covers**:Guaranteed Cumulative Bonus, Unlimited Reinstatement of Base Sum Insured, Consumable Cover	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.2	Double SI	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.3	Change in Room Rent limits	Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.4	Reduction in Pre-Existing Waiting Period	Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required

Benefit -3.7.5	Voluntary Aggregate Deductible	Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.6	Removal of Co-Payment	Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.7	Hospital Cash	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.8	**Convenience Cover**: Change in Pre-Post Hospitalization, Air Ambulance, Radio Taxi, Convalescence Cover	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required. ii. Radio Taxi bill and receipt
Benefit -4.7.9	**Preventive Cover**: Health Checkup and Vaccination	i. Duly completed and signed Claim Form, in original ii. Health Check up bills and Receipts iii. Vaccination bills and Receipts
Benefit -4.7.10	**Smart Cover**: Change in Modern Treatment, Vision Correction, Second Opinion	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required
Benefit -4.7.11	**Family Care Cover**: Home Care Treatment, Companion and Child Cover	i. Same Documents as mentioned for Benefit -4.1-Hospitalization Cover are required ii. Companion's accommodation bills and receipts
Note-The Company may call for any other documents as required by the Company to assess the Claim.		

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

Note :

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

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

7.5 Proportionate Deductions

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

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

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

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit-4.1.1 Hospitalization Expenses barring the below mentioned expense break ups:

a. Cost of Pharmacy and Consumables

b. Cost of Implants and Medical Devices

c. Cost of Diagnostics

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

Sr. No.		**Header**	**Explanation**
I		Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
II		Eligible Room Rent Limit	Room Rent allowed as per policy is Single Private A.C Room (upto Deluxe Room)
A		Actual Medical Bills Incurred	As per submitted documents
	(-)	Any expense not covered under Policy Benefits	
B	=	Covered Medical Expenses	
	(-)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
D	=	Covered Medical Expenses which shall be subject to Pro-portionate Deduction	
	(*)	(Eligible Room Rent Limit)/(Actual Room Rent)	

E	=	Claim after Proportionate Deduction	If Actual Room Rent is within eligibility, then no deduction to be applied [E=D]
	(+)	cost of Pharmacy and consumables, implants and medical devices and diagnostics	
F	=	Assessed Claim amount	
	(-)	Deduction for Copay	
G	=	Ground up claim amount	
	(-)	Deductions for Policy Deductibles and Limits*	
H	=	Payable claim amount	

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

a. Base Sum Insured

b. Benefit- 4.2.2- Extra Sum Insured or Benefit-4.7.2-Double Cover(whichever is applicable)

c. Benefit-4.5.1-Cumulative bonus

d. Benefit-4.6.3-Policy Service Guaranteed Sum Insured(if applicable)

e. Benefit-4.2.1 Reinstated Sum Insured or Benefit-4.7.1.2 Unlimited Reinstatement of Base Sum (whichever is applicable)

Proportionate Deduction is subject to the following:

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

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

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

7.6 Payment Terms

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

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

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

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

v. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year. This clause shall not be applicable to the Benefit 4.7.1.2 Unlimited Reinstatement Sum Insured in case Benefit 4.7.1 Enhanced Covers is opted

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

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

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

8. 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 claimat a rate 2% above the bank rate.

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

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

9. Free Look Period

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

migrating the policy.

The Insured Person shall be allowed free look period of fifteen days 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;

10. Renewal of Policy

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

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

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

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

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

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

11. Alterations in the Policy

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

12. Withdrawal of Policy

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

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

13. 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 onmigration

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

14. Portability

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

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

15. Cancellation

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

Retention % to be applied on Policy Premium

Cancellation date up to (x months) From Policy Period Start Date	**Retention % (of Full Policy Period Premium)**		
Policy Period	**1 year**	**2 years**	**3 years**
Upto1 Month	25.00%	12.50%	8.30%
Upto 3 Months	50.00%	25.00%	16.70%

