RELIANCE HEALTH INFINITY INSURANCE POLICY WORDINGS

We will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the receipt of premium in full, any applicable sub-limits and the terms, conditions and exclusions of this Policy.

Sections 1 – Basic Benefits:

The following Basic Benefits are available to all Insured Persons. Claims made in respect of any of these Basic Benefits will be subject to the availability of the Sum Insured, any applicable sub-limits for the Benefit claimed and will affect the eligibility for the More Options Benefits set out in Section 2.

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

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

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

b) **Special Treatment:**
Medical Expenses incurred for the following
i) Treatment for correction of eye sight due to refractive error above dioptre 14.0,
ii) Mental Illness, Parkinson and Alzheimer's disease. Coverage related to Mental Illness will be in accordance and comply with The Mental Healthcare Act,2017,
iii) Stem cell therapy or surgery,
iv) Administration of intra-articular or intra-lesional injections, monoclonal antibodies such as Rituximab/Infliximab/Tratsuzumab and supplementary medications such as Zoledronic acid,
v) Robotic surgery.

These Medical Expenses will be covered upto the amount specified in the Schedule of Benefits, provided that:

i) A Co-payment of 50% will be applicable on the admissible amount under this Benefit for each and every claim. This Co-payment will apply in addition to any other Co-payment already applicable under the Policy.

ii) The MoreCover Benefit and MoreGlobal Benefit under More Options Benefits 2.b) and 2.c) shall not apply to any claim under this Benefit, even if same are specified to be in in force for the Insured Person under this Policy.

iii) Our maximum liability will be restricted to the amount specified in the Schedule of benefits.

Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured

c) **Day Care Procedures:**

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

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

ii) Any Day Care Treatment which also falls within the scope of cover under Basic Benefit 1. b) will be considered under Basic Benefit 1.b) and not this Benefit.

iii) No list of Day Care Treatments will be provided for this benefit.

Day Care Treatment

means medical treatment, and/or Surgical Procedure which is:

i) undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and which would have otherwise required Hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Day Care Centre

means any institution established for Day Care Treatment of Illness and/or Injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under –

i) has qualified nursing staff under its employment;

ii)has qualified Medical Practitioner/s in charge;

iii)has fully equipped operation theatre of its own where Surgical Procedures are carried out;

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

d) **Domiciliary Hospitalisation:**

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

i) The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case We will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and If We accept a claim under this Benefit We will pay Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses in accordance with Basic Benefit 1.g) and Basic Benefit 1.h), respectively.

Domiciliary Hospitalisation

means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

i) the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or the patient takes treatment at home on account of non-availability of room in a Hospital.

e) **Organ Donor:**

i) Medical Expenses for an organ donor's treatment for the harvesting of the organ donated,

provided that: The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for the use of the Insured Person, and We will not pay any Pre-Hospitalisation Medical Expenses and Post-Hospitalisation Medical Expenses or expenses incurred towards any other medical treatment for or attributable to the organ donor consequent to the harvesting, and We have accepted a claim under Basic Benefit 1.a). Inpatient Care

ii) We will not pay for the Medical Expenses incurred by an Insured Person while donating an

organ.

f) **Ayush Benefit:**

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

i) The treatment is taken in a:

ii) Government Hospital or in any institute recognized by the government and/or accredited

by the Quality Council of India/National Accreditation Board on Health, or Teaching Hospitals of Ayush colleges recognised by Central Council Indian Medicine (CCIM) and Central Council of Homeopathy, or Ayush Hospital having registration with government authorities under applicable law in the state/UT and which complies with the following as minimum criteria:

a) has atleast fifteen in-patient beds;
b) has minimum five qualified and registered Ayush Medical Practitioners;
c) has qualified paramedical staff under its employment round the clock.
d) has dedicated AYUSH therapy sections;
e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

iii) We have accepted a claim under Basic Benefit 1.a) Inpatient Care,
iv) Cashless Facility will be provided under this Basic Benefit on a best efforts basis. Where Cashless Facility is not available, due to any reason, We shall consider the claim on a reimbursement basis.

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

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

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

ii) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

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

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

i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

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

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

v) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

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

Post-Hospitalisation Medical Expenses
means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the Hospital provided that:

i) Such Medical Expenses are for the same condition for which the insured person's Hospitalisation was required, and

ii) The inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

Emergency Ambulance:

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

i) We have accepted a claim under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

ii) The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that that transportation has been prescribed by a Medical Practitioner and is medically necessary, and

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

Ambulance

Ambulance means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention

Transportation Benefit:

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

i) We have approved a pre-authorization request for the Insured Person in respect of the same period of Hospitalisation under Basic Benefit 1.a) Inpatient Care or 1.c) Day Care Procedures.

