ReAssure
Prospectus cum Sales Literature

ReAssure – Start a healthy relationship

'ReAssure' from Niva Bupa provides health insurance coverage for you and your family. It not only gives you the flexibility to choose the right cover for your needs, but also gives you the option to choose from a varied list of benefits and rewards as per your requirements. Apart from offering you this health insurance cover, we are also committed to provide you with quality services when you need it the most.

Why Niva Bupa is the healthier Health Insurance for you and your family:

- You talk to us directly, not through any third parties. We will be there for you when you need us. Because you should concentrate on getting healthier, not chasing your claims.
- You can access our cashless facility at the hospitals of your city which are part of our partner network.
- To build a relationship that lasts a lifetime, we make all efforts to understand your health profile during enrollment, so that when you need us, we can provide speedy and efficient support.
- We assure you renewability of your policy for lifetime, if you pay renewal premium within the grace period of 30 days of expiry of your previous policy. You should renew on or before the renewal date of the policy to ensure you have continued medical insurance cover even during the grace period.
- As with all health insurance policies, you may save tax under Section 80D of the Income Tax Act when you buy a Niva Bupa health insurance policy. (Tax benefits are subject to changes in the tax laws, so please consult your tax advisor for more details)

Policy Design

- Niva Bupa's 'ReAssure' product can be issued to individual customer(s) or to a family with up to 4 children (refer to as family floater).
- This policy covers persons in the age group 91 days to 99 years. The maximum entry age is restricted to 99 years. The Minimum entry age for adult dependent is 18 years and maximum entry age is 99 years.
- There is no maximum cover ceasing age on renewals.
- In an Individual policy, maximum up to 6 members (maximum of 4 adults and a maximum of 5 children can be included in a single policy. The 4 adults can be a combination of self, spouse, father, father in law, mother or mother in law). 10% discount on premium if 2 or more members are covered under an individual policy.
- The family floater policy is available in any of the following combinations:
    - 1 Adult + 1 Child
    - 1 Adult + 2 Children
    - 1 Adult + 3 Children
    - 1 Adult + 4 Children
    - 2 Adults
    - 2 Adults + 1 Child
    - 2 Adults + 2 Children
    - 2 Adults + 3 Children
    - 2 Adults + 4 Children

- Relationship allowed for adults in a family floater policy is / are self, spouse, father, father in law, mother or mother in law.
- The premium for family floater policies depends on the age of the eldest insured person.
- The range of entry ages for dependent children under a family floater policy is from 91 days to 30 years. Please note if any Insured Person who is a child and has completed 31 years at the time of Renewal, then such Insured Person will have to take a separate policy based on our underwriting guidelines, as he/she will no longer be eligible to be covered under a family floater policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.
- **Term discount:** The default policy term for all plans is one year. Two year and three year policy term options are also available under the product. The level of discount is as below:
    - 2 year term: 7.5% on the premium for second policy year
    - 3 year term: 15% on the premium for third policy year + 7.5% on the premium for second policy year
- Term Discount is not applicable if premium is paid via Monthly, Half Yearly or Quarterly Instalments.
- **Staff discount:** A staff discount of 15% on the policy premium will be given for the first policy year and on every renewal of such policy. However, if the policy is also purchased through a direct sales channel, then direct sales discount of 5% will not be applicable.
- **Direct sales discount:** If You opts to buy the policy through a direct sales channel, a 5% discount on overall premium will be given for the first policy year and on every renewal of such policy.
- **Standing Instruction discount:** 2.5% discount on premium if standing instruction for renewal is provided and the policy is renewed using the same.
- **Doctor discount:** 5% discount on premium if an Insured Person is a certified Medical Practitioner.
- **Live healthy benefit discount:** Discount on renewal premium basis number of steps taken under 'Live healthy benefit'
- **Discount in Lieu of Commission:** we will offer a discount of 5% at new business and renewal in lieu of commission
- **Favourable Claim Experience Discount:**
    - You will get a discount on your policy of up to 39% on the renewal premium basis the value of the claims paid in a policy year.
    - A Trend and Level Score will be allotted to you each year.
        - **Trend Score:** A score for the policy basis the claim amount paid in the policy year.
        - **Level Score:** A calculated score at policy level which will determine the discount on the renewal premium.

Note: For Renewal policies, for the first time only, the claim experience since inception will be considered to offer the discount. Favourable claim experience discount will not apply to insureds aged 60 years and above

Level Grid

Level	-3	-2	-1	0	1	2	3	4	5	6	7	8	9	10
Discount	39%	36%	33%	30%	27%	24%	21%	18%	15%	12%	9%	6%	3%	0%

Level 0: When customer takes out a policy with Niva Bupa, they start at level 0 with 30% Discount

Level -3 is the highest level a customer can be at with 39% discount. And Level 10 can be the lowest level a customer can reach, with 0% discount.

The movement between levels will depend on following Trend Grid:

Customer Claim Scenario	Moement During Renewal
0 or No Claim	Moves up the grid by 1 level
Claim up to INR 40,000	Stays in the same level
More than INR 40,000- and up to INR 75,000	Moves down the grid by 1 level
More than INR 75,000- and up to INR 1,50,000	Moves down the grid by 2 levels
More than INR 1,50,000	Moves down the gird by 3 levels

Coverage Options

Sum Insured ranges from Rs. 3 lacs to Rs. 100 lacs. The details of the benefits/ limits/ amounts basis Sum Insured are available in the product benefit table.

I. **Product Features and Benefits – Key Highlights**

The policy covers reasonable charges incurred towards medical treatment taken during the Policy Period for an Illness or an Injury. We cover the following expenses

1. **Inpatient Care**

What is covered:

We will indemnify the Medical Expenses incurred for one or more of the following due to the Insured Person's Hospitalization during the Policy Period following an Illness or Injury:

a. Room Rent;

b. Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;

c. Medical Practitioners' fees, excluding any charges or fees for Standby Services;

d. Investigative tests or diagnostic procedures directly related to the Insured Event which lead to the current Hospitalization;

e. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;

f. Intravenous fluids, blood transfusion, injection administration charges, allowable consumables and /or enteral feedings;

g. Operation theatre charges;

h. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;

i. Intensive Care Unit Charges.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Hospitalization is for Medically Necessary Treatment and advised in writing by a Medical Practitioner.

b. We will pay the consultation charges for any Medical Practitioner visiting the Insured Person only if:

   i. The Medical Practitioner's treatment or advice has been specifically sought by the Hospital; and

   ii. The consultation charges are included in the Hospital's bill

2. **Day Care Treatment**

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's under any Day Care Treatment during the Policy Period following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Day Care Treatment is advised in writing by a Medical Practitioner as Medically Necessary Treatment.

b. The Day Care Treatment would be covered if the Insured Person is admitted for more than 2 hours and would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer.

c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with respective sections mentioned.