Upto 6 Months	75.00%	37.50%	25.00%
Upto 9 Months	100.00%	50.00%	33.30%
Upto 12 Months	100.00%	75.00%	50.00%
Upto 18 Months	NA	100%	75%
Upto 24 Months	NA	100%	87.50%
Beyond 24 months		NA	100%

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

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

16. Moratorium Period

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

17. Premium Payment Instalments

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

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

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

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

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

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

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

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

18. Possibility of Revision 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.

19. Cumulative Bonus

33 .33 % increase in Base SI for every claim free year ; Max up to 100%

33.33 % decrease in Base SI for every claim year ; Max up to Cumulative Bonus earned, the condition of reduction in Cumulative Bonus in case of a claim shall not be applicable, if Policyholder has opted Optional benefit-4.7.1.1-Guaranteed Cumulative Bonus under Benefit no-4.7-Enhanced Covers

20. Tele Underwriting or Pre-Policy Medical Check up

Tele Underwriting will be mandatorily carried out for Proposals where the age of the Insured Person is 51 years.

The underwriter may modify the above mentioned tele underwriting age depending on the details and declarations provided in the Proposal form.

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

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

The cases where the Proposal is rejected, or the Proposer denies the accepted proposal then 100% cost for such tests shall be borne by the Customer.

21. Co-Payment

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

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

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

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

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

The Co-Payment shall not be applicable on Benefit 4.1.1.3-Accomodation Bonus, Benefit - 4.3.1 Accidental Death Cover, Benefit -4.4.1-Waiver of Premium, Benefit 4.5.3 Loyalty Cover, Benefit-4.6 .1 Wellness Services, Benefit 4.7.7 Hospital Cash(if opted), Benefit - 4.7.8.4 Convalescence Cover, Benefit - 4.7.9.1 Health Check Up, Benefit - 4.7.9.2 Vaccination Cover, Benefit - 4.7.11.2 Companion Cover, Benefit - 4.7.11.3 Child Care Cover.

ii. **Zone Wise Co-Payment**

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

Zone B: Rest of India

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

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

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

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

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

Please Note-In addition to above, on each and every claim made under this Policy, Co-Payment mentioned in above Clause - 21 (i) (if applicable), shall apply over and above the Zone wise Co-Payment.

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

Illustration 1 - Reinstatement of Base Sum Insured - Inbuilt Cover

Double Cover: Not Opted (Applicable: In-built Extra Sum Insured (20% of Base Sum Insured)

Enhanced cover: Not Opted (Unlimited Reinstatement of Base Sum Insured not applicable)

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

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

Illustration 2 - Reinstatement of Base Sum Insured - inbuilt Cover

Double Cover: Opted (100% on same claim)

Enhanced Covers: Not Opted (Unlimited Reinstatement of Base Sum Insured not applicable)

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

In the above scenario, Total Hospitalization Amount is 24,00,000 and the claim outgo is Rs 18,70,000. Policyholder has paid 5,30,000 from his pocket and for future claims in the same Policy Year, Policyholder has zero Sum Insured balance.

Illustration 3 - Unlimited Reinstatement of Base Sum Insured

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

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

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

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

Illustration 4 - Unlimited Reinstatement of Base Sum Insured

Double Cover:Opted (100% on same claim)

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

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

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

23. Illustration for Guaranteed Cumulative Bonus

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

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

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

24. Illustration for Voluntary Aggregate Deductible

Below is the illustration on application of Voluntary Aggregate Deductible.

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

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

25. Illustration for Accommodation Bonus

The illustration below explains the working of Accommodation Bonus

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

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

*This would not have impact on Accommodation Bonus payable amount.

In the above example, the Accommodation Bonus gets triggered only on the basis of opting Room Category lower than single Private A.C Room.