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

Restore Benefit:

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

i) The Restore Benefit Sum Insured will be applied and can be utilised only after the Sum Insured has been completely exhausted;

ii) The Restore Benefit Sum Insured cannot be used for any claim in respect of an Illness (including its complications) for which a claim has been paid in the current Policy Year/Extended Policy Year (if applicable) under Section 1 for the same Insured Person;

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

If the Sum Insured is exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a Restore Benefit Sum Insured (equal to 100% of the Sum Insured) will apply to future claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits, provided that:
The Restore Benefit Sum Insured will be applied and can be utilised only after the Sum Insured has been completely exhausted;

ii) The Restore Benefit Sum Insured cannot be used for any claim in respect of an Illness (including its complications) for which a claim has been paid in the current Policy Year/Extended Policy Year (if applicable) under Section 1 for the same Insured Person;

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

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

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

vi) If the Restore Benefit and MoreCover under More Options Benefits 2.b) (if opted) are both applicable under the Policy, then the Restore Benefit will be applied and can be utilised only if the Sum Insured and the MoreCover Sum Insured have both been exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable.

vii) The Restore Benefit shall not be applicable to any claims made under Basic Benefit 1.b) Special Treatment;

viii) Our maximum, total and cumulative liability for any and all claims made during a Policy Year/Extended Policy Year (if applicable) in respect of the Insured Person for Individual Policies as specified in the Schedule and all Insured Persons for Family Floater Policies as specified in the Schedule shall be the total of:

1) Sum Insured
2) MoreCover Sum Insured (if applicable, and if Sum Insured is exhausted)
3) Restore Benefit Sum Insured (if applicable, and if Sum Insured + MoreCover Sum Insured is exhausted)

Section 2- more Options Benefits

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

1. You may choose any one of the following More Options Benefits and that Benefit will be applied to the Policy with no additional premium. Where more than one Insured Person is covered under the same Policy, the same More Options Benefit shall be applicable for all Insured Persons.

2. On Renewal with Us, if no claim has been made in respect of the Insured Person under this Policy and the Policy is renewed without any Break, We will continue offering that More Options Benefit for the next Policy Year.

a. For Individual Policies where claim has been made in respect of an Insured Person, We will continue offering this More Options Benefit without additional premium to the other Insured Persons in respect of whom no claim has been made in the previous Policy Year. However, the insured person who has made claim shall continue to avail this benefit or any other More Options Benefit on paying additional premium at the time of renewal.

b. For Family Floater Policies, We will continue offering this More Options Benefit for the next Policy Year, only if no claim has been made in respect of any of the Insured Persons under the Policy.

3. In the event of claim in the immediately preceding policy, we will not offer that More Options Benefit for the next Policy Year.

4. You may also, additionally, opt for any of the other More Options Benefits which will be applied under the Policy only on receipt of the additional premium payable for that Benefit in full.

5. Any changes to the More Options Benefits opted for can be made only on Renewal.

a) **MoreTime:**

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

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

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

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

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

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

iii) The MoreTime shall also be applicable to any claims made under Basic Benefits 1.b

a) More Cover:

If the Sum Insured is exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a MoreCover Sum Insured of the amount specified in the Schedule of Benefits will apply to claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits in Section 1, provided that:

i) The MoreCover Sum Insured will be applied and can be utilised in respect of the same claim or any future claim only after the Sum Insured has been completely exhausted;
ii) For Individual Policies as specified in the Schedule of Benefits, the MoreCover Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);
iii) For Family Floater Policies as specified in the Schedule of Benefits, the MoreCover Sum Insured will be applied only once under the Policy during the Policy Year/Extended Policy Year (if applicable);
iv) If the MoreCover Sum Insured is not utilised in a Policy Year/Extended Policy Year (if applicable), it shall not be carried forward to any subsequent Policy Year;
v) If the Restore Benefit under Basic Benefit 1.k) and MoreCover (if opted) are both applicable under the Policy, then the Restore Benefit will be applied and can be utilised only if the Sum Insured and the MoreCover Sum Insured have both been exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable;
vi) The MoreCover shall not be applicable to any claims made under Section 1.b) Special Treatment;
vii) Our maximum, total and cumulative liability for any and all claims made during a Policy Year/Extended Policy Year (if applicable) in respect of the Insured Person for Individual Policies as specified in the Schedule and all Insured Persons for Family Floater Policies as specified in the Schedule shall be the total of:
1) Sum Insured
2) MoreCover Sum Insured (if applicable, and if Sum Insured is exhausted)
3) Restore Benefit Sum Insured (if applicable, and if Sum Insured + MoreCover Sum Insured is exhausted)

a) **More Cover:**
If the Sum Insured is exhausted due to claims made and paid during the Policy Year/Extended Policy Year (if applicable) or made during the Policy Year/Extended Policy Year (if applicable) and accepted as payable, then it is agreed that a MoreCover Sum Insured of the amount specified in the Schedule of Benefits will apply to claims made under the Policy during that Policy Year/Extended Policy Year (if applicable) under the Basic Benefits in Section 1, provided that:

i) The MoreCover Sum Insured will be applied and can be utilised in respect of the same claim or any future claim only after the Sum Insured has been completely exhausted;
ii) For Individual Policies as specified in the Schedule of Benefits, the MoreCover Sum Insured will be applied only once for the Insured Person during a Policy Year/Extended Policy Year (if applicable);

b) **MoreGlobal:**
If opted, this benefit covers Emergency Care on treatment of illness or conditions first manifested during the Policy Period while travelling overseas, provided that:

i) The Insured Person's Hospitalisation or Day Care Treatment was Medically Necessary Treatment and was carried out up to limits specified in the Schedule of Benefits.
ii) The Insured Person's condition was certified in writing by the treating Medical Practitioner to be such that Emergency Care is required and treatment cannot be postponed until the Insured Person has returned to India.
iii) No claim under this More Options Benefits will be considered if the Insured Person was not an Indian resident per applicable Indian law on the date of the event giving rise to the claim.
iv) No Cashless Facility is available under this More Options Benefit and all claims will be considered on a reimbursement basis only.
v) The payment of any claim under this More Options Benefit will be based on the rate of exchange as on the date of invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
vi) The MoreGlobal Benefit shall not be applicable to any claims made under Section1.b).