What is not covered:

a. OPD Treatment and Diagnostic Services costs are not covered under this benefit.

3. **Alternative Treatments**

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization for Inpatient Care during the Policy Period on treatment taken under Ayurveda, Unani, Siddha and Homeopathy.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The treatment should be taken in AYUSH Hospital.

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with respective sections mentioned, provided that these Medical Expenses relate only to Alternative Treatments and not Allopathy.

c. Any non-allopathic treatment taken by the Insured Person shall only be covered under Alternative Treatments as per the applicable terms and conditions.

What is not covered:

a. Medical Expenses incurred on treatment taken under Yoga shall not be covered.

4. **Domiciliary Hospitalization**

What is covered.

We will indemnify on Reimbursement basis only, the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Domiciliary Hospitalization continues for at least 3 consecutive days, wherein We will make payment under this benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;

b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.

What is not covered:

a. Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses are not payable under this benefit.

5. **Modern Treatments**

What is covered:

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment, in a Hospital:

   i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

   ii. Balloon Sinuplasty

   iii. Deep Brain stimulation

iv. Oral chemotherapy

v. Immunotherapy- Monoclonal Antibody to be given as injection

vi. Intra vitreal injections

vii. Robotic surgeries

viii. Stereotactic radio surgeries

ix. BronchicalThermoplasty

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

xi. IONM - (Intra Operative Neuro Monitoring)

xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses within the overall benefit sub-limit.

Special condition applicable for robotic surgeries:

A limit of maximum INR 1 Lac will apply to all robotic surgeries, except the following:

i. Robotic total radical prostatectomy

ii. Robotic cardiac surgeries

iii. Robotic partial nephrectomy

iv. Robotic surgeries for malignancies

6. **Pre-hospitalization Medical Expenses**

What is covered:

We will indemnify on Reimbursement basis only, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments.

b. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments claim.

c. The expenses are incurred after the inception of the First Policy with Us. If any portion of these expenses is incurred before the inception of the First Policy with Us, then We shall be liable only for those expenses incurred after the commencement date of the First Policy, irrespective of the initial waiting period.

d. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.

e. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments claim has been incurred.

Sub-limit:

a. We will pay above mentioned Pre-hospitalization Medical Expenses only for period up to 60 days immediately preceding the Insured Person's admission for Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments.

7. **Post-hospitalization Medical Expenses**

What is covered:

We will indemnify on Reimbursement basis only, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments.

b. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments claim.

c. The expenses incurred shall be as advised in writing by the treating Medical Practitioner.

d. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.

e. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which Inpatient Care or Day Care Treatment or Alternative Treatments or Modern Treatments claim has been incurred.

Sub-limit:

a. We will pay Post-hospitalization Medical Expenses only for up to 180 days immediately following the Insured Person's discharge from Hospital or Day Care Treatment or Alternative Treatments or Modern Treatments.

8. **Living Organ Donor Transplant**

What is covered:

We will indemnify the Medical Expenses incurred for a living organ donor's treatment as an Inpatient for the harvesting of the organ donated.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.

b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.

c. We have accepted the recipient Insured Person's claim under Inpatient Care.

What is not covered:

a. Stem cell donation whether or not it is Medically Necessary Treatment except for Bone Marrow Transplant.

b. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.

c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalization for organ transplant.

d. Transplant of any organ/tissue where the transplant is Unproven / experimental treatment or investigational in nature.

e. Expenses related to organ transportation or preservation.

f. Any other medical treatment or complication in respect of the donor, which is directly or indirectly consequence to harvesting.

9. **Emergency Ambulance**

What is covered:

We will indemnify the costs incurred, on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained or;

b. The medical condition of the Insured Person requires immediate ambulance services from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.

c. This benefit is available for only one transfer per Hospitalization.

d. The ambulance service shall be offered by a healthcare or ambulance Service Provider.

e. We have accepted a claim under Inpatient Care or Day Care Treatment.

f. We will cover expenses up to Rs. 2,000 per Hospitalization.

What is not covered:

The Insured Person's transfer to any Hospital or diagnostic centre for evaluation purposes only.

10. **Air Ambulance**

What is covered:

We will indemnify the costs incurred for ambulance transportation in an airplane or helicopter, for Emergency life threatening health conditions which require immediate and rapid ambulance transportation to the Hospital / medical centre that ground transportation cannot provide.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Inpatient Care or Day Care Treatment.

b. Medically Necessary treatment is not available at the location where the Insured Person is situated at the time of Emergency.

c. The Medical Evacuation has been prescribed by a Medical Practitioner and is Medically Necessary.

d. The insured person is in India and the treatment is required in India only and not overseas in any condition whatsoever.

e. The air ambulance provider is registered in India.

f. We will cover expenses up to the amount specified in the Policy Schedule for transportation of the Insured Person under this benefit.

What is not covered:

a. Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.

11. **Home Care treatment**

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's treatment taken at home for Chemotherapy or Dialysis.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. These services shall be offered by a registered homecare provider.

What is not covered:

a. Treatment taken by automation machine for peritoneal dialysis.

b. Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses are not payable under this benefit.

12. **Loyalty Additions**

What is covered:

a. Upon every completion of policy year, at the policy anniversary, 50% of the previous year's Base Sum insured will be provided as Loyalty Additions subject to a maximum of 100% of the Base Sum Insured. There will be no change in the sub-limits applicable to various benefits due to increase in Sum Insured under this benefit.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. If the Insured Persons in the expiring Policy is covered under Individual Policies and has an accumulated Loyalty Additions in the expiring Policies under this benefit, and such expiring Policies are merged and Renewed with Us on a Family Floater Policy with or without an addition of a new Insured Person, then the accumulated Loyalty Additions to be carried forward to the Family Floater Policy would be the least of the accumulated Loyalty Additions amongst the Insured Persons of the expiring Policy.

b. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Loyalty Additions in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy by addition of a new Insured Person, then the accumulated Loyalty Additions to be carried forward to the Family Floater Policy would be the accumulated Loyalty Additions of the expiring Policy.

c. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Policy Schedule in to two or more floater / individual Policy, then We will provide the credit of the accumulated Loyalty Additions to each of the split Policy.

d. If the Insured Persons covered on a Family Floater Policy are reduced at the time of Renewal, the applicable accumulated Loyalty Additions shall remain same under the Policy.

e. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated Loyalty Additions shall also be reduced in proportion to the Base Sum Insured.

f. In case the Base Sum Insured under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Additions shall also be increased in proportion to the Base Sum Insured.

g. This benefit is not applicable for Health Check-up, Second Medical Opinion, Personal Accident Cover and Hospital Cash. Enhancement of Sum Insured due to Loyalty Additions cannot be utilized for the aforementioned benefits.

