RELIANCE GENERAL INSURANCE

Reliance HealthWise Policy - Policy Wording

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

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IRDAI Registration No. 103.
Reliance General Insurance Company Limited.
Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710.
Corporate Office: Reliance Centre, South Wing, 4th Floor, Off Western Express Highway, Santacruz (East), Mumbai - 400 055.
UIN: RELHLIP18124V021718
Corporate Identity No.: U66603MH2000PLC128300.

RGI/MCOM/CO/HL-07/HWPW/Ver.2.0/220318
An ISO 9001:2008 Certified Company

A RELIANCE CAPITAL COMPANY

PREAMBLE

WHEREAS the Policyholder designated in the Policy 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 and agreed for the Policy Period as specified in the Policy 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 Policy Period as specified in the Policy Schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms, conditions and benefits and exclusions and the limit of Sum Insured as set forth in this Policy.

1. DEFINITIONS

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Policy 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. **"Accident"** An Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **"Age"** The completed age of the Insured Person as on his last Birthday

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

4. **"Annexure"** A document attached and marked as Annexure to this Policy

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

6. **"Break in Policy"** occurs at the end of the existing Policy period end date, 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.

7. **"Cashless facility"** means a facility extended by the insurer to the Insured Person where the payments, of the costs of treatment undergone by the Insured Person 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.

8. **"Child"** means biological or legally adopted son or daughter of the Insured Person whose completed age is less than 21 years as on the Policy Period Start Date

9. **"Claim"** a demand made by the Insured Person or on his behalf, for payment under "Scope of Cover" as covered under the Policy

10. **"Company"** Reliance General Insurance Company Limited"

11. **"Condition precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

12. **"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.

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

    a) Internal Congenital Anomaly

       Congenital anomaly which is not in the visible and accessible parts of the body.

    b) External Congenital Anomaly

       Congenital anomaly which is in the visible and accessible parts of the body

14. **"Cosmetic Surgery"** Surgery / treatment which is primarily done for the enhancement of appearance through surgical and medical techniques. It concerns with maintaining normal appearance, restoring or enhancing it. Cosmetic Surgery is a multi-disciplinary and comprehensive approach directed to all areas of body and involves specialists in the anatomy, physiology, pathology and/or a physician across disciplines including contributing disciplines like dermatology, general surgery, plastic surgery, otolaryngology, maxillofacial surgery, oculoplastic surgery and others

15. **"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.

16. **"Day Care treatment"** means medical treatment, and/or surgical procedure which is:

    - 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 hospitalization of more than 24 hours.
    - Treatment normally taken on an out-patient basis is not included in the scope of this definition.
    - Day Care Treatment shall only include procedures listed in Annexure "1"

17. **"Dependant"** means financially dependant on the Insured Person and does not have independent source of income.

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

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

19. **"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.

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

21. **"Family"** means the Insured Person, his/her lawful spouse and maximum of two children below the age of 21 years.

22. **"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.

23. **"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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

    - has qualified nursing staff under its employment round the clock;
    - has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    - has qualified medical practitioner(s) in charge round the clock;
    - has a fully equipped operation theatre of its own where surgical procedures are carried out;
    - maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

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

25. **"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.

26. **"Illness"** impairment of normal physiological function and requires medical treatment.

(a) 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

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

27. **"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.

28. **"Inpatient Care"** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

30. **"Life Threatening Medical Condition"** a medical condition suffered by the Insured Person which has any of the following characteristics:

    - Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate)' or
    - Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or
    - Critical Care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or
    - Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department and
    - Is certified by the attending Medical Practitioner as a Life Threatening Medical Condition

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

32. **"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

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

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.

33. **"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. The registered practitioner should not be the insured or close member of the family.

34. **"Medically Necessary Treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

    - is required for the medical management of the illness or injury suffered by the Insured Person;
    - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    - 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.

35. **"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 Person by a cashless facility.

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

37. **"Non-Network Provider"** means any hospital, day care centre or other provider that is not part of the network.