For the purpose of this More Options Benefit alone, Hospital means "Any institution established for In-patient treatment and Day Care Treatment of injury or illness and which has been registered as a Hospital or a clinic as per law rules and/or regulation applicable for the country where the treatment is taken."

Emergency Care

means management for an illness or injury which results in symptom which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Section. 3 Voluntary Co-payment

We offer a discount on the premium if You opt for a voluntary Co-payment. If the Schedule specifies that a Co-payment has been opted for, We shall not be liable for the Co-payment share of the Medical Expenses incurred, and

a) The Co-payment shall be applicable to each and every claim, and
b) The Co-payment as specified in the Schedule of Benefits shall be applicable, and
c) The Co-payment is applicable on the admissible amount under any Benefits under Section 1 and Section 2.

Co-payment

means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured.

Section. 3 Renewal Benefit: MoreResults Discount:

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

a) The Insured Person will be entitled to the discount irrespective of the results of the tests,
b) The annual health check-up tests must include these tests: blood glucose, blood pressure, cholesterol and weight assessment,
c) The results of respective Policy Year/(s) must be submitted to Us at least 30 days prior to the expiry of the Policy Year/Extended Policy Year (if applicable),
d) For Individual Policies, this Benefit would be applicable to Insured Persons who are Aged 18 and above on the Policy Commencement Date,
e) For Family Floater Policies, this Benefit would not be applicable to Dependent Children covered under the Policy,
f) The cost of the health check-up will be borne by the Insured Person, and

The discount available will be as follows:

Policy Period	Discount applicable per adult for the Policy Period for an Individual Sum Insured Policy	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 2 adults	Discount applicable per adult for the Policy Period for a Family Floater Sum Insured Policy with 1 adult
1 Year	10.00%	5.00%	10.00%
2 Year	5.00%	2.50%	5.00%
3 Year	3.33%	1.66%	3.33%

a) We will not reassess or alter Your existing coverage based on annual health check-up report submitted to Us for availing MoreResults discount.
b) However, in the event of any fraud, misrepresentation or non-disclosure of material facts, We will re-evaluate Your coverage in accordance with the Policy terms and conditions.

Section. 3 Exclusions

Waiting Periods

We shall not be liable to make any payment for any treatment which begins during waiting periods unless the Insured Person suffers an Accident. All waiting periods shall apply individually for each Insured Person and claims shall be assessed accordingly.

a) Specified disease/procedure waiting period (Code:Excl02)

i) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an accident
ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase
iii) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply
iv) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion
v) If You are 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

Pre-existing Disease

means any condition, ailment , Injury or disease:

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

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

ii) A conditio for which any symptoms and or signs if presented and have resulted within three months of the issuance of the policy in a diagnostic illness or medical condition

a) **Pre-Existing Disease (Code:Excl01)**
Specified disease/procedure waiting period (Code:Excl02)

i) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an accident
ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase
iii) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply
iv) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion
v) If You are continuously covered without any Break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage

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

Organ / Organ System	Illness /Diagnosis ((irrespective of treatment being medical or surgical)	Surgeries / Surgical Procedure (irrespective of any Illness / diagnosis)
Ear, Nose, Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Surgery for turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps,	• Hysterectomy unless necessitated by

	including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed uterus	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 prolapsed	• 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 14.0
Others	• Mental Illness, Parkinson and Alzheimer's disease. • Congenital internal disease	• Surgery of varicose veins and varicose ulcers • Stem cell therapy or surgery • Administration of intra-articular or intra-lesional injections, Monoclonal antibodies such as Rituximab/Infliximab/Tratsuzumab and

		supplementary medications such as Zoledronic acid
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

a) 30 Days Waiting Period (Code:Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered
ii. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently

b) Reduction in Waiting Periods

If the proposed Insured Person is presently covered and has been continuously covered without any lapses under:

i) any health insurance plan with an Indian non-life insurer as per guidelines on Portability, or
ii) any other similar health insurance plan from Us,

Then:

i) The waiting periods specified in Section 5 a), Section 5 b) and Section 5 c) of the Policy shall stand waived if these waiting periods have been completed under the previous health insurance policy; OR
ii) The waiting periods specified in the Section 5 a), Section 5 b) and Section 5 c) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; and
iii) If the proposed Sum Insured for a proposed Insured Person is more than the sum insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the sum insured and any other accrued benefits under the previous health insurance policy.

c) The reduction in the waiting period specified above shall be applied subject to the following:

i) We will apply the reduction of the waiting period only if We have received the database and past claim history related information as mandated under Portability guidelines from the previous Indian insurance company (if applicable);
ii) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.
iii) We will retain the right to underwrite the proposal.
iv) We shall consider only completed years of coverage for waiver of waiting periods. Policy extensions, if any, sought during or for the purpose of porting the insurance policy shall not be considered for waiting period waiver.