13. **ReAssure**

What is covered:

This benefit is triggered with the first paid claim itself and is available for all subsequent claims in a Policy Year.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The maximum liability under a single claim under this benefit shall not be more than Base Sum Insured.

b. The sequence of utilization of Sum Insured will be as below:

   i. Base Sum Insured followed by;

   ii. Sum Insured Safeguard/Safeguard+ (if applicable) followed by;

   iii. Accumulated Loyalty Additions (if any) followed by;

   iv. ReAssure benefit

c. Claims under this benefit will be payable only under Inpatient Care or Day Care Treatment or Alternative Treatments or Domiciliary Hospitalization or Modern Treatments or Living Organ Donor Transplant or Home Care Treatment arising in that Policy Year for any or all Insured Person(s).

d. For Family Floater Policies, the amount under this benefit will be available on a floater basis to all Insured Persons in that Policy Year.

14. **Shared accommodation Cash Benefit**

What is covered:

If We have accepted an Inpatient Care Hospitalization claim and the Insured Person has occupied a shared room accommodation during such Hospitalization in a Network Hospital, We will pay a daily cash amount as specified in the Policy Schedule for the Insured Person for each continuous and completed period of 24 hours of Hospitalization.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

What is not covered:

a. This benefit will not be payable if the Insured Person stays in an Intensive Care Unit or High Dependency Units / wards.

15. **Health Checkup**

What is covered:

The Insured Person may avail a health check-up, only for Diagnostic Tests, up to a sub-limit as specified in Your Policy Schedule. This benefit is available ONLY on cashless and no re-imbursement is allowed

Conditions - The above coverage is subject to fulfilment of following conditions:

a. This benefit is available only once in a Policy Year and if you undergo multiple tests, make sure that all these are done within 7 days. The list of tests covered under this benefit will be Complete blood count, Urine Routine, Erythrocyte Sedimentation Rate (ESR), Fasting Blood Glucose, Electrocardiogram, S Cholesterol, Complete Physical Examination by Physician, Post prandial / lunch blood sugar (PPBS / PLBS), Uric Acid, Lipid Profile, Kidney function test, Serum Vitamin D, Serum Electrolytes, HbA1C, Thyroid profile (TSH), Liver Function Test (LFT), Treadmill test (TMT) and Ultrasound test.

What is not covered:

a. Any unutilized test or amount cannot be carried forward to the next Policy Year.

16. **Second Medical Opinion**

What is covered:

We will indemnify the costs incurred for availing a second medical opinion from any Medical Practitioner for which we have admitted a claim of Hospitalization.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. This benefit can be availed only once during a Policy Year.

b. We have accepted a claim under Inpatient Care or Day Care Treatment for which opinion is sought.

What is not covered:

a. The second medical opinion under this benefit shall not be valid for any medico legal purposes.

b. We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

17. **Live Healthy benefit**

What is covered:

We will offer a discount on Renewal premium if the eligible Insured Person(s) achieves the health points target on the mobile application provided by Us as per the grid mentioned below.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. Steps taken by the Insured Person everyday, earn 'health points'. Steps counted by the mobile App We provide you to use ONLY would be considered.

b. 1 health point would be earned for every completed 1000 steps.

c. Health points accumulated in last 3 months of the Policy Period would not be considered for discount on premium for the first renewal. The last 3 months are NOT LOST and will be considered in the next Policy Period. All renewals thereafter, will consider points gained in the Policy Period.

d. The mobile app must be downloaded within 30 days of the Policy commencement to avail this benefit. The step count completed by an eligible Insured Person would be tracked on this mobile application.

e. We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation.

Policy Period: 1 year

Policy duration	**End of 9 months**	**Points at the end of 9 months (A)** **This will be considered for discount on the first renewal.**	**Points in next 3 months (B)**	**Total points considered for discount (A + B) from 2nd Policy Period onwards**	**Discount on renewal premium (Renewal policy start date 1st Jan 2021)** **NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater**	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1st Jan 2020	30th September 2020	Up to 1500			0%	0%
		1501 –2250			5%	2.5%
		2251 – 3000			15%	7.5%
		3001 – 3750			20%	10%
		>=3751			30%	15%

Policy Period: 2 years

Policy duration	End of 21 months	Points at the end of 21 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2022) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1st Jan 2020	30th September 2021	Up to 3000			0%	0%
		3001 – 4500			5%	2.5%
		4501 – 6000			15%	7.5%
		6001 – 7500			20%	10%
		>=7501			30%	15%

Policy Period: 3 years

Policy duration	End of 33 months	Points at the end of 33 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st Jan 2023) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1st Jan 2020	30th September 2022	Up to 4500			0%	0%
		4501 – 6750			5%	2.5%
		6751 – 9000			15%	7.5%
		9001 – 11250			20%	10%
		>=11251			30%	15%

II. **Optional Benefits**

The following optional benefits shall apply under the Policy only if it is specified in the Policy Schedule. Optional benefits can be selected by You only at the time of issuance of the First Policy or at Renewal, unless specified otherwise, on payment of the corresponding additional premium.

The optional benefits 'Personal Accident Cover' and 'Hospital Cash' will be payable (only on Reimbursement basis) if the conditions mentioned in the below sections are contracted or sustained by the Insured Person covered under these optional benefits during the Policy Period.

The applicable optional benefits will be payable subject to the terms, conditions and exclusions of this Policy and subject always to any sub-limits for the optional benefit as specified in Your Policy Schedule.

All claims for any applicable optional benefits under the Policy must be made in accordance with the process defined under Section 'Claim Process & Requirements'.

1. **Personal Accident Cover**

What is covered:

If the Insured Person covered under this optional benefit dies or sustains any Injury resulting solely and directly from an Accident occurring during the Policy Period at any location worldwide, and while the Policy is in force, We will provide the benefits described below.

a. **Accident Death (AD)**

What is covered:

If the Injury due to Accident solely and directly results in the Insured Person's death within 365 days from the occurrence of the Accident, We will make payment of Personal Accident Cover Sum Insured specified in the Policy Schedule. If a claim is made under this optional benefit, the coverage for that Insured Person under the Policy shall immediately and automatically cease. Any claim incurred before death of such Insured person shall be admissible subject to terms and conditions under this Policy.

b. **Accident Permanent Total Disability (APTD)**

What is covered:

If the Injury due to Accident solely and directly results in the Permanent Total Disability of the Insured Person which means that the Injury results in one or more of the following conditions within 365 days from the occurrence of an Accident, We will make payment of 125% of the Personal Accident Cover Sum Insured as specified in the Policy Schedule.

1. Loss of use of limbs or sight

   The Insured Person suffers from total and irrecoverable loss of:

   1. The use of two limbs (including paraplegia and hemiplegia) OR
   2. The sight in both eyes OR
   3. The use of one limb and the sight in one eye

2. Loss of independent living

   The Insured Person is permanently unable to perform independently three or more of the following six activities of daily living.

   1. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene.
   2. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary.
   3. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available.
   4. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene.

5. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.
6. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Permanent Total Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and

b. We will admit a claim under this optional benefit only if the Permanent Total Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Total Disability unless it is irreversible, such as in case of amputation/loss of limbs etc; and

c. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under 'Accident Death' subject to terms and conditions mentioned therein; and

d. We will not make payment under Accident Permanent Total Disability more than once in the Insured Person's lifetime for any and all Policy Periods.

e. If a claim under this optional benefit is admitted, then coverage for the Insured Person will immediately and automatically cease under 'Personal Accident Cover' and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

c. **Accident Permanent Partial Disability (APPD)**

What is covered:

If the Injury due to Accident solely and directly results in the Permanent Partial Disability of the Insured Person which is of the nature specified in the table below within 365 days from the occurrence of such Accident, We will make payment under this optional benefit in accordance with the table below:

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Permanent Partial Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and

b. We will admit a claim under this optional benefit only if the Permanent Partial Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Partial Disability, unless it is irreversible; and

c. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under 'Accident Death' subject to the terms and conditions mentioned therein.

d. If a claim under this optional benefit has been admitted, then no further claim in respect of the same condition will be admitted under this optional benefit.

e. If a claim under this optional benefit is paid and the entire Personal Accident Sum Insured specified in the Policy Schedule does not get utilized, then the balance Personal Accident Cover Sum Insured shall be available for further claims under 'Personal Accident Cover' until the entire Personal Accident Cover Sum Insured is consumed. The Personal Accident Cover Sum Insured specified in the first Policy Schedule shall be a lifetime limit for the Insured Person and once this limit is exhausted, coverage for the Insured Person will immediately and automatically cease under 'Personal Accident Cover' and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

Permanent Partial Disability Grid		
S. No.	**Nature of Disability**	**% of Personal Accident Cover Sum Insured payable**
1	Loss or total and permanent loss of use of both the hands from the wrist joint	100%
2	Loss or total and permanent loss of use of both feet from the ankle joint	100%
3	Loss or total and permanent loss of use of one hand from the wrist joint and of one foot from the ankle joint	100%
4	Loss or total and permanent loss of use of one hand from the wrist joint and total and permanent loss of sight in one eye	100%
5	Loss or total and permanent loss of use of one foot from the ankle joint and total and permanent loss of sight in one eye	100%
6	Total and permanent loss of speech and hearing in both ears	100%
7	Total and permanent loss of hearing in both ears	50%
8	Loss or total and permanent loss of use of one hand from wrist joint	50%
9	Loss or total and permanent loss of use of one foot from ankle joint	50%
10	Total and permanent loss of sight in one eye	50%
11	Total and permanent loss of speech	50%
12	Permanent total loss of use of four fingers and thumb of either hand	40%
13	Permanent total loss of use of four fingers of either hand	35%
14	Uniplegia	25%
15	Permanent total loss of use of one thumb of either hand	
	a. Both joints	25%
	b. One joint	10%
16	Permanent total loss of use of fingers of either hand	
	a. Three joints	10%
	b. Two joints	8%
	c. One joint	5%
17	Permanent total loss of use of toes of either foot	
	a. All toes- one foot	20%
	b. Great toe- both joints	5%
	c. Great toe- one joint	2%
	d. Other than great toe, one toe	1%

2. **Hospital Cash**

What is covered:

If We have accepted an Inpatient Care Hospitalization claim under In-patient Care, We will pay the Hospital Cash amount specified in the Policy Schedule up to a maximum 30 days of Hospitalization during the Policy Year for the Insured Person for each continuous period of 24 hours of Hospitalization from the first day of Hospitalization.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

3. **Safeguard**

What is covered:

a. Claim Safeguard: If We have accepted a Hospitalization claim, then the items which are not payable as per List I – 'Expenses not covered' under Annexure II related to that particular claim will become payable.

b. Loyalty Additions Safeguard: Loyalty additions benefit will not be impacted if claim amount in the previos policy year does not exceed the overall amount of Rs 50,000

c. Sum Insured Safeguard: The Base Sum Insured will be increased on Cumulative Basis at each Policy Year on the basis of inflation rate in previous year. Inflation rate would be computed as the average Consumer Price index (CPI) of the entire calendar year published by the Central Statistical Organisation (CSO).

Conditions - The coverage under 'Sum Insured Safeguard' is subject to fulfilment of following conditions:

a. The % increase will be applicable only on Base Sum Insured under the Policy and not on Loyalty Additions or any other benefit which leads to increase in Sum Insured.

b. Consumer Price index (CPI) is a measure of inflation, changes in the CPI are used to assess price changes associated with the cost of living. It is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

c. The Central Statistics Office (CSO) is a government agency in India under the Ministry of Statistics and Programme Implementation responsible for co-ordination of statistical activities in India, and evolving and maintaining statistical standards.

d. In case of Sum Insured enhancement or reduction at the time of Renewal, any accumulated Sum Insured due to Sum Insured Safeguard Benefit will be added to the enhanced or reduced Sum Insured opted by Insured at the time of Renewal.

e. All accumulated Sum Insured Safeguard benefit will lapse and will roll back to the Base Sum Insured opted if this optional benefit is not Renewed.

Illustration of calculation of inflation rate based on CPI figures

Month	CPI 2019	CPI 2018
January	139.6	136.9
February	139.9	136.4
March	140.4	136.5
April	141.2	137.1
May	142.0	137.8
June	142.9	138.5
July	144.2	139.8
August	145.0	140.4
September	145.8	140.2

October	147.2	140.7
November	148.6	140.8
December	150.4	140.1
Average	**143.9**	**138.8**
CPI inflation rate for calendar year 2019	**3.72%** i.e. (Average CPI for 2019 – Average CPI for 2018) / Average CPI for 2018	

As per the table above:

- The average CPI for 2019 is 143.9, whereas the average CPI for 2018 is 138.8
- The increase in average CPI is calculated as:

  (Average CPI for 2019 – Average CPI for 2018) / Average CPI for 2018
- Hence, the average increase in Base Sum Insured applicable in 2020 will be 3.72%.

Note: CPI figure for a particular month is recorded from the following link: https://www.mospi.gov.in/

4. **Safeguard+**

What is covered:

a. Claim Safeguard+: If We have accepted a Hospitalization claim under Section 4, then the items which are not payable as per List I, II, III, IV–under Annexure II related to that particular claim will become payable.

b. Loyalty Additions Safeguard+: Loyalty additions benefit will not be impacted if claim amount in the previos policy year does not exceed the overall amount of Rs 100,000

c. Sum Insured Safeguard+: The Base Sum Insured will be increased on Cumulative Basis at each Policy Year on the basis of inflation rate in previous year. Inflation rate would be computed as the average Consumer Price index (CPI) of the entire calendar year published by the Central Statistical Organisation (CSO).

Conditions - The coverage under 'Sum Insured Safeguard+' is subject to fulfilment of following conditions:

a. The % increase will be applicable only on Base Sum Insured under the Policy and not on Loyalty Additions or any other benefit which leads to increase in Sum Insured.

b. Consumer Price index (CPI) is a measure of inflation, changes in the CPI are used to assess price changes associated with the cost of living. It is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

c. The Central Statistics Office (CSO) is a government agency in India under the Ministry of Statistics and Programme Implementation responsible for co-ordination of statistical activities in India, and evolving and maintaining statistical standards.

d. In case of Sum Insured enhancement or reduction at the time of Renewal, any accumulated Sum Insured due to Sum Insured Safeguard+ Benefit will be added to the enhanced or reduced Sum Insured opted by Insured at the time of Renewal.

e. All accumulated Sum Insured Safeguard+ benefit will lapse and will roll back to the Base Sum Insured opted if this optional benefit is not Renewed.

Illustration of calculation of inflation rate based on CPI figures

Month	CPI 2019	CPI 2018
January	139.6	136.9
February	139.9	136.4
March	140.4	136.5
April	141.2	137.1
May	142.0	137.8
June	142.9	138.5
July	144.2	139.8
August	145.0	140.4
September	145.8	140.2
October	147.2	140.7
November	148.6	140.8
December	150.4	140.1
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CPI inflation rate for calendar year 2019	**3.72%** i.e. (Average CPI for 2019 – Average CPI for 2018) / Average CPI for 2018	

As per the table above:

- The average CPI for 2019 is 143.9, whereas the average CPI for 2018 is 138.8
- The increase in average CPI is calculated as:

  (Average CPI for 2019 – Average CPI for 2018) / Average CPI for 2018
- Hence, the average increase in Base Sum Insured applicable in 2020 will be 3.72%.

Note: CPI figure for a particular month is recorded from the following link: https://www.mospi.gov.in/

Note: You can either choose Safeguard or Safeguard+ at a given point in time.

5. **Modern Treatment+**

If opted, will remove the sub-limit of INR 1,00,000 from the Modern Treatment benefit (Section 4.5), enhancing the limit for the benefit up to Base Sum Insured.

All other conditions remain same as the Modern Treatment Benefit (Section 4.5).

Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if the Sum Insured or any benefit sub-limit is enhanced, the Waiting Periods would apply afresh to the extent of the increased amount. The Waiting Periods set out below shall not apply to Health Checkup, Second Medical Opinion, Live Healthy benefit and Personal Accident Cover.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. **Pre-existing Diseases (Code–Excl01):**
    a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy.
    b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
    c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.
    d. Coverage under the Policy after the expiry of 36 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.
2. **Specified disease/procedure waiting period- Code- Excl02**
    a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-days waiting period).
    b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
    c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
    d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
    e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
    f. List of specific diseases/procedures:
        a. Pancreatitis and stones in biliary and urinary system
        b. Cataract, glaucoma and retinal detachment
        c. Hyperplasia of prostate, hydrocele and spermatocele
        d. Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy)
        e. Hemorrhoids, fissure, fistula or abscess of anal and rectal region
        f. Hernia of any site or type,
        g. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
        h. Varicose veins of lower extremities
        i. All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump
        j. Ulcer, erosion or varices of gastro intestinal tract
        k. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

3. **30-day waiting period (Code- Excl03):**

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

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

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

4. **Personal Waiting Periods:**

   Conditions specified for an Insured Person under Personal Waiting Period in the Policy Schedule will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us for that Insured Person and will be covered from the commencement of the third Policy Year for that Insured Person as long as the Insured Person has been insured continuously under the Policy without any break.

III. **Permanent Exclusions**

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy. Clause 1 to 33 are not applicable to Personal Accident Cover.

The permanent exclusions applicable to Personal Accident Cover have been specified separately under Clause 34.

1. **Investigation & Evaluation (Code-Excl04)**

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

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

2. **Rest Cure, rehabilitation and respite care (Code-Excl05)**

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

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

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

3. **Obesity/ Weight Control (Code-Excl06)**

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

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

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

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

   d. Body Mass Index (BMI);

      i. greater than or equal to 40 or

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

1. Obesity-related cardiomyopathy
2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

4. **Change-of-Gender treatments (Code-Excl07)**

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

5. **Cosmetic or plastic Surgery (Code-Excl08)**

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

6. **Hazardous or Adventure sports (Code-Excl09)**

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

7. **Breach of law (Code-Excl10)**

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

8. **Excluded Providers (Code-Excl11)**

   Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure **(Code-Excl14)**

12. **Refractive Error (Code-Excl15)**

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

13. **Unproven Treatments (Code-Excl16)**

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

14. **Sterility and Infertility (Code-Excl17**)

    Expenses related to sterility and infertility. This includes:

    a. Any type of contraception, sterilization

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

    c. Gestational Surrogacy

    d. Reversal of sterilization

15. **Maternity Expenses (Code-Excl18)**

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

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

16. Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for RMO charges, surcharges and service charges levied by the Hospital.

17. **Circumcision:**

    Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

18. **Conflict & Disaster:**

    Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

19. **External Congenital Anomaly:**

    Screening, counseling or treatment related to external Congenital Anomaly.

20. **Dental/oral treatment:**

    Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

21. **Hormone Replacement Therapy:**

    Treatment for any condition / illness which requires hormone replacement therapy.

22. Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

23. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**

    Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

24. **Sleep disorders:**

    Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

25. Any treatment or medical services received outside the geographical limits of India.

26. Any expenses incurred on OPD treatment.

27. **Unrecognized Physician or Hospital:**

    a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.

    b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.

    c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

28. The condition which is not clinically significant or is related to anxiety, bereavement, relationship or academic problems, acculturation difficulties or work pressure.

29. Treatment related to intentional self inflicted Injury or attempted suicide by any means.

30. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:
    a. Deep coma and unresponsiveness to all forms of stimulation; or
    b. Absent pupillary light reaction; or
    c. Absent oculovestibular and corneal reflexes; or
    d. Complete apnea.
31. If as per any or all of the medical references herein below containing guidelines and protocols for evidence based medicines, the Hospitalization for treatment under claim is not necessary or the stay at the Hospital is found unduly long:
    a. Medical text books,
    b. Standard treatment guidelines as stated in clinical establishment act of Government of India,
    c. World Health Organisation (WHO) protocols,
    d. Published guidelines by healthcare providers,
    e. Guidelines set by medical societies like cardiological society of India, neurological society of India etc.
32. **Permanent Exclusions for Personal Accident Cover**

    We shall not be liable to make any payment under any benefits under Personal Accident Cover if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:
    a. Suicide or self inflicted Injury, whether the Insured Person is medically sane or insane.
    b. Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
    c. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time.
    d. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule.
    e. Committing an assault, a criminal offence or any breach of law with criminal intent.
    f. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.
    g. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.
    h. Engaging in or taking part in professional/adventure sports or any hazardous pursuits, 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, polo, snow and ice sports, hunting.

IV. **Claims Process & Requirements**

The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Policy Schedule) in so far as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to Admission of Liability under this Policy.

1. **Claims Administration:**

   On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Policy, the Claims Procedure set out below shall be followed:

   a. We advise You to submit all claims related documents, including documents for claims within the Deductible amount, once the Deductible limit has been exhausted.

   b. We/Our Service Provider must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

   c. We and Our Service Provider must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

   d. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of such change will be considered on merits where the change has been proven to be for reasons beyond the claimant's control.

2. **Claims Procedure:** On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a Condition Precedent to Admission of Liability under the Policy the following procedure shall be complied with:

   a. **For Availing Cashless Facility:** Cashless Facility can be availed only at Our Network Providers or Service Providers (as applicable). The complete list of Network Providers are available on Our website and at Our branches and can also be obtained by contacting Us over the telephone. In order to avail Cashless Facility, the following process must be followed:

      i. Process for Obtaining Pre-Authorization

         A. For Planned Treatment:

            We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider.

         B. In Emergencies:

            If the Insured Person has been Hospitalized in an Emergency, We must be contacted to pre-authorize Cashless Facility within 48 hours of the Insured Person's Hospitalization or before discharge from the Hospital, whichever is earlier.

      Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.

      Each request for pre-authorization must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

      I. The health card We have issued to the Insured Person at the time of inception of the Policy (if available) supported with KYC document;

      II. The Policy Number;

      III. Name of the Policyholder;

      IV. Name and address of Insured Person in respect of whom the request is being made;

V. Nature of the Illness/Injury and the treatment/Surgery required;

VI. Name and address of the attending Medical Practitioner;

VII. Hospital where treatment/Surgery is proposed to be taken;

VIII. Date of admission;

IX. First and any subsequent consultation paper / Medical Record since beginning of diagnosis of that treatment/Surgery;

X. Admission note;

XI. Treating Medical Practitioner certificate for Illness / Insured Event history with justification of Hospitalization.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles / Co-payment and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

In case of preauthorization request where chronicity of condition is not established as per clinical evidence based information, We may reject the request for preauthorization and ask the claimant to claim as Reimbursement. Claim document submission for Reimbursement shall not be deemed as an admission of Our liability.

Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital, locations, indications and disease details, match with the details of the actual treatment received. For Hospitalization on a Cashless Facility basis, We will make the payment of the amount assessed to be due, directly to the Network Provider / Service Provider.

We reserve the right to modify, add or restrict any Network Provider or Service Provider for Cashless Facility at Our sole discretion.

ii. Reauthorization

Cashless Facility will be provided subject to re-authorization if requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding prior to the discharge from the Hospital.

Note: We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx

b. **For Reimbursement Claims:**

For all claims for which Cashless Facility has not been pre-authorized or for which treatment has not been taken at a Network Provider/Service Provider or for which Cashless Facility is not available, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

i. The Policy Number;

ii. Name of the Policyholder;

iii. Name and address of the Insured Person in respect of whom the request is being made;

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

v. Name and address of the attending Medical Practitioner;

vi. Hospital where treatment/Surgery was taken;

vii. Date of admission and date of discharge;

viii. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

3. **Claims Documentation:**

For medical claims – Reimbursement Facility:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

For medical claims – Cashless Facility:

We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital.

Necessary information and documentation for medical claims

a. Claim form duly completed and signed by the claimant.

b. Details of past medical history record, first and subsequent consultation.

c. Age / Identity proof document of Insured Person in case of claim approved under Cashless Facility (not required if submitted at the time of pre-authorization request) and Policyholder in case of Reimbursement claim.

   i. Self attested copy of valid age proof (passport / driving license / PAN card / class X certificate / birth certificate);

   ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);

   iii. Recent passport size photograph

d. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).

e. Original discharge summary.

f. Bar code sticker and invoice for implants and prosthesis (if used and only in case of Surgery/Surgical Procedure).

g. Original final bill from Hospital with detailed break-up and paid receipt.

h. Room tariff of the entitled room category (in case of a Non-Network provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.

   (In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of Our Network Provider within the same geographical area for identical or similar services.)

i. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.

j. For Medico-legal cases (MLC) or in case of Accident

   i. MLC/ Panchnama / First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);

   ii. Original self-narration of incident in absence of MLC / FIR.

k. Original laboratory investigation, diagnostic, radiological & pathological reports with supporting prescriptions.

   In the event of the Insured Person's death during Hospitalization, written notice accompanied by a copy of the post mortem report (if any) shall be given to Us regardless of whether any other notice has been given to Us.

   For Personal Accident claims

   Additional claim documentation for Personal Accident Cover:

   a. Accident Death

      i. Copy of death certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)

      ii. Copy of post mortem report wherever applicable

b. Accident Permanent Total Disability or Accident Permanent Partial Disability

i. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government.

4. **Claims Assessment & Repudiation:**

a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized by Us in writing.

b. Claim Settlement (provision for Penal Interest):

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim intimation till the date of payment of claim at a rate 2% above the bank rate.

c. Complete discharge: Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

d. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-

i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Inpatient benefit.

ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per policy terms and conditions exceeds the Deductible limit within the same Policy Year.

iii. Co-payment (if applicable) as specified in the Policy Schedule shall be applicable on the amount payable by Us.

e. The claim amount assessed in point (d) above would be deducted from the amount / sub-limit mentioned against each benefit or treatment as per terms and conditions and Sum Insured as specified in the Policy Schedule.

5. **Delay in Claim Intimation or Claim Documentation:**

If the claim is not notified to Us or claim documents are not submitted within the stipulated time as mentioned in the above sections, then We shall be provided the reasons for the delay, in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

6. **Claims process for Air Ambulance, if availed on Cashless Facility:**

a. In the event of an Emergency, Our Service Provider shall be contacted immediately on the helpline number.

b. Our Service Provider will evaluate the necessity for evacuation of the Insured Person and if the request for Medical Evacuation is approved by Us, the Service Provider shall pre-authorise the type of travel that can be utilized to transport the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.

c. If the Service Provider pre-authorises the Medical Evacuation of the Insured Person by means of Air Transportation through an air ambulance or commercial flight whichever is best suited, the Service Provider shall also arrange for the same to be provided to the Insured Person unless there are any logistical constraints or the medical condition of the Insured Person prevents Emergency Medical Evacuation.

7. **Claims process for Health Checkup, if availed on Cashless Facility:**

a. The Insured Person shall seek appointment by contacting Our Service Provider.

b. Our Service Provider will facilitate Your appointment.

c. Reports of the medical tests can be collected directly from the Service Provider.

8. **Claim process for Second Medical Opinion, if availed on Cashless Facility:**

   a. In the event of submission of request for Second Medical Opinion, Our Service Provider shall be contacted on the helpline number.

   b. Our Service Provider will evaluate the information of the Insured Person and if the request for Second Medical Opinion is approved, the Service Provider will facilitate arrangement as per conditions specified in the benefit.

V. **General Terms and Conditions**

1. **Free Look Provision**

   The Free Look Period shall be applicable on individual health insurance policies and not on renewals.

   The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy.. If he/she is not satisfied with any of the terms and conditions , he/she has the option to cancel his/her policy.

   In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to retun the policy to the insurer for cancellation, stating the reasons for the same.

   Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

2. **Cancellation**

   The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall:

   a. Refund proportionate premium for unexpired policy period, if the term of the policy upto one year and there is no claim(s) made during the policy period.

   b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.

3. **Pre-Insurance Medical Check-up**

   We may consider various attributes like age, sum insured, sum insured type, channel, location, insuring self vs insuring self + family etc to deploy different pre-policy medical check-ups and underwriting approaches (tele underwriting, tests etc).

   If we issue you the policy, the costs of pre-policy medical check-up (if any) will be borne by Us.

4. **Loading on Premium**

   a. Upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading applicable shall not exceed more than 100% of the premium per diagnosis / medical condition and an overall risk loading shall not exceed more than 150% of the premium per Insured Person.

   b. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.

   c. We may apply a specific personal Waiting Period on a medical condition/ailment depending on the past history or additional Waiting Periods on Pre-existing Diseases as part of the special conditions on the Policy.

5. **Renewal of Policy**

   A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured.

   An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.

c. Coverage is available during the grace period.

d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.

e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

6. **Renewal Premium:**

Renewal premium will alter based on Age. The reference of age for calculating the premium for Family Floater Policies shall be the age of the eldest Insured Person.

7. **Disclosures on Renewal:**

You shall make a full disclosure to Us in writing of any material change in the health condition or geographical location of any Insured Person at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing Policy will not be altered.

8. **Renewal for Insured Persons who have achieved Age 31:**

If any Insured Person who is a child and has completed Age 31 years at the time of Renewal in a Family Floater Policy, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under such Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

9. **Addition of Insured Persons on Renewal:**

Where an individual is added to this Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy with Us for that Insured Person.

10. **Changes to Sum Insured on Renewal:**

You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit or any benefit's enhanced sub-limit from the effective date of such enhancement.

11. **Change of Policyholder**

a. The Policyholder may be changed only at the time of Renewal. The new Policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The Renewed Policy shall be treated as having been Renewed without break. The Policyholder may be changed upon request in case of Your death, Your emigration from India or in case of Your divorce during the Policy Period.

b. Any alteration in the Policy due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately.

c. Renewal of such Policies will be according to terms and conditions of existing Policy.

12. **Nomination**

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. For claim settlement under Reimbursement, 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 / Policy Certificate / Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy. The insurer shall obtain nomination at the time of new business and at the time of renewal for existing policies.

13. **Obligations in case of a minor**

If an Insured Person is less than 18 years of Age, You or another adult Insured Person or legal guardian (in case of Your and all other adult Insured Person's demise) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

14. **Authorization to obtain all pertinent records or information:**

As a Condition Precedent to Admission of Liability for payment of benefits, We and/or Our Service Provider shall have the authority to obtain all pertinent records or information from any Medical Practitioner, Hospital, clinic, insurer, individual or institution to assess the validity of a claim submitted by or on behalf of any Insured Person.

15. **Fraudulent claims**

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his / her behalf to obtain any benefit under this Policy, all benefits under this Policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this Policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c. any other act fitted to deceive; and

d. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the Policy on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or beneficiaries.

16. **Policy Disputes**

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

17. **Territorial Jurisdiction**

All benefits are available in India only and all claims shall be payable in India in Indian Rupees only.

18. **Notices**

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

a. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.

b. Us at the following address:

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park

opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Fax No.: +91 11 41743397

c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.

d. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

19. **Alteration to the Policy**

This Policy constitutes the complete contract of insurance. Any change in the Policy will only be evidenced by a written endorsement signed and stamped by Us. No one except Us can within the permission of the IRDAI change or vary this Policy.

20. **Zonal pricing**

For the purpose of calculating premium, the country has been divided into the following 3 zones:

a. Zone 1: Delhi NCR, Mumbai (including Navi Mumbai and Thane)and Gujarat State, Delhi NCR includes Delhi, Baghpat, Bulandshahr, Gautam Buddh Nagar, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Faridabad, Gurugram, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak and Sonipat

b. Zone 2: Pune, Ludhiana, Jaipur, Nasihk, Hyderabad, Kolkata

c. Zone 3: Rest of India

21. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

22. **Withdrawal of Product**

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

b. Insured Person will have the option to either renew (up to 90 days from renewal date) same product or to migrate to a similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Loyalty Additions, waiver of waiting period etc. provided the Policy has been maintained without a break as per extant regulatory framework.

23. **Redressal of Grievance:**

In case of any grievance the Insured Person may contact the company through:

Website: www.nivabupa.com

Toll free: 1860-500-8888

E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/

(Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)

Fax : +91 11 41743397

Courier: Customer Services Department, Niva Bupa Health Insurance Company Limited, D-5, 2nd Floor, Logix Infotech Park, opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:

Grievance Redressal Officer

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park

opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Email: Email our Grievance officer through our Grievance Redressal platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx

For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx

If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.com.

If insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Policy Terms and Conditions).

Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in

24. **Assignment**

The Policy can be assigned subject to applicable laws.

25. **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The morarorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would applicable from the date of enhancement of sums insured only on the enhanced limits.

The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period.

26. **Multiple Policies**

A. **Indemnity Based Policies:**

a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his / her claim in terms of any of his / her policies. In all such cases the insurer chosen by the Policyholder shall be considered as the Primary Insurer and will 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.

b. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement pf the balance amount as per the policy conditions, without causing any hassles to the policy holder.

B. **Benefit Based Policies:**

a. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies.

27. **Migration**

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months

28. **Portability**

A Policyholder has the choice to port his/ her policies from one Insurer to another irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers.

The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.

29. **Premium Payment in Installments**

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 30 days in all policy types, and a period of 15 days in case of monthly installments.

ii. For policies where premium is paid in instalments only, the coverage will be given during grace period

iii. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.

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

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

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

The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

ANNEXURE I – Product Benefit Table (all limits in INR unless defined as percentage)

Plan Type (all limits in Rs unless defined as percentage)	Individual / Family Floater											
Base Sum Insured	3 lacs	4 lacs	5 lacs	7.5 lacs	10 lacs	12.5 lacs	15 lacs	20 lacs	25 lacs	50 lacs	75 lacs	100 lacs
Benefits												
Inpatient Care	Covered up to Sum Insured											
Day Care Treatment	Covered up to Sum Insured											
Alternative Treatments	Covered up to Sum Insured											
Domiciliary Hospitalization	Covered up to Sum Insured											
Modern treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries											
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured											
Post-Hospitalization Medical Expenses (180 days)	Covered up to Sum Insured											
Living Organ Donor Transplant	Covered up to Sum Insured											
Emergency Ambulance	Covered upto Rs.2,000 per hospitalization											
Air Ambulance	Cashless claim: Covered up to Sum Insured / Reimbursement claim: Covered up to Rs. 2.5 Lacs											
Home care treatment	Covered up to Sum Insured											
Loyalty Additions	Upon every completion of policy year, increase of 50% of the previous year's Base Sum insured; maximum up to 100% of the Base Sum Insured											
ReAssure	Unlimited reinstatement up to base Sum Insured. (Applicable for both same & different illness)											
Shared accommodation Cash Benefit	Rs. 800 per day; maximum Rs. 4,800							Rs. 1,000 per day; maximum Rs. 6,000				
Health Check-up	Annual (From Day 1); For defined list of tests; up to Rs. 500 for every Rs. 1 Lac Sum Insured (Individual policy: maximum Rs. 5,000 per Insured; Family Floater policy: maximum Rs. 10,000 per policy)											
Second Medical Opinion	Once for any condition for which hospitalization is triggered											
Live healthy benefit	Discount on renewal premium basis number of steps taken											
Optional benefits												
Hospital Cash [1]	1,000/day			2,000/day				4,000/day				
Personal Accident cover (for insured aged 18 years & above on individual basis)	Personal Accident cover will be up to 5 times of Base Sum Insured; subject to maximum of Rs. 100 Lacs											
Safeguard	a. Claim Safeguard: Non-payable items paid up to Sum Insured (List I) b. Loyalty additions Safeguard: No impact on Loyalty additions if claim in a policy year is less than Rs. 50,000 c. Sum Insured Safeguard: CPI linked increase in Base Sum Insured											
Safeguard+	a. Claim Safeguard+: Non-payable items paid up to Sum Insured (List I, II, III, IV) b. Loyalty additions Safeguard+: No impact on Loyalty additions if claim in a policy year is less than Rs. 100,000 c. Sum Insured Safeguard+: CPI linked increase in Base Sum Insured											
Modern Treatment+	Removal of Sub-limit of INR 1,00,000 from the Base Modern Treatment Benefit. Enhancing the limit to Up to Base Sum Insured.											

Annexure II - The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment

List I – Expenses not covered

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT

39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS

8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES/ TPA CHARGES LEVIED BY THE HOSPITAL
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT

8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
Illustration 1										
18	18,306.27	5,00,000	18,306.27	1,830.63	16,475.64	5,00,000	18,306.27	34,213.33	48,119.58	5,00,000
21	18,306.27	5,00,000	18,306.27	1,830.63	16,475.64	5,00,000	18,306.27			
39	22,860.19	5,00,000	22,860.19	2,286.02	20,574.17	5,00,000	22,860.19			
45	22,860.19	5,00,000	22,860.19	2,286.02	20,574.17	5,00,000	22,860.19			
Total premium for all members of the family is **Rs. 82,332.91**, when each member is covered separately. Sum Insured available for each individual is **Rs. 500,000**.			Total premium for all members of the family is **Rs. 74,099.62**, when they are covered under a single policy. Sum Insured available for each family member is **Rs. 500,000**.				Total premium when the policy is opted on floater basis is **Rs. 48,119.58**. Sum Insured of **Rs. 500,000** is available for the entire family.			
Illustration 2										
55	45,285.78	5,00,000	45,285.78	4,528.58	40,757.20	5,00,000	45,285.78	25,102.87	87,307.57	5,00,000
63	67,124.67	5,00,000	67,124.67	6,712.47	60,412.20	5,00,000	67,124.67			
Total premium for all members of the family is **Rs. 1,12,410.44**, when each member is covered separately. Sum Insured available for each individual is **Rs. 500,000**.			Total premium for all members of the family is **Rs. 1,01,169.40**, when they are covered under a single policy. Sum Insured available for each family member is **Rs. 500,000**.				Total premium when the policy is opted on floater basis is **Rs. 87,308.57**. Sum Insured of **Rs. 500,000** is available for the entire family.			
Illustration 3										
65	67,124.67	5,00,000	67,124.67	6,712.47	60,412.20	5,00,000	67,124.67	39,027.57	1,11,867.94	5,00,000
70	83,770.84	5,00,000	83,770.84	8,377.08	75,393.76	5,00,000	83,770.84			
Total premium for all members of the family is **Rs. 1,50,895.91**, when each member is covered separately. Sum Insured available for each individual is **Rs. 500,000**.			Total premium for all members of the family is **Rs. 1,35,805.96**, when they are covered under a single policy. Sum Insured available for each family member is **Rs. 500,000**.				Total premium when the policy is opted on floater basis is **Rs. 1,11,867.94**. Sum Insured of **Rs. 500,000** is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.

Zone 1 premium is considered