RELIANCE
General Insurance

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Reliance HealthWise Policy
Policy Wording

PREAMBLE

WHEREAS the Insured designated in the Schedule to this Reliance HealthWise Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the period as specified in the Schedule to this Policy, the Insured/Insured Person shall contract any disease, illness or injury and if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require any such Insured/Insured Person, to incur hospitalisation and / or other related expenses at any Hospital/ Nursing Home in India (hereinafter called "Hospital") as an inpatient or domiciliary hospitalisation expenses in any of the circumstances mentioned hereunder, then the Company will pay to the Insured/Insured Person, his/her nominee, or his/her legal representatives, as the case may be, the amount of such expenses/charges as would fall under the different heads mentioned below and as are reasonably and necessarily incurred by or on behalf of such Insured/Insured Person for

1. Hospital (Room & Boarding and Operation theatre) charges
2. Fees of Surgeon, Anesthetist, Nurse, Specialists etc.,
3. Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4. Pre and post hospitalisation expenses
5. Ambulance charges
6. Day Care treatment

in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

DEFINITIONS

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meanings set forth:

1. **"Critical Illness"** means disease/illness/surgery limited to the following:
   a. Cancer
   b. Coronary artery bypass surgery
   c. First Heart attack
   d. Kidney Failure
   e. Multiple Sclerosis
   f. Major organ transplant
   g. Stroke
   h. Aorta graft surgery
   i. Paralysis
   j. Primary Pulmonary Arterial Hypertension
2. **"Day Care Treatment"** means treatment undertaken in a Hospital / Nursing Home on the recommendation of a Medical Practitioner for the following diseases, illness or injury which require hospitalisation for less than 24 hours:
   a. Dialysis
   b. Chemotherapy
   c. Radiotherapy
   d. Eye surgery
   e. Dental surgery
   f. Lithotripsy (kidney stone removal)
   g. Tonsillectomy
   h. Dilatation & Curettage
   i. Cardiac Catheterization
   j. Hydrocele surgery
   k. Hernia repair surgery
   l. Surgeries/procedures that require less than 24 hours hospitalisation due to advancement in technology
3. **"Disease"** means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.
4. **"Domiciliary Hospitalisation"** means medical treatment for a period exceeding three days for any disease, illness or injury which in the normal course would require care and treatment at a Hospital/Nursing Home but is actually taken whilst confined at home in India under any of the following circumstances, namely:
   a. the condition of the patient is such that he/she cannot be removed to Hospital/Nursing Home, or
   b. the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein

   Domiciliary hospitalisation benefits shall be subject to the limits as specified in the Schedule to this Policy, and shall, in no case, cover expenses incurred for:

   a. Pre and Post Hospital treatment,

   b. Treatment of any of the following diseases:
      i. Asthma
      ii. Bronchitis
      iii. Chronic nephritis and nephritic syndrome
      iv. Diarrhoea and all types of dysenteries including gastroenteritis
      v. Diabetes mellitus and insipidus
      vi. Epilepsy
      vii. Hypertension
      viii. Influenza, cough and cold
      ix. All psychiatric or psychosomatic disorders
      x. Pyrexia of unknown origin for less than 10 days
      xi. Tonsillitis and upper respiratory tract infection including laryngitis and pharangitis
      xii. Arthritis, gout and rheumatism
5. **"Family"** means the Insured, his/her lawful spouse and maximum of two children below the age of 21 years.
6. **"Hospital/Nursing Home"** means an establishment in India for indoor medical care and treatment of patients which:
   a. is registered with the appropriate local authorities as such and benefits from the supervision of a Medical Practitioner on a 24 hour basis, or

b. complies with at least the following criteria:

i) it has at least 15 inpatient beds (at least 10 inpatient beds in places with a population of less than 10,00,000);

ii)it has a fully equipped operating theatre where surgery is performed;

iii) it employs qualified nursing staff on a 24 hour basis;

iv) maintains daily records of patients.

c. By the nature of the medical treatment provided is an establishment properly recognized as a Hospital/Nursing Home within the locality and fulfils all the demands ordinarily or customarily of a Hospital for medical treatment, and where all medical treatment is administered by a Medical Practitioner, and is not, except incidentally, a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel, health spa, massage center or any similar establishment.

7. **"Hospitalisation Expenses"** mean expenses on hospitalisation for minimum period of 24 hours, which are admissible under this Policy. However, this time limit will not apply for specific treatments defined under Day Care treatment taken in a Hospital / Nursing Home.