Permanent Exclusions

a) We will not make any payment for any claim in respect of any Insured Person directly or indirectly
for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy:

Investigation & Evaluation (Code:Excl04)

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

excluded

2. Any diagnostic expenses which are not related or not incidental to the current diagnosis and

treatment are excluded

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

1. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
2 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.
3 Any services for people who are terminally ill to address physical, social, emotional and spiritual needs..

Obesity/ Weight Control (Code:Excl06):

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. 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 Type2 Diabetes

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

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

Cosmetic or Plastic Surgery (Code:Excl08):
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

Hazardous or Adventure sports (Code:Excl09):
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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

Breach of law (Code:Excl10):

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

Excluded Providers (Code:Excl11):

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

Drugs or treatments (Code:Excl12):

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

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.

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

Refractive Error (Code:Excl15):

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

Unproven Treatments-Code (Code:Excl16):

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

Unproven/Experimental treatment
means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

Birth control, Sterility and Infertility (Code:Excl17):

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

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

Maternity (Code:Excl18)

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

Alternative Treatments
Alternative Treatment or any other non-allopathic treatment, except to the extent covered under Basic Benefit 1.f).

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

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

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

Dental Treatments
Dental Treatments of any kind, unless requiring Hospitalisation due to accident.

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

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

Enteral feedings
Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements.

External Congenital Anomaly
External Congenital Anomaly and genetic disorders.

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

i. Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body;
ii. External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body.

Hearing aids
Provision or fitting of hearing aids

Hormonal therapies
1. Growth hormone therapy.
2. Any form of hormone replacement therapy (HRT) and or administration of other hormonal medication.

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

Medically Necessary Treatment
means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which:
i) i) is required for the medical management of the Illness or Injury suffered by the Insured;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
iii) must have been prescribed by a Medical Practitioner;
must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Medical supplies
Medical supplies including elastic stockings, diabetic test strips, and similar products.

Non-medical expenses
Any non-medical expenses mentioned in Annexure I.

Outpatient treatment (OPD)
Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.

OPD treatment
means the one in which the Insured visits a clinic /hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Overseas treatment
Treatment availed outside India except in case of the MoreGlobal Benefit (Benefit 2.c) under More Options Benefits) is in force for the Insured Person and subject to the conditions contained therein.

Peritoneal dialysis
Charges related to peritoneal dialysis, including supplies.

Prosthetic and other devices
Prosthetic and other devices which are self-detachable/ removable without surgery involving anaesthesia.

Reasonable & Customary Charges
Any Medical Expenses which are not Reasonable & Customary Charges.

Reasonable & Customary Charges
means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of Illness/Injury involved.

Self-injury or suicide
Intentional self-injury or attempted suicide while sane or insane.

Sexually transmitted diseases
Venereal disease, sexually transmitted disease or Illness

Sleep-apnoea
Treatment of sleep-apnoea

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

extremities.

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

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

Vaccination and immunisation
Vaccination including inoculation and immunisation (except in case of post-bite treatment).

War or similar situations
Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

Irrespective of waiting period or portability, below mentioned Diseases are permanently excluded under the Policy in the case where such Diseases are Pre-Existing at the time of first proposal of this Product with Us.

Sr.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9

2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic

		rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 - Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083

10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus

16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

Section.6 General Conditions

a) **Condition Precedent & Premium Payments**

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be Conditions Precedent to Our liability. The premium shall be paid in full at the inception of the Policy as single premium for opted Policy Period. The premium for the Policy will remain the same for the Policy Period. The Policy will be issued for a period of 1 or 2 or 3 year(s) based on the Policy Period selected and specified in the Schedule. The Sum Insured and the benefits under the Policy will be applicable on Policy Year/Extended Policy Year (if applicable) basis.

b) **Geography & Currency**

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

This Policy only covers medical treatment taken within India, unless section 2.c) MoreGlobal Benefit is opted and in force for the Insured Person under the Policy. All payments under this Policy will only be made in Indian Rupees within India.

c) **Insured Person**

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

All health insurance policies are portable. Any Insured Person has the option to migrate to similar indemnity health insurance policy available with Us or any other non-life insurer, at the time of Renewal subject to underwriting with all the accrued continuity benefits such as waiver of waiting period provided the Policy has been maintained without a Break as per Portability guidelines. You should initiate action to approach another insurer to take advantage of Portability well before the renewal date to avoid any break in the policy coverage due to delay in acceptance of the proposal by the other insurer. If you are insured continuously and without interruption in any health insurance plan with an Indian non-life insurer and Health Insurer and want to shift to us on renewal, this policy will allow so as per guidelines on portability issued by the insurance regulator. You may apply for portability at least 45 days before, but not earlier than 60 days from the premium renewal date of existing policy that is proposed to be ported.

Loadings & Discounts

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum

risk loading applicable for an individual will not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent Renewal(s) with Us or on the receipt of the request for increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 7 days, We will cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after receiving Your consent and additional premium (if any). The application of loading does not mean that the Illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section 5 a), Section 5 b) and Section 5 c) above or specifically mentioned on the Schedule shall be applied on the Illness/condition, as applicable.