1. Plan Details

Policy Period	1, 2 years and 3 years
Plan Type	There are 3 plans Plus, Power and Prime
New Business Base Sum Insured (in lakhs)	Plus: 3,5 Power: 10,15,20 Prime: 25,30,50,100
Renewal Business/ Call Option Base Sum Insured (in lakhs)	Plus: 3,5, 6,9 Power: 10,12,15,18,20,24, Prime: 25,30,36, 40,48,50,60,72,80,100
Room Category	For Plus and Power: Single Private Air-Conditioned Room For Prime: Actuals

Benefit No.	Covers	Limits for Plus	Limits for Power	Limits for Prime	Basis of Payment	Pre-Requisite for Claim
Benefit4.1:-Hospitalization Cover:						
4.1.1	Hospitalization Expenses: 4.1.1.1- In Patient Treatment 4.1.1.2-Day Care Treatment 4.1.13-Accomodation Bonus	Upto the Sum Insured **Accommodation Bonus:** Additional fixed daily amount of Rs 1000(Payable, only if applicable)	Upto the Sum Insured **Accommodation Bonus:** Additional fixed daily amount of Rs 1000 (Payable, only if applicable)	Upto the Sum Insured **Accommodation Bonus:** Additional fixed daily amount of Rs 1000 (Payable, only if applicable)	Indemnity	Not applicable 4.1.1.1 - In Patient Treatment (applicable for Accommodation Bonus)
4.1.2	Domestic Road Ambulance	upto 1500 per hospitalization Intercity Ambulance cost (beyond 100km): Rs 20000 per hospitalization	upto 3000 per hospitalization Intercity Ambulance cost (beyond 100km): Rs 20000 per hospitalization	Actuals (even for Intercity ambulance , beyond 100km)	Indemnity	4.1.1.1-In Patient Treatment
4.1.3	Domiciliary Hospitalization	Within the Sum Insured			Indemnity	Not applicable
4.1.4	Modern Treatment	upto 50% of Base Sum Insured		upto 100% of Base Sum Insured	Indemnity	4.1.1- Hospitalization Expenses or 4.1.3-Domiciliary Hospitalization
4.1.5	Pre Hospitalization	upto 60 days, within the Sum Insured			Indemnity	4.1.1- Hospitalization Expenses, 4.1.3-Domiciliary Hospitalization or4.1.4-Modern Treatment
4.1.6	Post Hospitalization	upto 60 days, within the Sum Insured		upto 90 days, within the Sum Insured	Indemnity	4.1.1 - Hospitalization Expenses, 4.1.3 - Domiciliary Hospitalization or 4.1.4 - Modern Treatment
4.1.7	Organ Donor Expenses	Upto 50% of Base Sum Insured,subject to maximum of Rs 5 lakhs		Upto 50% of Base Sum Insured, subject to maximum of Rs 10 lakhs	Indemnity	4.1.1.1-In Patient Treatment
Benefit - 4.2: Extra Cover						
4.2.1	Reinstatement of Base Sum Insured	On subsequent claim, one reinstatement up to 100% of Base Sum Insured for unrelated illness/injury, sub-limit of 20% of Base Sum Insured for related illness/injury			Indemnity	4.1-Hospitalization Cover
4.2.2	Extra Sum Insured	Additional,20% of Base Sum Insured on same claim, in single Hospitalization			Indemnity	4.1-Hospitalization Cover
Benefit - 4.3 - Personal Accident Cover						
4.3.1	Accidental Death Cover	Not Applicable	5% of Base Sum Insured subject to minimum of Rs 1lakh		Benefit	Not applicable
Benefit - 4.4 - Critical Illness Cover						
4.4.1	Waiver of Premium	Not Applicable	Waives off renewal Policy Premium on diagnosis of listed Critical Illness		Not Applicable	Not applicable
Benefit - 4.5 - Renewal Benefits						
4.5.1	Cumulative Bonus	33.33% increase in Base Sum Insured for every claim free Policy Year,max upto 100% of Base Sum Insured and 33.33% decrease for every claim year			Indemnity	4.1-Hospitalization Cover