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

39. **"Policy"** The Company's contract of insurance with the Policyholder providing cover as detailed in the Policy Terms and Conditions, the Proposal form, Policy Schedule, Endorsements, if any and Annexures, which form part of the contract and must be read together

40. **"Policy schedule"** The Schedule attached to and forming part of the Policy mentioning apart from other details, Policyholder's details, details of the Insured Person, the Sum Insured, the Policy Period, Premium paid (including duties, taxes and levies thereon) and the limits to which benefits under the Policy are subject to

41. **"Policyholder"** means the person who is the proposer and whose name specifically appears in the Policy Schedule as such

42. **"Policy Period"** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date and as specifically appearing in the Policy Schedule.

43. **"Policy Period End Date"** the date on which the Policy expires, as specifically appearing in the Policy Schedule

44. **"Policy Period Start Date"** the date on which the Policy commences, as specifically appearing in the Policy Schedule

45. **"Post-hospitalisation Medical expenses"** Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the

    I. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

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

46. **"Portability"** means the right accorded to an Individual health insurance policyholder (including family cover) to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer

47. **"Pre-existing Disease"** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter..

48. **"Pre-hospitalisation Medical expenses"** Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

    I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

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

49. **"Qualified nurse"** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State of India.

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

51. **"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.

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

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

53. **"Senior Citizen"** means any person who has completed sixty or more years of age as on the date of Policy Period Start Date or renewal of policy.

54. **"Sum Insured"** means the sum as specified in the Policy Schedule, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy Period.

55. **"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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

2. SCOPE OF COVER

The Company undertakes, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon that if during the Policy Period, the Insured Person shall contract any illness or injury and if such illness or injury shall upon the written medical advise of a Medical Practitioner require any such Insured Person within the policy period, to incur hospitalisation at any Hospital, day care treatment at any day care centre or domiciliary hospitalization in India, for the medically necessary treatment of the Insured Person, under any of the Basic Cover as mentioned hereunder, then the Company will indemnify the Insured Person, for the amount of such medical expenses, which should be reasonable and customary charges, as would fall under the different heads mentioned below and are incurred by or on behalf of such Insured Person for

1. Hospital (Room & Boarding and Operation theatre) charges,
2. Fees of Surgeon, Anaesthetist, Nurse, Specialists etc.,
3. Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4. Pre hospitalization medical expenses and post hospitalisation medical expenses
5. Local Road Ambulance Service
6. Medical expenses on day care treatment
7. Medical expenses on Domiciliary hospitalization

in manner, for the period and to the extent of the Sum Insured as specified in this Policy. The Company's total liability in aggregate for all claims paid under the policy shall not exceed the Sum Insured.

Basic Cover

1) Hospitalisation

This benefit covers payment of medical expenses incurred for medically necessary treatment taken during for Hospitalisation of the Insured Person for illness / injury contracted or sustained by the Insured Person during the Policy Period, in a Hospital, for Inpatient Care, 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.

2) Domiciliary Hospitalisation

This benefit covers payment of medical expenses incurred for medically necessary treatment pertaining to domiciliary hospitalisation of the Insured Person subject to the following:-

I. The period of domiciliary hospitalisation should exceed three consecutive days for illness or injury, which in the normal course would require inpatient care and medically necessary treatment at a Hospital, but is actually taken whilst the Insured Person is confined at home in India

ii. This benefit covers relevant Pre-hospitalisation medical expenses incurred by the Insured Person for 30 days prior to Hospitalisation

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

a. Post-Hospitalisation medical expenses

b. Treatment of any of the following 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 medical expenses on qualified nurses engaged on the written medical advise of the attending medical practitioner. The same shall be subject to the Sum Insured as specified in the Policy Schedule.

3) Day care treatment

This benefit covers payment of medical expenses incurred for medically necessary treatment pertaining to Day Care treatment of the Insured Person. Treatment normally taken on out-patient basis is not included in the scope of this definition.

The list of covered Day Care Treatment / Surgical

Procedure is appended as per Annexure 1.

4) Pre-Hospitalisation Medical Expenses

This benefit covers relevant Pre-hospitalisation medical expenses incurred by the Insured Person during a period, as specified in Policy Schedule, prior to Hospitalisation.