We will provide the following discounts at inception and Renewal of the Policy:

Prime Discount: A one-time discount of 10% on the Premium is applicable if the Insured Person is a

1. Reliance Group employee (full time employee) / Reliance Group shareholder at the time of enrolment, or
2. Repeat customer (customers who hold an active health insurance policy with Us at the time of enrolment).

Provided that the such Policy is purchased through Our website or Our mobile app and without the involvement of any insurance agent or insurance intermediary.

This discount is not available at subsequent renewals and if two or more family members are covered under the same Policy under the individual Sum Insured policy option.

Buy Online Discount:
The Insured Person is eligible for 10% discount on premium in case of buying or Renewing the Policy online from Our website, Our mobile app, or any duly licensed web aggregator provided that the first Policy with Us was also purchased through Our website, Our mobile app, or such web aggregator, and without the involvement of any other insurance agent or insurance intermediary.

Family Discount:
The Insured Person will be entitled to receive 10% discount on the premium if two or more family members are covered under the same Policy under the individual policy option.

Policy Tenure Discount:
If the Policy Period is more than one year, the Insured Person will be entitled to receive a discount of 10%, if You pay 2 years or 3 years premium in advance as a single premium.

Voluntary Co-payment Discount
: The Insured Person is eligible for 10% discount on the premium if You opt for a Voluntary Co-payment of 10%.

MoreResults Discount:
The Insured Person will be entitled upto 10% discount (refer table under section 4.g) on the premium at the time of Renewal of the Policy for getting an annual health check-up carried out and sharing results of the same with Us.

Please note that the above-mentioned discounts are additive in nature. The maximum discount available is 30% (excluding Voluntary Co-payment Discount and More Results Discount)

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

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

Cashless Facility:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Facility is Available:	We must be given notice that the Insured Person wishes to take advantage of the Cashless Facility accompanied by full particulars:
1)	For any planned treatment, consultation or procedure for which a claim may be made:	Network Provider	Yes, We will make payment to the extent of Our liability directly to the Network Provider.	At least 48 hours before the planned treatment or Hospitalisation.
2)	For any treatment, consultation or	Network Provider	Yes, We will make payment to the	Within 24 hours after the treatment

	procedure for which a claim may be made to be taken in an emergency:		extent of Our liability directly to the Network Provider.	or Hospitalisation.
3)	For any planned or emergency treatment, consultation or procedure for which a claim may be made:	Non- Network Provider	No, We will consider claims on a reimbursement basis only.	N/A

Supporting Documentation & Examination

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

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

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

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

i) Our claim form, duly completed and signed for on behalf of the Insured Person, provided that no signatures are required if the same is being completed or populated digitally in Our website.
ii) Original bills/certified true copies (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto such as receipts or prescriptions in support of any amount claimed which will then become Our property.
iii) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
iv) A precise diagnosis of the treatment for which a claim is made.
v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).
vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.
vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made.
viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection.
ix) Treating Medical Practitioner's certificate regarding missing information in case histories e.g. circumstance of Injury and alcohol or drug influence at the time of Accident.

x) Copy of settlement letter from other insurance company or TPA.
xi) Stickers and invoice of implants used during surgery.
xii) Copy of MLC (medico legal case) records and FIR (First Information Report), in case of claims arising out of an Accident.
xiii) Regulatory requirements as amended from time to time.
xiv) Original Cancelled cheque in CTS 2010 format (Printed A/C No. IFSC Code, Printed Name), In case the Name is not printed on the cheque Leaf, duly attested scanned copy of the first page of the Pass-book or the authorized bank statement for NEFT (to enable direct credit of claim amount in bank account) and KYC (recent photo ID/address proof and photograph) requirements.
xv) Legal heir certificate, in the event of death.

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

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

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

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

i) We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule) in India.

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

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

iv) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. Where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document.

v) All claims shall be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulations), 2017 as amended from time to time. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and conditions, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulations), 2017, we shall pay interest at a rate which is 2% above the bank rate. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Non-Disclosure or Misrepresentation:
This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form and any other details submitted in relation to the Proposal Form. If at the time of issuance of Policy or during continuation of the Policy, any material fact in the information provided to Us in the Proposal Form or otherwise, by You or the Insured Person, or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

i) cancelled *ab initio* from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at Our sole discretion, upon 30 day's notice by sending an endorsement to Your address shown in the Schedule without refund of premium; and

ii) any claim made under such Policy, shall be rejected/repudiated forthwith.

Dishonest or Fraudulent Claims
If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy will be void and all benefits otherwise payable under it will be forfeited.

Other Insurance
If at the time when any claim is made under this Policy, the Insured Person has two or more policies from one or more insurers to indemnify treatment cost, then You shall have the right to require a settlement of the claim in terms of any of the policies. The insurer so chosen by You shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.
Claims under other policy/ies may be made after exhaustion of sum insured in the earlier chosen policy / policies. Provided that, if the amount to be claimed under the policy chosen by You, exceeds the sum insured under a single policy after considering the deductibles or Co-payment (if applicable), You shall have the right to choose the insurers by whom the balance claim amount is to be settled. Where You have policies from more than one insurer to cover the same risk on indemnity basis, You shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Endorsements
This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except Us, and any change We make will be

evidenced by a written endorsement signed and stamped by Us.