Benefit No.	Covers	Limits for Plus	Limits for Power	Limits for Prime	Basis of Payment	Pre-Requisite for Claim
4.5.2	Call Option for Enhancement of Base Sum Insured	After 4 continuous and consecutive claim free Policy Years,if Policyholder avails this benefit then enhanced Sum Insured is sum of expiring Policy's Base Sum Insured and accumulated Cumulative Bonus			Indemnity	4.1-Hospitalization Cover
4.5.3	Loyalty Cover	Refer Benefit-4.5.3 Loyalty Cover			Benefit and Indemnity	4.1.1.1-In Patient Treatment (applicable for Hospital Cash and Leave Compensation benefit)
Benefit - 4.6 - Value Added Covers						
4.6.1	Wellness Services	This is Service in which Insured Person can seek Medical advice through telephonic or online mode			Not Applicable	Not applicable
4.6.2	Claim Service Guarantee	Cashless Claim - 1% of Delayed Claim Amount (for delay beyond 6 hours to 12 hours), additional 1% for every additional delay of 6 business hours Reimbursement Claim-1% of Delayed Claim Amount (for delay beyond 21 days to upto 42 days), additional 1% for every additional delay of 6 business hours Maximum limit - 6% of Delayed Claim Amount			Indemnity	4.1.1 Hospitalization Expenses
4.6.3	Policy Service Guarantee	10000	20000	20000	Indemnity	Not applicable
Benefit -4.7-Optional Covers*						
Benefit -4.7.1-Enhanced covers						
4.7.1.1	Guaranteed Cumulative Bonus	This benefit waives off the condition of decrease in Cumulative Bonus in case of a claim in immediate previous Policy Year			Indemnity	4.1-Hospitalization Cover
4.7.1.2	Unlimited Reinstatement of Base Sum Insured	On subsequent claim,Unlimited reinstatement of Base Sum Insured on unrelated illness or injury, sub-limit of 100% of Base Sum Insured for related illness/injury. This benefit supersedes Benefit no-3.2.1-Reinstatement of Base Sum Insured			Indemnity	4.1-Hospitalization Cover
4.7.1.3	Consumable Cover	Within Sum Insured			Indemnity	4.1-Hospitalization Cover,3.2- Extra Cover,3.5-Renewal Benefits,3.7.1-Enhanced Covers(if applicable),3.7.2-Double Cover,3.7.10-Smart Covers
4.7.2	Double Cover	Additional,100% of Base Sum Insured This benefit supersedes-Benefit no-4.2.2 Extra Sum Insured			Indemnity	4.1-Hospitalization Cover
4.7.3	Change in Room Rent limits	Category of Room capped to: Twin sharing	Category of Room upgrade to : Actuals OR Category of Room capped to: Twin sharing	Category of Room capped to: Single Private A.C room	Indemnity	4.1.1 Hospitalization Expenses
4.7.4	Reduction in Pre-Existing Waiting Period	This benefit reduces the Pre-Existing Waiting Period to 24 months or 12 months			Not Applicable	4.1-Hospitalization Cover
4.7.5	Voluntary Aggregate Deductible	Options are:10000,25000,50000,100000			Indemnity	4.1-Hospitalization Cover
4.7.6	Removal of Co-Payment	This benefit waives off the Co-Payment condition of 20% on the Assessed Claim Amount, applicable on Policies where the Insured age, first time entering into the Policy is >=61 years			Indemnity	4.1-Hospitalization Cover

Benefit No.	Covers	Limits for Plus	Limits for Power	Limits for Prime	Basis of Payment	Pre-Requisite for Claim
4.7.7	Hospital Cash	Daily Cash options:1000,1500,2000,2500 max up to 30 days for In Patient Hospitalization and 15 days for ICU Hospitalization Minimum Hospitalization of 72 hours			Benefit	4.1.1.1-In Patient Treatment
Benefit 4.7.8-Convenience Cover						
4.7.8.1	Change in Pre-Post Hospitalization limit	Pre-Hospitalization-90 days Post Hospitalization-180 days			Indemnity	4.1.1 - Hospitalization Expenses, 4.1.3-Domiciliary Hospitalization or 4.1.4-Modern Treatment
4.7.8.2	Air Ambulance	7.5% of Base Sum Insured or Rs 5 Lakhs whichever is higher			Indemnity	4.1.1.1 - In Patient Treatment
4.7.8.3	Radio Taxi	1000 per Hospitalization			Indemnity	4.1.1.1 - In Patient Treatment
4.7.8.4	Convalescence Cover	10000		25000	Benefit	4.1.1.1 - In Patient Treatment
Benefit 4.7.9 - Preventive Care Cover						
4.7.9.1	Health Checkup	3000(Annual)			Indemnity	Not applicable
4.7.9.2	Vaccination Cover	2000(Annual)		3500 (Annual)	Indemnity	Not applicable
Benefit - 4.7.10 - Smart Cover						
4.7.10.1	Change in Modern Treatment limits	100% of Base Sum Insured		Not Applicable	Indemnity	4.1.1 - Hospitalization Expenses or 3.1.3 - Domiciliary Hospitalization
4.7.10.2	Vision Correction	50000	100000		Indemnity	4.1.1 - Hospitalization Expenses
4.7.10.3	Second Opinion	3000		5000	Indemnity	Not applicable
Benefit - 4.7.11 - Family Care Cover						
4.7.11.1	Home Care Treatment	Within Sum Insured			Indemnity	Not applicable
4.7.11.2	Companion Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours			Benefit	4.1.1.1-In Patient Treatment
4.7.11.3	Child Care Cover	Per day Daily Cash:1000, max up to 30 days Minimum Hospitalization of 72 hours			Benefit	4.1.1.1-In Patient Treatment

*Optional Covers are available for Sum Insured Rs 5 lakhs and above except for Benefit no.4.7.3 Change in Room Rent Limits and Benefit no-4.7.5 Voluntary Aggregate Deductible.

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

2. Redressal of Grievance

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

Website: www. Relianceada.com

Toll free: 1800-3009

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

E-mail: rgicl.services@relianceada.com

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

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, Winway Building 2nd & 3rd Floor, 11/12 Block No-4, Old no-67, South 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.

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

IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Insurance Ombudsman -The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

3. Premium Rate & Illustration

i. Rate Chart, Discounts and Loadings

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

ii. Premium Illustration

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

Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)**			
	Premium (Rs.)	Sum insured (Rs .)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
51 years	14,524	5 lakhs	14,524	10%	13,072	5 lakhs	25,691	0%	25,691	5 lakhs
44 years	7,551	5 lakhs	7,551		6,796	5 lakhs				
23 years	5,055	5 lakhs	5,055		4,550	5 lakhs				
18 years	3,428	5 lakhs	3,428		3,085	5 lakhs				
Total Premium for all members of the family is Rs. 30,558 when each member is covered separately.			Total Premium for all members of the family is Rs. 27,502 when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 25,691			
Sum insured available for each individual is Rs. 5 lakhs			Sum insured available for each family member is Rs. 5 lakhs				Sum insured of Rs 5 lakhsis available for the entire family.			
Note: Premium rates specified in the above illustration are standard premium rates for Zone A without any loading. Also, the premium rates are exclusive of taxes applicable.										

4. Contact us

For any product or service related information or assistance, here's how you can reach us.

SMS To reach us **SMS 'protect'** to **55454**

Contact details for Policy Servicing	**Contact details for Claim Servicing**
Name- Reliance General Insurance Company Limited Correspondence Address – Reliance General Insurance., Winway Building 2nd & 3rd Floor,11/12 Block No-4,Old no-67,South Tukoganj Indore(M.P) -452001 Email ID- rgicl.services@relianceada.com Contact No.- 022-41112600 Website- www.reliancegeneral.co.in Toll Free No.- 1800 3009	Name- Reliance General Insurance Company Limited Correspondence Address - RCare Health: Claims and care management Reliance General Insurance Co. Limited, No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire Building, Madhapur, Hyderabad - 500081 Near Durgam Cheruvu Metro Station. Contact No - 022 - 41112600 Website- www.reliancegeneral.co.in Toll Free No.- 1800 3009

5. Disclaimer

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

6. Statutory warning

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

i. No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to life or property in India any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

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