8. **"Illness"** means sickness or disease first diagnosed during the Policy period for which immediate treatment by a Medical Practitioner is necessary.

9. **"Injury"** means physical injury caused by unintended means during the Policy period.

10. **"In-patient"** means an Insured / Insured Person who is admitted to Hospital / Nursing Home and stays for at least 24 hours for the sole purpose of receiving treatment.

11. **"Insured"** means the individual who has a permanent place of residence in India and on whose name the Policy is issued.

12. **"Insured Person"** means the person named in the Schedule to this Policy, who has a permanent place of residence in India and for whom the insurance is proposed and the appropriate premium paid.

13. **"Medical Charges"** mean reasonable charges unavoidably incurred by the Insured/Insured Person for the medical treatment of disease, illness or injury the subject matter of the claim as an In-patient in a Hospital/Nursing Home, and includes the costs of a bed; treatment and care by medical staff; medical procedures, Medical Practitioner's/ Consultants/specialists fees, medicines and consumables including cost of pacemaker, cost of organs, artificial limbs etc. as long as these are recommended by the attending Medical Practitioner.

14. **"Medical Practitioner"** means a person who holds a degree/diploma of a recognized institution and is registered with the Medical Council in respective states of India. The term Medical Practitioner includes a Physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

15. **"Policy period"** means the date between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

16. **"Post-hospitalisation Expenses"** mean relevant medical expenses incurred during a period up to the number of days specified in this Policy after hospitalisation for treatment of disease, illness or injury sustained and considered a part of a claim admissible under this Policy.

17. **"Pre-existing Condition"** means any condition, ailment or injury or related condition(s) for which the Insured/Insured person had signs or symptoms and/or were diagnosed and/or received medical advice/ treatment, within 48 months prior to the first policy with us.

18. **"Pre-hospitalisation Expenses"** mean relevant medical expenses incurred during a period up to the number of days specified in the Schedule to this Policy after hospitalisation for disease, illness or injury sustained and considered a part of a claim admissible under this Policy.

19. **"Qualified Nurse"** means a person who holds a certificate of a recognised Nursing Council and is employed on recommendation of the attending Medical Practitioner.

20. **"Third Party Administrator (TPA)"** means any organisation or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured/Insured Person as well as to the Company for an insurable event

21. **"Schedule"** means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Person/s, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

22. **"Sum Insured"** means the sum as specified in the Schedule to this Policy against the name of Insured/Insured Person/s, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period.

23. **"Surgical Operation"** means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital/Nursing Home.

SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay and/or reimburse following benefits in the manner, for the period and to the extent of the Sum Insured as specified in this Policy.

BASIC COVER

1. **Hospitalisation Expenses**

This benefit covers payment of hospitalisation expenses incurred by the Insured/Insured Person for disease/illness/injury contracted or sustained by the Insured/Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital, as an in-patient, which, includes, Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs.

The Insured/Insured Person should have been hospitalised as an in-patient for a minimum period of 24 hours. However, in respect of the Day Care treatment undertaken in a Hospital/Nursing Home, 24 hours hospitalisation is not necessary.

2. **Domiciliary Hospitalisation**

This benefit covers payment of expenses incurred for medical treatment pertaining to domiciliary hospitalisation for a period exceeding three days for disease, illness or injury, which in the normal course, would require care and treatment at a Hospital/Nursing Home, but is actually taken whilst the Insured / Insured Person is confined at home in India, under any of the following circumstances namely:

a. the condition of the patient is such that he/she cannot be removed to Hospital/Nursing Home, or

b. the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the Sum Insured as specified in the Schedule to this Policy, and shall, in no case cover expenses incurred for:

a. Pre and Post Hospital treatment,

b. Treatment of any of the following diseases/illness/injury:

i. Asthma

ii. Bronchitis

iii. Chronic nephritis and nephritic syndrome

iv. Diarrhea & all types of dysenteries including gastroenteritis

v. Diabetes mellitus and insipidus

vi. Epilepsy

vii. Hypertension

viii. Influenza, cough and cold

ix. All psychiatric or psychosomatic disorders

x. Pyrexia of unknown origin for less than 10 days

xi. Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis

xii. Arthritis, gout and rheumatism.