Renewal
All applications for Renewal must be received by Us before the end of the Policy Period. Grace Period of 30 days for renewing the policy is provided under this Policy. Any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing Disease.

This Policy is ordinarily Renewable for life except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

We are NOT under any obligation to:
i) Send Renewal notice or reminders.
ii) Renew it on same terms or premium as the expiring Policy.

Any change in benefit or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority of India (IRDAI) and will be intimated to You at least 3 months in advance.

In the event of this policy being withdrawn in future, We will intimate you about the same 3 months prior to expiry of the Policy. You will have the option to migrate to similar indemnity health insurance policy available with Us at the time of Renewal with all the accrued continuity benefits such as waiver of waiting periods provided that the Policy has been maintained without a Break as per Portability guidelines.

We will not apply any additional loading on your policy premium at Renewal based on claim experience.

The Sum Insured can be enhanced only at the time of Renewal subject to the underwriting norms and acceptability criteria of the Policy. If You increase the sum insured, the case may be subject to health check-up. In case of increase in the Sum Insured, the waiting periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at Our discretion and subject to Our underwriting guidelines. Additional premium if any, shall be charged as per terms and conditions of the Policy.

We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

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

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

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

ii) Us, it will be delivered to Our address specified in the Schedule.

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

Governing Law & Dispute Resolution Clause

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

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

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

Free Look Period

You have a period of 15 days (30 days if the policy is sold through distance marketing or if the Policy Period is 3 years) from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the full premium paid by You. You can cancel Your Policy only if no claims have been made under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of Renewal of the Policy.

Cancellation (other than Free Look Period)

You may terminate this Policy at any time by giving Us written notice, and the Policy will terminate when such written notice is received. If no claim has been made under the Policy, then We will refund premium in accordance with the table below:

Length of time Policy in force	Refund of premium
Upto 90 days	100%
Above 90 days	Pro-rata

i) We may at any time terminate this Policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by You or any Insured Person upon 30 days' notice by sending an endorsement to Your address shown in the Schedule without refund of premium.

ii) If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person if there are no claims made in respect of that Insured Person under the Policy for that Policy Period.

Section. 7 Schedule of Benefits

Sum Insured mentioned below for

- Per Insured Person per Policy Year for Individual policies.
- Per Policy per Policy Year for Family Floater policies

Sum Insured (in Rs.)	**300,000**	**500,000**	**10,00,000**	**15,00,000**	**50,00,000**	**100,00,000**
Section 1: Basic Benefits						
1 a) Inpatient Care	Covered					
1 b) Special Treatments (in Rs.) Co-payment of 50% of admissible Medical Expenses for all Sum Insured options	100,000	100,000	100,000	150,000	500,000	10,00,000
1 c) Day Care Procedures	Covered					
1 d) Domiciliary Hospitalisation	Covered					
1 e) Organ Donor	Covered					
1 f) Ayush Benefit	Covered					

1 g) Pre-Hospitalisation Medical Expenses	Covered, upto 90 days					
1 h) Post-Hospitalisation Medical Expenses	Covered, upto 180 days					
1 i) Emergency Ambulance	Covered					
1 j) Transportation Benefit	Maximum upto Rs. 500					
1 k) Restore Benefit	Equal to 100% of Sum Insured					
Section 2: More Options Benefits						
2 a) MoreTime ^	Extended Policy Year of 13 months if Policy period is 1 year and Extended Policy Year of 26 months if Policy Period is 2 years					
2 b) MoreCover ^ (in Rs.)	100,000	200,000	300,000	500,000	15,00,000	30,00,000
2 c) MoreGlobal ^ (in Rs.)	Equal to 100% of Sum Insured, maximum upto Rs. 20,00,000					
Section 3: Voluntary Co-payment						
3 Voluntary Co-payment	10%, if opted					
Section 4: Renewal Benefit – MoreResults Discount						
4 Renewal Benefit - MoreResults Discount	Upto 10% discount on renewal premium					

If opted and specified to be in force in the Schedule.

Section. 7 Interpretations & Definitions

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

Accident means a sudden, unforeseen and involuntaryevent caused by external, visible and violent means.

Activities of Daily Living are:

i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv) Mobility: the ability to move indoors from room to room on level surfaces;
v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi) Feeding: the ability to feed oneself once food has been prepared and made available

Age or Aged means "Age as on last birthday" as determined on the date of first Policy issuance or at renewal. In case of change in Age during the proposal stage, then "Age" shall be determined on the date of proposal form submission would be considered for premium calculation.

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

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

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

i) **The following are excluded**:

- Any other type of irreversible organic disorder/dementia
- Non-organic disease such as neurosis and psychiatric Illnesses; and
- Alcohol-related brain damage.

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

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

AYUSH Treatment refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

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

Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

Condition Precedent means a policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

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

i) Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body;
ii) External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body.

Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured.

Day Care Centre means any institution established for Day Care Treatment of Illness and/or Injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under –

i) has qualified nursing staff under its employment;
ii) has qualified Medical Practitioner/s in charge;
iii) has fully equipped operation theatre of its own where Surgical Procedures are carried out;
iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Day Care Treatment means medical treatment, and/or Surgical Procedure which is:

i) undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and
ii) which would have otherwise required Hospitalisation of more than 24hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

Dependents means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;
ii) Your children Aged between 91 days and 25 years if they are unmarried, financially depended on You and do not have his/her independent source of income;
iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in this Policy and the parent is financially depended on You;
iv) Your parents -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in this Policy and the parent-in law is financially depended on You.