5) Post-Hospitalisation Medical Expenses

This benefit covers relevant Post-hospitalisation medical expenses incurred by the Insured Person during a period, as specified in Policy Schedule, post Hospitalisation.

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 under this Policy with the Company, for medically necessary treatment of pre-existing disease during Hospitalisation in a Hospital.

7) Critical illness

The Policy provides as applicable to the relevant plan specified in the Policy 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 Policy Period and shall only include those defined hereunder. If these illness, medical event or surgical procedure and 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.

1. Cancer of Specified Severity

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

ii. The following are excluded –

- All tumors which are histologically described ascarcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- All tumors in the presence of HIV infection.

2. Open Chest CABG

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

II. The following are excluded:

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

3. Myocardial Infarction (First Heart Attack of specific severity)

I. The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of
- acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

4. Kidney Failure requiring Regular Dialysis

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

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

5. Multiple Sclerosis with persisting symptoms

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

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

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

6. Major Organ / Bone MarrowTransplant

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

7. Stroke resulting in permanent symptoms

a. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and 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 findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

ii. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

8. 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 aneurysms)
- Angiography (an x-ray of the blood vessels)

9. Permanent Paralysis of Limbs

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 and must be present for more than 3 months.

10. Primary (Idiopathic) Pulmonary Hypertension

i. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by aCardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

ii. The NYHA Classification of Cardiac Impairment are as follows:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. Class IV: Unable to engage in any physical activity without discomfort.

Symptoms may be present even at rest.

iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

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 Policy Schedule.

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 Policy Schedule and shall not exceed the overall limit of Sum Insured under Hospitalisation opted by the Insured during the Policy Period. Benefits under each value added cover shall be available separately to each Insured Person and available per hospitalisation.

A valid claim should have been admitted under the basic

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

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 Person of Daily Hospital Allowance up to limits specified in the Policy Schedule in case of hospitalisation exceeding 3 days.

2. Nursing Allowance

This benefit provides for payment to the Insured Person of an allowance up to the limit as specified in the Policy Schedule for services of a qualified nurse at the Insured Person's residence or the Hospital on the medical advise which is confirmed as medically necessary by the attending Medical practitioner and the same relate directly to an illness / injury for which the Insured Person has been hospitalized.

3. Local Road Ambulance Service

This benefit provides the payment to the Insured Person of expenses of reasonable and customary charges up to the limit as specified in the Policy Schedule incurred for his / her transportation by ambulance to the Hospital for medically necessary treatment of the illness / injury necessitating his / her admission to Hospital.

4. Recovery Benefit

This Policy provides for payment to the Insured Person of the sum as specified in the Policy Schedule in the event of his / her hospitalisation for an illness / injury exceeds 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 Person of expenses incurred by the accompanying person at the Hospital during medically necessary treatment of Insured Person for an illness, injury necessitating his / her hospitalisation, as per limits specified in this Policy Schedule.

3. 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:

3.1 Waiting Period:

3.1.1. All pre-existing diseases, until 24/48 months of continuous cover for the respective Insured Person has elapsed as per the plan opted, since inception of the first Policy with us.

3.1.2. Any disease contracted by the Insured and treatment undertaken during the first 30 days of Policy Period Start Date except in case of accidental injuries. This exclusion doesn't apply for 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.

3.1.3. 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 anomaly/ diseases, 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 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.

3.2 Portability

3.2.1. If the Policyholder/ Insured Person renews with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDAI, then the Waiting Period as defined in Clause 3.1.1, 3.1.2 and 3.1.3 of this Policy shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s). However the company's maximum liability for payment of any claim on account of any illness/injuries/surgeries/disease as excluded under Clause 3.1.1, 3.1.2 and 3.1.3 of this Policy shall be capped to the limits as defined in Clause 3.2.2 below subject to Sum Insured and completion of waiting periods as mentioned under the respective Clause 3.1.1, 3.1.2 and 3.1.3

3.2.2. For portability in case of individual to individual or floater to floater the limits applicable for payments of claim under the Policy on account of reduction of Waiting Periods as defined above in 3.1.1, 3.1.2 & 3.1.3 shall be available as per the following criteria:

a. Sum Insured opted with the Company is lower than the expiring policy sum insured then the limit shall be available upto the Sum Insured opted with the Company

b. Sum Insured opted with the Company is equal to the expiring policy sum insured then the limit shall be available upto the Sum Insured opted with the Company.

c. Sum Insured opted with the Company is higher than the sum of expiring policy sum insured and cumulative bonus then the limit shall be available upto the sum of expiring policy sum insured and the accrued cumulative bonus as mentioned in the Policy Schedule.

d. In case where cover type of floater to floater portability the portability limit shall also be on

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

floater basis

e. Waiting Periods shall apply afresh to the amount which is equal to the difference between the Sum Insured opted with the Company and the expiring policy sum insured as mentioned in the Policy Schedule.

f. The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum Insured limit for Portability with a capping upto applicable sub-limit for Portability for each Insured Person as defined in Policy Schedule.

3.2.3. The Waiting Periods as defined in Clause 3.1.1, 3.1.2 & 3.1.3 and this clause shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

3.3 Permanent Exclusions

3.3.1 Circumcision unless necessary for treatment of an illness not excluded hereunder, or, as may be necessitated due to an accident.

3.3.2 Any dental treatment or surgery unless necessitated due to an Injury and requiring Hospitalization

3.3.3 Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. However, this exclusion will not apply to ectopic pregnancy, which is proved by diagnostic means and certification by a gynaecologist that it is life threatening.

3.3.4 Any treatment arising from or traceable to any fertility, infertility, sub-fertility or assisted conception procedure or sterilization, birth control procedures, hormone replacement therapy, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

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

3.3.6 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, cochlear implants, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

3.3.7 Any charges incurred to procure any medical certificate, treatment/Illness related documents pertaining to any period of Hospitalization/Illness

3.3.8 Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health

3.3.9 Personal comfort & convenience items or services including but not limited to T.V. (wherever specifically

charged separately), charges for access to telephone and telephone calls(wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body / baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

3.3.10 Stem Cell implantation, harvesting, storage or any kind of treatment using stem cells.

3.3.11 Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the Hospital under whatever head.

3.3.12 Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

3.3.13 Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner.

3.3.14 Any expenses incurred on injection bevacizumab or similar injections, organ transplant surgery involving organs not harvested from a human body , corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.)and oxygen concentrator for asthmatic condition

3.3.15 Weight management services and treatment, services and supplies including treatment of obesity (including morbid obesity).

3.3.16 Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, rest home, health hydros, remodeling/ nature cure clinics or similar institutions, sanatorium treatment, Rehabilitation measures, convalescent homes for de-addiction/detoxification centers, private duty nursing, respite care, long-term nursing care, home for aged, mentally disturbed, custodial care or any treatment in an establishment that is not a Hospital.

3.3.17 Treatment of mental illness, stress, Parkinsonism, Alzheimer, psychiatric or psychological disorders.

3.3.18 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.

3.3.19 Act of self-destruction or self-inflicted Injury or any form of organ donation by Insured Person, attempted suicide or suicide while sane or insane or Illness/

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol.

3.3.20 Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.

3.3.21 All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

3.3.22 Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

3.3.23 Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants

3.3.24 Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

3.3.25 Any Illness / Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with any criminal intent.

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

3.3.27 Prostheses, corrective devices and medical appliances, which are not, required intra-operatively or for the disease/ illness/ injury for which the Insured Person was hospitalised.

3.3.28 Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.

3.3.29 Aesthetic treatment, Cosmetic Surgery and plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury.

3.3.30 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 Person).

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

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

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

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

Also excluded herein is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above.

3.2.32 Unproven / Experimental treatments, investigational, devices and pharmacological regimens or unproven treatments or treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment. Any diagnosis/treatment of an Illness/ Injury which does not require Hospitalization.

3.2.33 Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/ Day Care Treatment is required.

3.2.34 All expenses related to donor screening, treatment, including surgery to remove organ(s) from the donor, in case of transplant surgery.

3.2.35 Naturopathy treatment, any other form of Non Allopathic treatment or local medication.

3.2.36 Treatment received outside India or any robotic / remote surgery performed by medical practitioners from outside the geographical territory of India.

3.2.37 Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

3.2.38 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.

3.2.39 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.

3.2.40 Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule or any non-medical charges as mentioned in "List of Medical Expenses excluded"

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

4. Claims Procedure

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

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

4.1 Claims Intimation

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

In the event of

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

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

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by the Company

4.2 Claims Procedure

The Company shall settle the claim within 30 days from the date of receipt of last necessary document.

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

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

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

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

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

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

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

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

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

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 4.4 with the Network Hospital.

Note:

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

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

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

the Company's website.

4.2.2 Re-imbursement :

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in Clause 4.4 shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

4.3 Policyholder's / Insured Person's duty at the time of Claim

a. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.

b. Forthwith intimate / file / submit a Claim in accordance with Clause 4 of this Policy.

c. Forthwith pay the entire premium for the cover period in case of EMI applicable

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

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

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

- Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

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

4.4 Claim Documents

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

- Duly completed and signed Claim Form, in original
- Medical Practitioner's referral letter advising Hospitalization
- Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- Original bills, receipts and discharge card from the Hospital / Medical Practitioner

- Original bills from pharmacy / chemists
- Original pathological / diagnostic test reports and payment receipts
- Indoor case papers
- Ambulance receipt and bill
- First Information Report/ Final Police Report, if applicable
- Post mortem report, if available
- Any other document as required by the Company to assess the Claim

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

Note :

- Claim once paid under one Benefit cannot be paid again under any other Benefit.
- All invoices / bills should be in Insured Person's name.

4.5 Payment Terms

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

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

4.5.3 The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure 1 (List of Day Care Treatments).

4.5.4 The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.

4.5.5 The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

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

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

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

4.5.8 The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form

5. 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 Policy Schedule, 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 Policy Schedule.

Where the Policy is issued on Floater basis, the Policy can cover only the Insured Person, 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. Disclosure to information norm

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

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 Policyholder / Insured Person or any one acting on his / her behalf to obtain a benefit under this Policy, the Company may cancel this Policy at its sole discretion and the premium paid shall be forfeited in its favor.

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 Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

4. Complete Discharge

Payment made by the Company to the Policyholder/ adult Insured Person or the Nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

5. Material change

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or

premium, if necessary, accordingly.

6. Records to be maintained

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

7. No constructive Notice

Any knowledge or information of any circumstance or condition in connection with the 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. Notification of Claim

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

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. Multiple Policies

i. In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the Company shall make the claim payments independent of payments received under other similar policies

ii. If two or more policies are taken by an Insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his / her policies

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy

2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies

11. Fraudulent claims

If a Claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a Claim, or if any fraudulent means or devices are used by the Policyholder / Insured Person or anyone acting on his/ their behalf to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to the Company by the Policyholder / all Insured Persons who shall be jointly liable for such repayment.

12. Cancellation/termination

The Company may at any time, cancel this Policy, on grounds as specified in Point No. 2 under Terms and Condition, by giving 15 days notice in writing by Registered Post Acknowledgement Due / recorded delivery to the Policyholder at his last known address

The Policyholder may also give 15days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy by the Policyholder/ Insured Person:

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.

In case of demise of the Policyholder / Insured Person, this Policy shall continue till the end of Policy Period or next premium due whichever is earlier. In case the other Insured Person want to continue with the same Policy, the Company would renew the Policy providing all continuity benefits, subject to there being atleast one adult member as an Insured Person who would then become the Policyholder. This will be subject to the Company receiving a written application in this regard before Policy Period End Date.

13. Cause of Action

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.

14. Policy Disputes

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

15. Withdrawal / Revision / Modification of the Product / Policy

The Company reserves the right to withdraw, revise or modify this Product / Policy in the future. The revision / modification may be in respect of Benefits, coverage's, premiums, Policy Terms and Condition and / or exclusions.

In the event of any such withdrawal of Product / Policy, the Company will notify in advance to the Policyholder providing him the option to port to the specified existing health products of the company with continuity benefits

In the event of any revision / modification of the Product / Terms of Policy / Premium the company will notify the Policyholder of such changes 3 months in advance

Such modification / revision / withdrawal is subject to approval of Authority, as per extant regulations.

16. Migration of health Insurance policy

The Policyholder would be given an option to migrate to a suitable alternative available health insurance policy at the end of the specific exit age or at the time of withdrawal of the policy at the option exercised by the said lives by allowing suitable credits for all the previous policy years, provided the policy has been maintained without a break if the existing policy is specific to age groups such as maternity covers, children under family floater policies, students etc..

17. Payment of Interest

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

18. Overriding effect of Policy Schedule

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

19. Electronic Transactions

The Policyholder/ 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, tele-service 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 the 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.

20. Pre-policy medical test

The prospect whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, the company shall be liable to re-imburse 50% of the cost of such medicals conducted at the Company's designated centre

21. Free Look Period

The Policyholder would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review the entire Policy. Where the Policyholder disagrees to any of those terms or conditions, the Policyholder has the option to return the Policy stating the reasons for his objection and the Policyholder shall be entitled to a refund of the premium paid, provided no Claim has been incurred under this Policy, subject only to a deduction of the expenses incurred by the Company on medical examination and the stamp duty charges. In cases where the risk has already commenced when the option of returning this Policy is exercised, within the free look period, by the Policyholder, the refund of the premium paid will also be subject to a deduction for proportionate risk premium for the period on cover. Where only part of the risk

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

(e.g. only accidental hospitalization risk) has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

This clause shall not be applicable on renewal of this Policy and Portability cases.

22. Renewal Notice

i. This Policy will automatically terminate at the end of the Policy Period. All renewal applications should reach the Company before the end of the Policy Period.

ii. 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 prior mentioned and that nothing is known to the Policyholder/ Insured Person(s) that may result in enhancing the Company's risk.

iii. This Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of this Policy and in any case not later than the expiry of the Grace Period.

iv. Grace period refers to a period of 30 days immediately following the premium due date during which a payment can be made to renew or continue this Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Disease. Coverage is not available for the period for which Premium is not received by the Company

v. The Company shall not be liable for any Claims incurred during such period for which premium is not received by due date and in advance.

vi. Ordinarily renewals will not be refused by the Company except on ground of fraud, moral hazard or misrepresentation.

vii. Renewal premium would be as per the age/ Sum Insured / Plan / Zone etc. selected on the date of renewal.

viii. Renewal Discount equivalent to 5%, on cumulative basis, of renewal premium for each continuous claim free year will offered as No Claim Bonus subject to maximum upto 20%, where the Policy which is claim free & is renewed without a break. In case of claim all discount shall be forfeited at renewal.

23. 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.

24. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 4 – Claims procedure above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

25. Alterations in the Policy

This Policy constitutes the complete contract of Insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company

26. Communication

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

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

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

27. Grievances

If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

Website	:	https://reliancegeneral.co.in
e-mail	:	rgicl.services@relianceada.com
Telephone	:	1800-3009
Post/Courier	:	Any branch office, the correspondence address, during normal business hours
Write to us at (Correspondence Only)	:	Reliance General Insurance, Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)

For further details on Grievance redressal procedure please refer:
https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx

If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Address of the Ombudsman Offices
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in
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
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
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
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
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 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

Address of the Ombudsman Offices
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
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
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
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
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
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
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
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

Address of the Ombudsman Offices
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
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in

The details of Insurance Ombudsman are available on IRDA website: www.irda.gov.in, on the website of General Insurance Council: www.gbic.co.in, the Company's website www.reliancegeneral.co.in or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council –
(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz(West), Mumbai – 400054, Tel: 022 - 26106889 / 671
Email id: inscoun@gbic.co.in

Reliance HealthWise Policy (UIN: RELHLIP18124V021718)