Domiciliary hospitalisation benefits also cover expenses on nurses engaged on the recommendation of the attending medical practitioner. The same shall be subject to the Sum Insured as specified in the Schedule to this Policy.

3. **Day Care Treatment**

This benefit covers relevant medical expenses incurred by the Insured / Insured Person in case of day care treatment (where 24 hours of hospitalisation is not required) such as dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy and any other procedure that requires less than 24 hours hospitalization due to advancement in technology undertaken in a Hospital/Nursing Home as defined herein above.

4. **Pre-Hospitalisation**

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule to this Policy prior to hospitalisation for treatment of disease, illness or injury sustained and considered a part of a claim admissible under this Policy.

5. **Post-Hospitalisation**

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule to this Policy, after discharge from Hospital/Nursing Home for continuous treatment of the disease, illness or injury sustained for which the Insured/Insured Person was hospitalised giving rise to an admissible claim under this Policy.

6. **Pre-Existing Disease**

This Policy covers relevant medical expenses incurred from the 3rd year/5th year of the policy after 2 or 4 continuous renewals of this Policy with the Company, subject to the Plan opted, for treatment of pre-existing diseases, illness, injury or condition in a Hospital/Nursing Home as an in-patient.

7. **Critical Illness**

The Policy provides as applicable to the relevant plan specified in the schedule to the policy, for an additional amount equivalent to the Sum Insured opted under Hospitalisation, towards treatment of listed critical illnesses. For the purposes of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence more than 30 days after the commencement of Period of Insurance and shall only include those defined hereunder. If these diseases are found to be pre-existing at the time of taking the Policy then the relevant waiting period as defined under pre-existing disease shall apply.

Cancer

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

The following are excluded –

- Tumors showing the malignant changes of carcinoma in situ & tumors which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 & CIN-3
- Any skin cancer other than invasive malignant melanoma
- All tumors of the prostrate unless histologically classified as having a Gleason score greater than 6 or having progressed to atleast clinical TNM classification T2N0M0
- Papilary Micro-carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumors in the presence of HIV infection

Coronary Artery Bypass Graft

The actual undergoing of open heart chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner and evidenced by any two of the following:

- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Angiography (an x-ray of the blood vessels)

Excluded are:

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser surgery

First Heart Attack

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for eg. Typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

The following are excluded:

- Non ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
- Other acute Coronary Syndromes
- Any type of angina pectoris

Kidney Failure

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

Multiple Sclerosis

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months, and
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.
- Other causes of neurological damage such as SLE and HIV are excluded.

Major Organ Transplant

The actual undergoing of a transplant of:

- One of the following organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cell.

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

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

Stroke

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical

practitioner and evidenced by typical clinical symptoms as well as typical finding in CT scan or MRI of the brain.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve vestibular functions

Aorta graft surgery

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

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

Paralysis

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

Primary Pulmonary Arterial Hypertension

The first occurrence of narrowing of the arteries of the lungs causing it harder for the right side of the heart to circulate the blood to the lungs which is evidenced by shortness of breath, dizziness, fainting etc., all of which are exacerbated by exertion which is evidenced by the following:

- Physical examinations
- Pulmonary function test
- Arterial Blood Gas Levels
- Right-sided Cardiac Catheterisation.

Primary Pulmonary Hypertension caused due to the following are excluded:

- A genetic defect
- Intake of diet medications
- As a consequence of HIV infection

This additional Sum Insured mentioned above is exclusive and specific for the treatment of the diagnosed critical illness as defined herein above undertaken in a Hospital/Nursing Home as an in-patient and will not be available for other treatments/ hospitalization. For all other treatments/hospitalization benefits the limits shall be Sum Insured as specified in the Schedule to this Policy. Once a claim is accepted and paid for an Insured Person under this section of the policy, coverage under this section will not be available for that particular Insured Person for all future renewals of the Policy.

8. **Donor Expenses**

   This benefit covers the expenses towards donor in case of major organ transplant subject to the overall limit of the Sum Insured and Plan opted as specified in the Schedule to this Policy.

9. **Cost of health check up**

   Reimbursement of the cost of medical check-up up to 1% of average Sum Insured for Individual Policies and up to 1.25% for Floater covers, once at the end of a block of four consecutive years provided there are no claims reported under the Policies by any member, during this block. The limit specified for floater cover is the overall limit available for all members.

VALUE ADDED COVERS

Benefits under this Section are Value added services payable up to the limit of the Sum Insured as specified in the Schedule to this Policy and shall not exceed the overall limit of Sum Insured under basic Hospitalisation opted by the Insured during the policy period. Benefits under each value added cover shall be available separately to each Insured/Insured Person and available per hospitalisation.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers.

1. **Daily Hospitalisation Allowance**

   This benefit provides for payment to the Insured / Insured Person of Daily Hospital Allowance up to limits specified in the Schedule to this Policy in case of hospitalisation exceeding 3 days.

2. **Nursing Allowance**

   This benefit provides for payment to Insured / Insured Person of an allowance for services of a nurse at the Insured / Insured Person's residence or the Hospital provided such services are confirmed as being necessary by the attending Medical Physician and the same relate directly to a disease / illness / injury for which the Insured / Insured Person has been hospitalized.

3. **Ambulance Charges**

   This benefit provides the payment to the Insured/ Insured Person of expenses incurred for his / her transportation by ambulance to the Hospital / Nursing Home for treatment of the disease / illness / injury necessitating his / her admission to Hospital / Nursing Home.

4. **Recovery Benefit**

   This Policy provides for payment to the Insured / Insured Person of the sum as specified in the Schedule to this Policy in the event of his / her hospitalisation for a disease / illness / injury for a period of 10 days or more. This benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy period subject to overall limit of the Sum Insured.

5. **Expenses on Accompanying Person**

   This benefit provides for payment to Insured / Insured Person of expenses incurred by the accompanying person at the Hospital / Nursing Home during treatment of Insured / Insured Person for a disease, illness, injury necessitating his / her hospitalisation, as per limits specified in this Policy.

POLICY EXCLUSIONS

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. All pre-existing diseases / illness / injury / conditions as defined in the Policy, until 24/48 months of continuous covers have elapsed as per the plan opted, since inception of the first Policy with us.
2. Any disease contracted by the Insured and treatment undertaken during the first 30 days from the commencement date of the Policy except in case of accidental injuries. This exclusion doesn't apply for Insured/Insured Person having any health insurance policy in India atleast for 1 year prior to taking this policy as well as for subsequent renewals with the Company without a break.
3. Expenses incurred on treatment of following diseases, illness, injury within the first year from the inception of this Policy:
   - Cataract
   - Benign Prostatic Hypertrophy
   - Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
   - Dilation and curettage
   - Hernia, hydrocele, congenital internal disease, fistula in anus, sinusitis
   - Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant /adenoids and hemorrhoids
   - Dialysis required for chronic renal failure
   - Gastric and Duodenal ulcers

This exclusion doesn't apply for Insured/Insured Person having any health insurance policy in India atleast for 1 year prior to taking this Policy as well as for subsequent renewals with the Company without a break.

4. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident.
5. Dental treatment or surgery of any kind unless requiring hospitalisation with minimum of 24 hours stay and treatment.
6. Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
7. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for correction of refractive error, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel.
8. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
9. Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner,
10. Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital external disease/ illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.
11. Sex change or treatment, which results from, or is in any way related to, sex change.
12. Vaccination and inoculation of any kind.
13. Treatment by a family member and self-medication or any treatment that is not scientifically recognised.
14. Any criminal act.
15. Disease / illness / injury, directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.
16. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
17. Any medical, physical or mental condition or treatment or service, which is specifically excluded under this Policy.
18. Alcohol or drug abuse.
19. Prostheses, corrective devices and medical appliances, which are not, required intraoperatively or for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised.
20. Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.
21. Treatment of mental disease/illness, stress, psychiatric or psychological disorders.
22. Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any disease/ illness / injury.
23. Any loss, directly or indirectly, due to contamination due to an act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured /Insured Person).
24. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
25. Disease, illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination.
26. Experimental and unproven treatment.
27. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a Hospital/Nursing Home or at home under domiciliary hospitalisation as defined.
28. Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.
29. Naturopathy treatment, any other form of Non Allopathic treatment or local medication.
30. Any treatment received outside India.
31. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
32. Insured/Insured Person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports.
33. Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air charter Company.

CLAIMS PROCEDURE

When & How to Claim

It is a condition precedent to the Company's liability that upon the discovery or happening of any disease/illness/injury that may give rise to a claim under this Policy, the Insured/Insured Person shall undertake the following:

1. **Claim Notification**

   The Insured / Insured Person shall give immediate notice to the Third Party Administrator named in the Schedule to this Policy, by calling the toll free number as specified in the Schedule to the Policy and also in writing at the address shown in the Schedule with particulars as below: Policy Number, Name of the Insured/Insured Person availing treatment, nature of disease / illness / injury, name and address of the attending Medical Practitioner/Hospital and any other relevant information. This information can also be provided to the Company immediately and prior to availing treatment and in any case within 7 days of hospitalisation/ treatment.

2. **Cashless Facility for Hospitalisation**

   The Company shall provide cashless facility for hospitalisation to the Insured /Insured Person through the Third Party Administrator (TPA). The Insured/Insured Persons can avail of cashless facility for hospitalisation up to the limit of Sum Insured as specified in the Schedule to this Policy, subject to obtaining pre-authorisation from the TPA.

   Insured/Insured Person need to submit to the TPA complete information of the disease, illness or injury requiring treatment to be undertaken in a Hospital which is within the TPA network, along with certification from the Medical Practitioner and/or Hospital. Considering the above, the TPA shall issue pre-authorisation to the Hospital concerned for cashless hospitalisation for the treatment of the Insured / Insured Person up to the limit of the Sum Insured specified in the Schedule to this Policy.

   However, cashless facility for hospitalisation will not be available if the treatment is undertaken in a non-network Hospital, in which case, the Insured / Insured Person shall, after due intimation about the hospitalisation details to the Company/TPA as mentioned hereinabove, pay the hospitalisation expenses directly to the Hospital concerned and claim reimbursement from the Company for the same.

   For the updated list of Hospitals within the TPA network from time to time, the same can be obtained from the website of the TPA as specified in the Schedule to the Policy.

   Where cashless facility for hospitalisation is pre-authorised by the TPA, the Insured / Insured Person need not pay the hospitalisation expenses for the treatment undertaken for diseases, illness or injuries which are

covered under the Policy, and the same shall be paid by the TPA directly to the Hospital.

Cashless facility for hospitalisation benefit shall be limited exclusively to hospitalisation expenses incurred for treatment in a network hospital undertaken for disease, illness or injury which are covered under the Policy and shall not extend to any other value added benefits.

3. **Claim Processing**

The Third Party Administrator appointed by the Company will process the claim on behalf of the Company and make all payments. The Company requires the Insured/Insured Persons to deliver to the Third Party Administrator at their own expense, within 30 days of the Insured's/Insured Person's discharge from Hospital (for post-hospitalisation expenses, completion of post-hospitalisation period or completion of treatment, whichever is earlier), any and all information and documentation concerning the claim or the Company's liability for it, including but not limited to:

- Duly filled claim form(s)
- Original bills, receipts and discharge/card from the Hospital /Medical Practitioner
- Original bills from chemists supported by proper prescription
- Original Investigation test reports and payment receipts
- Medical Practitioner's referral letter advising hospitalisation
- Original bills and receipts for claiming Ambulance charges
- Original bills, receipts and Medical Practitioner's prescription for claiming benefits under external mobility aids and appliances.

Apart from the above, if so required, the Company/TPA may request for additional documents/information, if any, for processing the claim. If so, requested by the Company, the Insured / Insured Person will have to submit for a medical examination by the Company's or Third Party Administrator's Medical Practitioner as often as the Company considers necessary.

TERMS AND CONDITIONS

1. **Floater Policy**

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period, upto the limit of Sum Insured specified in the Schedule to this Policy Where the Policy is issued on Floater basis, the Policy can cover only the Insured, his/her lawful spouse and 2 dependant children who are upto the age of 21 years. A Floater Policy cannot cover any other person apart from the above category of persons.

2. **Duty of Disclosure**

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent` means or device being used by the Insured/Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

3. **Observance of Terms and Conditions**

The due observance and fulfillment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured / Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

4. **Reasonable Care**

The Insured/Insured Person shall take all reasonable steps to safeguard the interests of the Insured / Insured Person against accidental loss or damage that may give rise to a claim.

5. **Material change**

The Insured/ Insured Person shall immediately notify the Company in writing of any material change in the risk and cause at his own expense/ such additional precautions to be taken as circumstances may require to ensure safety and containing the circumstances that may give rise to the claim, and the Company may adjust the scope of cover and / or premium, if necessary, accordingly.

6. **Records to be maintained**

The Insured/ Insured Person shall keep an accurate record containing all relevant particulars and shall allow the Company to inspect such record. The Insured /Insured Person shall within one month after the expiry of the Policy furnish such information as the Company may require.

7. **No Constructive Notice**

Any knowledge or information of any circumstance or condition in connection with the Insured/Insured Person in possession of any official of the Company shall not be notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

8. **Notice of Charge**

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured /Insured Person or his/her nominees or his/her legal representatives, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

9. **Special Provisions**

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

10. **Electronic Transactions**

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

11. **Duties of the Insured/Insured Person on occurrence of loss**

On the occurrence of any loss, within the scope of this Policy the Insured/Insured Person shall:

a) Forthwith file/submit a Claim Form in accordance with 'Claim Procedure'.

b) Allow the Medical Practitioner or Surveyor or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured/Insured Person.

c) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties.

If the Insured/Insured Person does not comply with the provisions of this Condition, all benefits under this Policy shall be forfeited, at the option of the Company.

12. **Position after a Claim**

As from the day of receipt of the claim amount by the Insured/ Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by a corresponding amount.

13. **Subrogation**

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person's rights or recovery thereof against any person or organisation, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure

such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

14. **Contribution**

If there shall be existing any other insurance of any nature whatsoever covering the same Insured/Insured Person whether effected by the Insured/Insured Person or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage.

15. **Fraudulent Claims**

If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured/Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no Court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

16. **Cancellation/Termination**

The Company may at any time, cancel this Policy, on grounds of misrepresentation, fraud non disclosure of material fact or non co-operation of the insured by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured/Insured Person at his/their last known address in which case the Company shall be liable to repay a rateable proportion of the premium for the unexpired term from the date of the cancellation. The Insured/Insured Person may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case where the Policy is issued on Annual basis the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales mentioned below:

Period on Risk	Rate of Premium Refunded
Up to I month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate
Exceeding six months	Nil

However, in case of a valid claim having being paid under this Policy, there would be no refund of premium. For long term contracts, the Company shall, from the date of receipt of notice cancel the Policy after retaining proportionate premium for the covered period and 30% of the premium relating to the balance premium for the unexpired period.

17. **Cause of Action/Currency for Payment**

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India and in Indian Rupees only.

18. **Policy Disputes**

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy.

19. **Arbitration Clause**

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

20. **Renewal Notice**

A Policy shall be ordinarily renewable upto a maximum of 75 years, except on grounds such as fraud, non disclosure, moral hazard or misrepresentation. The Company shall not be bound to accept any renewal premium nor give notice that such is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the Insured that may result in enhancing the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company. Renewals are deemed to be continuous when received within a period of 15 days from the date of expiry of last policy subject however to the effective policy inception date being reckoned from such period when the renewal premium is received by the Company.

21. **Notices**

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to -

In case of the Insured/Insured Person, at the address specified in the Schedule to this Policy.

In case of the Company, to the Policy issuing office / nearest office of the Company.

22. **Customer Service**

If at any time the Insured/Insured Person requires any clarification or assistance, the Insured/Insured Person may contact either Service Provider or our customer care centre at the number mentioned in the Schedule to this Policy.

23. **Grievances**

In case the Insured/Insured Person is aggrieved in any way, the Insured /Insured Person may contact the Company at the specified addresses, during normal business hours or the Insured/Insured Person may also contact our Customer Service desk at (022) 39898282 (call charges apply).

In respect of any disputes or difference which remain unresolved and where the claim amount is not more than Rs.20 lakhs, the individual Insured/Insured Person can approach the Insurance Ombudsman set up at different territorial locations for resolution. The details of the Insurance Ombudsmen and their jurisdiction are available in their websites www.ombudsmanindia.org/www.gbic.co.in

Reliance HealthWise Policy

Schedule of Benefits

Coverage	Standard Plan	Silver Plan	Gold Plan
Basic Covers			
Hospitalisation	Minimum 24 hours hospitalisation. Maximum cover up to the Sum Insured selected by the Insured.		
Domiciliary Hospitalisation	Limited to 10% of the Sum Insured opted by the Insured.		
Day Care Treatment	Covered within the limit of Sum Insured opted by the Insured		
Pre and Post Hospitalisation	Relevant expenses incurred for 30 days prior to hospitalisation and expenses incurred up to 60 days after hospitalisation are covered.	Relevant expenses incurred for 60 days prior to hospitalisation and expenses incurred up to 90 days after hospitalisation are covered.	
Pre-Existing	Pre-existing disease expenses are covered from the 5th year of the Policy after 4 continuous renewals of this Policy with the company	Pre-existing disease expenses are covered from the 3rd year of the Policy after 2 continuous renewals of this Policy with the company.	
Critical illness	Additional Sum Insured Not Applicable		An additional amount equivalent to the Sum Insured opted under hospitalisation will be available for treatment of the following critical illnesses undertaken in a Hospital/Nursing Home: Cancer, Coronary Artery Bypass Surgery, First Heart Attack, Kidney Failure, Multiple Sclerosis, Major Organ Transplant, Stroke, Aorta Graft Surgery, Paralysis and Primary Pulmonary Arterial Hypertension
Donor Expenses	Not Applicable	Hospitalisation expenses incurred towards the donor is covered in case of major organ transplant within the overall limit of Sum Insured.	
Cost of health check up	The Insured/Insured Person (s) is entitled to reimbursement of the cost of medical check-up at the end of a block of 4 consecutive years provided there were no claims reported under the Policies by any member, during this block. The cost so reimbursable shall not exceed an amount equal to 1% of the average Sum Insured during the block of 4 Underwriting years. In case of Family Floater the above limit is 1.25% of the average Sum Insured for all the Insured Person covered in the policy put together.		
Value Added Covers (Subject to the overall limit of Sum Insured opted by the Insured during the policy period)			
Daily Hospitalisation Allowance	Not Applicable		In addition to hospital expenses, where the hospitalization is for more than 3 days, a daily hospital cash allowance of Rs 250 per day up to 7 days will be paid to cover daily expenses starting from day 4 to day 10. However, in case of hospitalization for critical illness, the said cash allowance will be paid up to 14 days. This allowance is irrespective of the number of occurrences. Even if two people of the same floater are hospitalized, concurrently, each one of them will be eligible for hospital daily allowance separately.
Nursing Allowance	Not Applicable	Allowance towards charges for medical services of a nurse at the residence of Insured/Insured Person or during the period they are hospitalized is payable provided they are confirmed to be necessary by the attending medical practitioner and relate directly to the disease, illness or injury for which the Insured/Insured Person has been hospitalized. The allowance is payable at of Rs. 250/- per day for a maximum period of 5 days	Allowance towards charges for medical services of a nurse at the residence of Insured/Insured Person or during the period they are hospitalized is payable provided they are confirmed to be necessary by the attending medical practitioner and relate directly to the disease, illness or injury for which the Insured/Insured Person has been hospitalized. The allowance is payable at Rs. 300/- per day for a maximum period of 5 days. However, in case of listed critical illnesses the said reimbursement will be extended to maximum 10 days.
Ambulance charges	Cost of transportation of the Insured/ Insured Person(s) by a local road Ambulance Service to the Hospital reimbursable to a maximum of Rs. 500/-	Cost of transportation of the Insured/Insured Person(s) by a local road Ambulance Service to the Hospital shall be reimbursable to a maximum of Rs. 750/-	Cost of transportation of the Insured/Insured Person(s) by a local road Ambulance Service to the Hospital shall be reimbursable to a maximum shall be of Rs. 1000/-
Recovery Benefit	Not Applicable		If in case a person is hospitalised for more than 10 days, a lump-sum of Rs. 10, 000 will be paid. This condition is applicable for all the members of the floater separately irrespective of the number of occurrences during the Policy period subject to overall limit of Sum Insured.
Expenses on accompanying person at the Hospital	Subject to the Insured/Insured Person(s) being hospitalised for a period of 5 days at a given time, an allowance towards expenses of accompanying person at the hospital is payable at Rs.200 per day for a maximum of 5 days (i.e. from the 6th day to the 10th day of hospitalisation).	Subject to the Insured/Insured Person(s) being hospitalised for a period of 5 days at a given time, an allowance towards expenses of accompanying person at the hospital is payable at Rs.250 per day for a maximum of 5 days (i.e. from the 6th day to the 10th day of hospitalisation).	Subject to the Insured/Insured Person(s) being hospitalised for a period of 5 days at a given time, an allowance towards expenses of accompanying person at the hospital is payable at Rs. 300 per day for a maximum of 5 days (i.e. from the 6th day to the 10th day of hospitalisation).

(All the above coverages are subject to exclusions, terms and conditions as specified in the Policy Wording)