Dependent Children means Your children Aged between 91 days and 25 years if they are unmarried, financially depended on You and do not have his/her independent source of income.

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

Domiciliary Hospitalisation means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
i) the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a Hospital.

Emergency Care means management for an illness or injury which results in symptom which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

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

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

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

Hospital means any institution established for Inpatient Care and Day Care Treatment of Illness and/or Injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii) has qualified Medical Practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospitalisation means admission in a Hospital for a minimum period of24 consecutive 'Inpatient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24consecutive hours.

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

i) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
ii) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;
2) it needs ongoing or long-term control or relief of symptoms;
3) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
4) it continues indefinitely;
5) it recurs or is likely to recur.

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

Inpatient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Insured Person means You and those of Your Dependents who are named as insured person(s) in the Schedule.

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

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

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

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

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

Medically Necessary Treatment means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which:

iv) is required for the medical management of the Illness or Injury suffered by the Insured;
v) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
vi) must have been prescribed by a Medical Practitioner;
vii) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Mental illness as per The Mental Health Act, 2017 means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless Facility.

Non-Network Provider means any Hospital, day care centre or other provider that is not part of the Network.

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

OPD treatment means the one in which the Insured visits a clinic /hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Parkinson's Disease means

I. The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

(i) The disease cannot be controlled with medication; and
(ii) objective signs of progressive impairment; and
(iii) There is an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the Activities of Daily Living for a continuous period of at least 6 months.

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

Portability means right to transfer by an individual health insurance policyholder (including family cover) of the credit gained for Pre-existing Disease and time-bound exclusions if he/she chooses to switch from one insurer to another or from one plan to another plan of the same insurer.

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

ii) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
iii) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement
iv) A condition for which any symptoms and or signs if presented and have resulted within three months of the issuance of the policy in a diagnostic illness or medical condition.

Pre-Hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that:
i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

Post-Hospitalisation Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the Hospital provided that:
i) Such Medical Expenses are for the same condition for which the insured person's Hospitalisation was required, and
ii) The inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

Policy means your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendices to the Policy and the Schedule (as the same may be amended from time to time).

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

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

Policy Decision is the decision made by Us whether to issue the Policy to You or reject the proposal.

Policy Period means the period between the Policy Commencement Date and the Policy Expiry Date specified in the Schedule. If the Extended Policy Year is applicable under the Policy, the Policy Period will end on the Extended Expiry Date specified in the Schedule.

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

Qualified Nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

Reasonable & Customary Charges means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of Illness/Injury involved.

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

Room Rent means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

Sum Insured means:

(a) For a Policy issued as an Individual Policy as specified in the Schedule: the sum shown in the Schedule which represents Our maximum, total and cumulative liability for each Insured Person for any and all claims made in respect of that Insured Person during the Policy Year or Extended Policy Year (if applicable); and

(b) For a Policy issued as a Family Floater Policy as specified in the Schedule: the sum shown in the Schedule which represents Our maximum, total and cumulative liability for any and all claims made in respect of any and all Insured Persons during the Policy Year or Extended Policy Year (if applicable).

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

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

We/Our/Us/Company means Reliance General Insurance Company Limited.

You/Your/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

Section. 7 Service related Information:

You can reach Us through any of the following methods for any service related issue and assistance:

Claims Servicing	
Name	R Care
Correspondence Address :	Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081.
Contact No. :	022-41112600
E-mail :	rcarehealth@rcap.co.in
Fax No. :	1800 3009(toll free)/(022)4890 3009

Section. 10Claim Related Information & Claim Procedure

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

To help us to provide you with fast and efficient service, we kindly ask you to note the following:

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

Intimation & Assistance	Please contact Reliance General Insurance Company at least 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact Reliance General Insurance Company within 24 hours of the event. Reliance General Insurance Company can be contacted through: Website : www.reliancegeneral.co.in Email : rgicl.rcarehealth@relianceada.com Helpline : 1800 3009(toll free)/022-41112600 Fax : (022)4890 3009 Courier : Reliance General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad-500081
Procedure for Reimbursement of Medical Expenses	Please send the duly signed claim form and all the information/ Documents mentioned therein to us within 15 days of the occurrence of incident. Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 10 days of receipt of the claim documents.

	• On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. **Note**: Payment will only be made for items covered under your policy and upto the limits therein.
Procedure to avail Cashless facility	For any emergency hospitalisation, Reliance General must be informed no later than 24 hours after hospitalisation. For any planned hospitalisation, kindly seek cashless authorization from Reliance General atleast 48 hours prior to the start of the Insured Person's hospitalisation. We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 4 hours of receipt of documents. Please pay the non-medical and expenses not covered to the hospital prior to the discharge. For details on non-medical expenses, please refer Annexure I of Policy wording. In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 4 hours. **Note:** • Insured person is entitled for cashless only in our network hospitals. • Please refer to the list of network hospitals on our website. • Please refer to the list of non-medical expenses not covered in the policy in Annexure I of Policy wordings. • Rejection of cashless in no way indicates rejection of the claim.

Section.11 Grievance Redressal Procedure

If You have a grievance that You wish Us to redress, You may contact Us with the details of Your grievance through:

For resolution of any query or grievance, Insured may contact the respective branch office of the Company or may call at 1800 3009 or may write an email at rgicl.services@relianceada.com. In case the insured is not satisfied with the response of the office, insured may contact the Nodal Grievance Officer of the Company at rgicl.grievances@relianceada.com. In the event of

unsatisfactory response from the Nodal Grievance Officer, insured may email to Head Grievance Officer at rgicl.headgrievances@relianceada.com.

In case Your complaint is not fully addressed by Us, You may use the Integrated Grievance Management System (IGMS) for escalating the complaint to IRDAI. Through IGMS, Insured can register the complaint online and track its status. For registration please visit IRDAI website www.irdai.gov.in If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

If you have a grievance, approach the grievance cell of Insurance Company first. If the complaint is not resolved/ not satisfied/not responded for 30 days then You can approach The Office of the Insurance Ombudsman (Bimalokpal). The contact details of Ombudsman offices are mentioned below.

Please visit Our website for details to lodge complaint with Ombudsman.
The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.reliancegeneral.co.in

Ombudsman Office	
Jurisdiction	**Office Address**
Gujarat, Dadra & Nagar Haveli, Daman and Diu	AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@gbic.co.in
Karnataka	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in
Madhya Pradesh Chattisgarh	BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in
Orissa	BHUBANESHWAR Office of the Insurance Ombudsman,

	62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
Delhi	DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
Rajasthan	JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg,

	Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in
Kerala, Lakshadweep, Mahe-a part of Pondicherry.	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in
Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi , Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur,	LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in

Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in
Bihar, Jharkhand.	PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in
Maharashtra, Area of Navi Mumbai and ThaneexcludingM	PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198,

umbai Metropolitan Region.	N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in

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

Annexure I: List of excluded expenses (Non-medical)

List of excluded expenses (non-medical) are below and are uploaded on Our website. Please login to http:// www.reliancegeneral.co.in

S. No.	List of expenses generally excluded ("Non-Medical") in Hospital Indemnity Policy	
TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Not Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable

26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in varicose vein surgery and will be payable if the surgery itself is payable
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by the Insurer then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Payable for upper fractures
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in the Policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in the Policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in the Policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in the Policy unless

		otherwise specified
63	HOME VISIT CHARGES	Exclusion in the Policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in the Policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in the Policy unless otherwise specified
66	PSYCHIATRIC AND PSYCHOSOMATIC DISORDERS	Exclusion in the Policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in the Policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in the Policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in the Policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in the Policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in the Policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Exclusion in the Policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS +OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not Payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not payable except Bone Marrow Transplantation where covered by Policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE, BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT charges, not payable separately
76	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of instrument not payable
77	MICROSCOPE COVER	Payable under OT charges, not payable separately
78	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT charges, not payable separately
79	SURGICAL DRILL	Payable under OT charges, not payable separately
80	EYE KIT	Payable under OT charges, not payable separately
81	EYE DRAPE	Payable under OT charges, not payable separately
82	X-RAY FILM	Payable under Radiology charges, not as consumable
83	SPUTUM CUP	Payable under Investigation charges, not as consumable

84	BOYLES APPARATUS CHARGES	Payable under OT charges, not payable separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of cost of Blood, not payable
86	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable - Part of Dressing charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable - Part of Dressing charges
89	COTTON BANDAGE	Not Payable - Part of Dressing charges
90	MICROPORE/ SURGICAL TAPE	Not Payable - Payable by the patient when prescribed, otherwise included as Dressing charges
91	BLADE	Not Payable
92	APRON	Not Payable - Part of Hospital Services / Disposable Linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable - (Service is charged by hospital, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of dressing charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sublimit
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION AND AIR CONDITIONER CHARGES	Part of room charge not payable separately
101	SURCHARGES	Part of room charge not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of room charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry /Housekeeping not payable separately
105	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET ADMINISTRATIVE OR NON-MEDICAL CHARGES	Not Payable - Part of room charges
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable

112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Not Payable
135	INFUSION PUMP – COST	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Not Payable
138	SPACER	Not Payable
139	SPIROMETRE	Not Payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (Paid by Patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine

151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs.200/day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post-surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, explanatory laparotomy for intestinal liver transplant etc. Obstruction.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC	May be payable when prescribed for patient not payable for hospital use in OT or ward or for dressing in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post-Hospitalisation nursing charges not payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable - Sugar free variants of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For Longer stay in ICU, may require a change and atleast one set every second day must be payable
163	GLOVES Sterilized Gloves	Payable /unsterilized gloves not payable
164	HIV KIT	Payable - Payable Pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during Hospitalisation is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not payable / post bite vaccination payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		

173	AHD	Not Payable - Part of Hospital's internal cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Payable as per plan
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, OVERY KIT, ETC)	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not Payable, except for telemedicine consultation where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case PIVI requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not Payable Pre-Hospitalisation or post hospitalisation/ Reports and charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable as per plan
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 Hrs. and then 1 in 24 hrs.
197	URINE BAG	Payable where medically necessary till a reasonable cost - Maximum 1 per 24 hrs.
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid