Policy Document (for Variant 1, 2, 3, Family First)

1. Preamble

This is a contract of insurance between **You** and **Us** which is subject to the payment of the full premium in advance and the terms, conditions and exclusions to this **Policy**. This **Policy** has been issued on the basis of the **Disclosure of Information Norm**, including the information provided by **You** in respect of the **Insured Persons** in the Proposal and the **Information Summary Sheet**.

Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

Note: The terms listed in Section 2(Definitions) and used elsewhere in the Policy in Initial Capitals and Bold shall have the meaning set out against them in Section 2 wherever they appear in the Policy.

2. Definitions

For the purposes of interpretation and understanding of this **Policy**, **We** have defined, herein below some of the important words used in the **Policy** and for the remaining language and the words; they shall have the usual meaning as described in standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the **IRDAI** and circulars and guidelines issued by the **IRDAI** shall carry the meanings explained therein.

Note: ***Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.***

2.1. Standard Definitions

I. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

II. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

III. **AYUSH Hospital:**

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner(s)* comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching Hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council of Homeopathy; or

c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion*:*

i. Having at least 5 in-patient beds

ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

V. **Associated Medical Expenses** shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

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

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

a. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.

VII. **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the **Policyholder**/insured will bear a specified percentage of the admissible claim amount. A **Co-payment** does not reduce the **Sum Insured**.

VIII. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

X. **Day Care Centre** means any institution established for **Day Care Treatment** of **Illness** and/or **Injuries** or a medical set-up within a **Hospital** and which has been registered within the local authorities, wherever

applicable, and is under the supervision of a registered and qualified **Medical Practitioner** AND must comply with all the following minimum criteria:

a. has **Qualified Nursing** staff under its employment;
b. has qualified **Medical Practitioner(s)** in charge;
c. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

X. **Day Care Treatment** refers to medical treatment, and/or **Surgical Procedure** which is:

a. undertaken under General or Local Anaesthesia in a **Hospital/Day Care Centre** in less than 24 hrs because of technological advancement, and
b. which would have otherwise required a **Hospitalization** of more than 24 hours.

Treatment normally taken on an Out patient basis is not included in the scope of this definition.

XI. **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the **Sum Insured**.

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

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

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

XIV. **Emergency** means a medical condition or symptom resulting from **Illness** or **Injury** which arises suddenly and unexpectedly and requires immediate care and treatment by a **Medical Practitioner** to prevent death or serious long term impairment of the **Insured Person's** health.

XV. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period..

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

a. has **Qualified Nursing** staff under its employment round the clock;
b. has at least 10 **Inpatient** beds in towns having a population of less than 10,00,000 and at least 15 **Inpatient** beds in all other places;
c. has qualified **Medical Practitioner (s)** in charge round the clock;
d. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

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

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

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

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

(a) **Acute condition** – Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / illness / injury which leads to full recovery

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

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

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

XXIII. **Maternity Expense** shall mean:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

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

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

XXVII. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in **Hospital** or part of a stay in **Hospital** which:

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

XXVIII. **Migration:** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing conditions and specific waiting periods from one health insurance policy to another with the same insurer.

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

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

XXXI. **Non-Network** means any **Hospital**, **Day Care Centre** or other provider that is not part of the network.

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

XXXIII. **Pre-existing Disease** means any condition, ailment, **Injury** or disease

a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer, or
b. For which medical advice or treatment was recommended by, or received from, a physician , not more than 36 months prior to the date of commencement of the policy

XXXIV. **Pre-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined number of days preceding the hospitalization of the **Insured Person**, provided that:

a. Such **Medical Expenses** are incurred for the same condition for which the **Insured Person's Hospitalization** was required, and
b. The **Inpatient Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

XXXV. **Post-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined number of days immediately after the **Insured Person** is discharged from the **Hospital**, provided that:

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

b. The **Inpatient Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

XXXVI. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing disease and specific waiting periods from one insurer to another..

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

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

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

XL. **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **Associated Medical Expenses**.

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

2.2. Specific Definitions

I. **Age** means age last birthday.

II. **Base Sum Insured** means the amount stated in the **Schedule of Insurance Certificate.**

III. **Bone Marrow Transplant** is a condition where the **Insured Person** needs necessary medical treatment to replace malignant or defective bone marrow with normal bone marrow from healthy donors to stimulate the production of formed blood cells.

IV. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

V. **Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.

VI. **Complementary & Alternative Medicine** means **Alternative Treatments** done alone or along with conventional/modern medicine.

VII. **Diagnostic Tests** means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.

VIII. **Diagnostic Services** means a broad range of **Diagnostic Tests** and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.

IX. **Evidence Based Clinical Practice** means process of making clinical decisions for **Inpatient Care** using current best evidence in conjugation with clinical expertise.

X. **Family Floater Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where the family members (two or more) named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family Floater Policy**:

a. **Insured Person**; and/or
b. **Insured Person's** legally married spouse (for as long as they continue to be married); and/or
c. **Insured Person's** children who are less than 21 years of **Age** on the commencement of the **Policy Period** (maximum 4 children can be covered).

XI. **Family First Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where **You** and **Your** family members named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family First Policy**:

a. **Your** legally married spouse for as long as **Your** spouse continues to be married to **You**;
b. Son;
c. Daughter-in-law as long as **Your** son continues to be married to **Your** Daughter-in-law;
d. Daughter;
e. Son-in-law as long as **Your** daughter continues to be married to **Your** Son-in-law;
f. Father;
g. Mother;
h. Father-in-law as long as **Your** spouse continues to be married to **You**;
i. Mother-in-law as long as **Your** spouse continues to be married to **You**;
j. Grandfather;
k. Grandmother;

l. Grandson;
m. Granddaughter;
n. Brother;
o. Sister;
p. Sister-in-law;
q. Brother-in-law;
r. Nephew;
s. Niece.

XII. **First Policy** means the **Schedule of Insurance Certificate** issued to the **Policyholder** at the time of inception of the **Policy** mentioned in the **Schedule of Insurance Certificate** with **Us**.

XIII. **Information Summary Sheet** means the information and details provided to **Us** or **Our** representatives over the telephone for the purposes of applying for this **Policy** which has been recorded by **Us** and confirmed by **You**.

XIV. **Individual Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where the individual named in the **Schedule of Insurance Certificate** is insured under this **Policy**.

XV. **Insured Person** means person named as insured in the **Schedule of Insurance Certificate**.

XVI. **IRDAI** means the Insurance Regulatory and Development Authority of India.

XVII. **Medical Devices** are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.

XVIII. **Medical Record** means the collection of information as submitted in claim documentation concerning a **Insured Person's Illness** or **Injury** that is created and maintained in the regular course of management, made by **Medical Practitioner**s who has knowledge of the acts, events, opinions or diagnoses relating to the **Insured Person's Illness** or **Injury**, and made at or around the time indicated in the documentation.

XIX. **No Claim Bonus** means an increase to the **Base Sum Insured** in accordance with the provisions of Section 3.11 in respect of claim free **Policy Years**.

XX. **Policy** means these terms and conditions, the **Schedule of Insurance Certificate** (as amended from time to time), **Your** statements in the Proposal and the **Information Summary Sheet** and any endorsements attached by **Us** to the **Policy** from time to time.

XXI. **Policy Period** is the period between the inception date and the expiry date of the **Policy** as specified in the **Schedule of Insurance Certificate** or the date of cancellation of this **Policy**, whichever is earlier.

XXII. **Policy Year** means the period of one year commencing on the date of commencement specified in the **Schedule of Insurance Certificate** or any anniversary thereof.

XXIII. **Product Benefits Table** means the **Product Benefits Table** issued by **Us** and accompanying this **Policy** which specifies the Plan applicable, the Benefits available to the **Insured Persons** and any sub-limits applicable to each Benefit.

XXIV. **Reimbursement** means settlement of claims paid directly by **Us** to the **Policyholder**/**Insured Person**.

XLII. **Schedule of Insurance Certificate** means a certificate issued by **Us**, and, if more than one, then the latest in time. The **Schedule of Insurance Certificate** contains details of the **Policyholder**, **Insured Persons** and the Benefits applicable under the **Policy**.

XLIII. **Service Provider** means any person, organization, institution that has been empanelled with **Us** to provide services specified under the benefits to the **Insured Person**.

XLIV. **Standby Services** are services of another **Medical Practitioner** requested by treating **Medical Practitioner** and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

XLV. **Suite Room** means
a. a space available for boarding in a **Hospital** which contains two or more rooms; Or
b. a space available for boarding in a **Hospital** which contains an extended living/dining/kitchen area

XLVI. **Sum Insured**: In case of **Individual Policy**, **Sum Insured** means the total of the **Base Sum Insured,** re-fill amountas per Section 3.12 and **No Claim Bonus** as per Section 3.11 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of the **Insured Person**. However in case of a single claim, **Our** maximum liability for that claim during the **Policy Year** in respect of the **Insured Person** shall be the total of the **Base Sum Insured** and No Claims Bonus as per Section 3.11.

In case of **Family Floater Policy**, **Sum Insured** means the total of the **Base Sum Insured,** re-fill amountas per Section 3.12 and **No Claim Bonus** as per Section 3.11 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of all **Insured Persons**.

In case of **Family First Policy**, **Sum Insured** means the total of the **Base Sum Insured** for each **Insured Person, No Claim Bonus** as per Section 3.11 for each **Insured Person** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** which is **Our** maximum, total and cumulative liability for all claims during a **Policy Year** in respect of all **Insured Persons**. For these purposes:

a. The **Base Sum Insured** stated in the **Schedule of Insurance Certificate** for each **Insured Person** is available for claims in respect of that **Insured Person** only, during the **Policy Year**.
b. If the **Base Sum Insured** for an **Insured Person** is exhausted due to payment of claims, then that **Insured Person** may utilise the Floater Sum Insured stated in the **Schedule of Insurance Certificate** for any claims arising in that **Policy Year**. In the event of a claim being admitted from the Floater Sum Insured**,** the Floater Sum Insured shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and only the remaining amount of the Floater Sum Insured shall be available for claims arising in that **Policy Year** in respect of the **Insured Persons** who have exhausted their **Base Sum Insured** during that **Policy Year**.
c. The total of the **Base Sum Insured** for all **Insured Persons, No Claim Bonus** as per Section 3.11 for all **Insured Persons,** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** is **Our** maximum, total and cumulative liability for all claims during a **Policy Year** in respect of all **Insured Persons**.

If the **Policy Period** is 2 or 3 years, then the **Sum Insured** shall be applied separately for each **Policy Year** in the **Policy Period**.

XXV. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the **Schedule of Insurance Certificate**or the **Policy** which shall be served before a claim related to such condition(s) becomes admissible.
XXVI. **We/Our/Us** means Max Bupa Health Insurance Company Limited.
XXVII. **You/Your/Policyholder** means the person named in the **Schedule of Insurance Certificate** who has concluded this **Policy** with **Us**

3. Benefits covered under the Policy

a. The Benefits available under this **Policy** are described below.
b. The **Policy** covers **Reasonable and Customary Charges** incurred towards medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness**, **Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this **Policy** and the availability of the **Sum Insured** and subject always to any sub-limits in respect of that Benefit as specified in the **Product Benefits Table** and any limits specified in the **Product Benefits Table** as applicable under the Plan in force for the **Insured Person** as specified in the **Schedule of Insurance Certificate**.
c. The expenses that are not covered or subsumed into room charges/ procedure charges/ costs of treatment are mentioned in Annexure II.
d. All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 7.2 (XIII) (Claim process &Requirements).
e. All claims paid under any benefit except for Section 3.10 (Health Check-up) and Section 4.1 (Hospital Cash) shall reduce the **Sum Insured** for that **Policy Year** and only the balance **Sum Insured** after payment of claim amounts admitted shall be available for all future claims arising in that **Policy Year**.

3.1. Inpatient Care

We will indemnify the **Medical Expenses** incurred on the **Insured Person's Hospitalization** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period**, provided that:

a. The **Hospitalization** is **Medically Necessary** and advised and follows **Evidence Based Clinical Practices** and Standard Treatment Guidelines.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for one or more of the following:
   i. **Room Rent**;
   ii. Nursing charges for **Hospitalization** as an **Inpatient** excluding private nursing charges;
   iii. **Medical Practitioners'** fees, excluding any charges or fees for **Standby Services**;
   iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
   v. Medicines, drugs as prescribed by the treating **Medical Practitioner**;
   vi. Intravenous fluids, blood transfusion, injection administration charges, consumables and/or enteral feedings;
   vii. Operation theatre charges;
   viii. The cost of prosthetics and other devices or equipment, if implanted internally during **Surgery**;
   ix. **Intensive Care Unit** charges.
c. If the **Insured Person** is admitted in the **Hospital** in a room category higher than the eligibility as specified in the **Product Benefits Table**, then **We** shall be liable to pay only a pro-rated proportion of the total

Associated Medical Expenses(including surcharge or taxes thereon) in the proportion of the difference between the **Room Rent** actually incurred and the entitled room category to the **Room Rent** actually incurred.

d. **We** shall not be liable to pay the visiting fees or consultation charges for any **Medical Practitioner** visiting the **Insured Person** unless such:
   i. **Medical Practitioner's** treatment or advice has been sought by the **Hospital**; and
   ii. Visiting fees or consultation charges are included in the **Hospital's** bill; and
   iii. Visiting fees or consultation charges are not more than the treating or referral **Medical Practitioner's** consultation charges.

3.2. Pre-hospitalization Medical Expenses

We will indemnify the **Insured Person's Pre-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

a. **We** have accepted a claim for **Inpatient Care** under Section 3.1 (**Inpatient Care**) above.
b. **We** will not be liable to pay **Pre-hospitalization Medical Expenses** for more than 30 days immediately preceding the **Insured Person's** admission to **Hospital** for **Inpatient Care** or such expenses incurred prior to inception of the **First Policy** with **Us**.
c. **Pre-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Pre-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed as **Complementary & Alternative Medicine** only.

3.3. Post-hospitalization Medical Expenses

We will indemnify the **Insured Person's Post-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy Period** as advised by the treating **Medical Practitioner** provided that:

a. **We** have accepted a claim for **Inpatient Care** under Section 3.1 (**Inpatient Care**) above.
b. **We** will not be liable to pay **Post-hospitalization Medical Expenses** for more than 60 days immediately following the **Insured Person's** discharge from **Hospital**.
c. **Post-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Post-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed as **Complementary & Alternative Medicine** only.

3.4. **Alternative Treatments**

We will indemnify the **Reasonable and Customary Charges** for **Medical Expenses** incurred on the **Insured Person's Medically Necessary** and **Medically Advised Inpatient Hospitalization** during the **Policy Period**on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in **AYUSH Hospital**.

Pre-hospitalization Medical Expenses incurred for upto30 days prior to the **Alternative Treatments** being commenced and **Post-hospitalization Medical Expenses** incurred for up to 60 days following the **Alternative Treatment** being concluded will also be indemnified under this Benefit provided that these **Medical Expenses** relate only to **Alternative Treatments** only and not Allopathy.

Section 6.2 (XIII) of the Permanent Exclusions shall not apply to the extent this Benefit is applicable.

3.5. Day Care Treatment

We will indemnify the **Medical Expenses** incurred on the **Insured Person's Hospitalization** for any **Day Care Treatment** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

a. The **Day Care Treatment** is **Medically Necessary** and follows the written advice of a **Medical Practitioner**.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for any procedure where such procedure is undertaken by an **Insured Person** as **Day Care Treatment**.
c. The following procedures will be covered as **Day Care Treatment** under this benefit as they each require a period of specialized observation or care after completion of the procedure:
   i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer(approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
   ii. Renal dialysis(Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)

d. **We** will not cover any **OPD Treatment** and **Diagnostic Services** under this Benefit.

e. If We have accepted a claim under this benefit, We will also indemnify the **Insured Person's Pre-hospitalisation Medical Expenses** and **Post-hospitalisation Medical Expenses** in accordance with Sections 3.2 and 3.3 within the overall benefit sub-limit.

3.6. **Domiciliary Hospitalization**

We will indemnify on a **Reimbursement** basis the **Medical Expenses** incurred for **Domiciliary Hospitalization** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

a. The **Domiciliary Hospitalization** continues for at least 3 consecutive days in which case **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.

c. If We have accepted a claim under this benefit, We will also indemnify the **Insured Person's Pre-hospitalisation Medical Expenses** and **Post-hospitalisation Medical Expenses** in accordance with Sections 3.2 and 3.3 within the overall benefit sub-limit.

3.7. **Living Organ Donor Transplant**

We will indemnify the **Medical Expenses** incurred for a living organ donor's **Inpatient** treatment for the harvesting of the organ donated provided that:

a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the **Insured Person**.
b. The recipient **Insured Person** has been **Medically Advised** to undergo an organ transplant.
c. **We** have accepted the recipient **Insured Person's** claim under Section 3.1 (**Inpatient Care**).
d. **Medical Expenses** incurred are **Reasonable and Customary Charges**.

We shall not be liable to make any payment in respect of:

a. The living organ donor's stay in a **Hospital** that is needed for them to donate their organ.
b. Stem cell donation except for **Bone Marrow Transplant**.
c. **Pre-hospitalization Medical Expenses** or **Post-hospitalization Medical Expenses** of the organ donor.
d. Screening or any other **Medical Expenses** of the organ donor.
e. Costs directly or indirectly associated with the acquisition of the donor's organ.
f. Transplant of any organ/tissue where the transplant is experimental or investigational.
g. Expenses related to organ transportation or preservation.
h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

3.8. **Emergency Ambulance**

We will indemnify the **Reasonable and Customary Charges** for ambulance expenses incurred to transfer the **Insured Person** by surface transport following an **Emergency** provided that:

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 the nearest **Hospital** where appropriate medical treatment can be obtained or from the existing **Hospital** to another nearest **Hospital** with advanced facilities as advised by the treating **Medical Practitioner** for management of the current **Hospitalization**.
b. This benefit is available for one transfer per **Hospitalization**.
c. The ambulance service is offered by a healthcare or ambulance **Service Provider**.
d. **We** have accepted a claim under Section 3.1 (**Inpatient Care**) above.
e. **We** will cover expenses upto the amount specified in the **Product Benefits Table**.
f. **We** will not make any payment under this Benefit if the **Insured Person** is transferred to any **Hospital** or diagnostic centre for evaluation purposes only.

3.9. Vaccination for Animal Bite

We will indemnify the **Medical Expenses** incurred on **OPD Treatment** for vaccinations or immunizations required by the **Insured Person** for an animal bite that occurs during the **Policy Period** provided that:

a. The **Medical Expenses** incurred are **Medically Necessary** and are **Reasonable and Customary Charges**.
b. Claims under this Benefit can be availed on a **Reimbursement** basis only.

3.10. Health Checkup

If the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 or 3 year **Policy Period** (if applicable), then the **Insured Person** may avail a health check-up as per the Plan applicable to the **Insured Person**as specified in the **Product Benefits Table** on **Cashless Facility** basis provided that:

a. Health check-up will be arranged only at **Our** empanelled **Service Providers**.
b. The **Insured Person** is above **Age** 18 on the commencement of that **Policy Year**.
c. The **Insured Person** will not be eligible to avail a health check-up in the first **Policy Year** in which he/she is covered as an **Insured Person** under the **Policy**.
d. Any unutilized test or amount cannot be carry forwarded to the next **Policy Year**.
e. The list of tests covered under this benefit is Complete Blood Count, Urine Routine, ESR, HBA1C, S Cholesterol, Sr. HDL, Sr LDL, Urea and Kidney Function Test.

3.11. No Claim Bonus

a. For an **Individual Policy** or **Family Floater Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 or 3 year **Policy Period** (if applicable) and no claim has been made in the immediately preceding **Policy Year**, each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 20% of the **Base Sum Insured** of the immediately preceding **Policy Year**; subject up to maximum of 100% of the expiring **Base Sum Insured**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

b. For a **Family First Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 or 3 year **Policy Period** (if applicable) and no claim has been made in the immediately preceding **Policy Year**, each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 20% of the **Base Sum Insured** of each individual **Insured Person** only and the increase shall not apply to the Floater Sum Insured stated in the **Schedule of Insurance Certificate** as applicable under the **Policy**; subject up to maximum of 100% of the expiring **Base Sum Insured** of each individual **Insured Person**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

c. If the **Insured Person** in the expiring **Policy** is covered under an **Individual Policy** and has an accumulated **No Claim Bonus** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family Floater Policy**, then **We** shall not provide any credit for the accumulated **No Claim Bonus** to the **Family Floater Policy**.

d. If the **Insured Person** in the expiring **Policy** is covered under an **Individual Policy** and has an accumulated **No Claim Bonus** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family First Policy**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the accumulated **No Claim Bonus** for that **Insured Person** only.

e. If the **Insured Persons** in the expiring **Policy** are covered under a **Family First Policy** and have an accumulated **No Claim Bonus** for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family Floater Policy** with same or higher **Base Sum Insured**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the least of the accumulated **No Claim Bonus** amongst all the **Insured Persons**.

f. If the **Insured Persons** in the expiring **Policy** are covered under **Family First Policy** and have an accumulated **No Claim Bonus** for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on an **Individual Policy** with same or higher **Base Sum Insured**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the accumulated **No Claim Bonus** for that **Insured Person**.

g. 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 **Schedule of Insurance Certificate** in to two or more floater / individual / **Family First Policy**, then We shall not provide any credit of the accumulated **No Claim Bonus** to the split **Policy**.

h. In case the **Base Sum Insured** under the **Policy** is reduced at the time of **Renewal**, the applicable accumulated **No Claim Bonus** shall also be reduced in proportion to the **Base Sum Insured**.

i. In case the **Base Sum Insured** under the **Policy** is increased at the time of **Renewal**, the applicable accumulated **No Claim Bonus** shall be carried forward.

j. If a claim has been made in the immediately preceding **Policy Year, We** will not increase or decrease the **Sum Insured** due to this benefit for the **Policy Year**. Whereas, if a reported claim has been denied by **Us**, the **Insured Persons** will be eligible for this benefit.

3.12. Re-fill Benefit (applicable for Individual Policy and Family Floater Policies only)

If the **Base Sum Insured** and **No Claim Bonus** (if any) has been partially or completely exhausted due to claims made and paid or claims made and accepted as payable for a particular **Illness** during the **Policy Year** under Section 3, then **We** will provide a re-fill amount of up to 100% of the **Base Sum Insured** which may be utilized for claims arising in that **Policy Year**, provided that:

a. The re-fill amount may be used for only subsequent claims in respect of the **Insured Person** and not against any **Illness** (including its complications or follow up) for which a claim has been paid or accepted as payable in the current **Policy Year**;
b. We will provide a re-fill amount only once in a **Policy Year**;
c. For **Family Floater Policies**, the re-fill amount will be available on a floater basis to all **Insured Persons** in that **Policy Year**;
d. If the re-fill amount is not utilized in whole or in part in a **Policy Year**, it cannot be carried forward to any extent in any subsequent **Policy Year**.

3.13. Modern Treatments

The following procedures / treatments will be covered either as **Inpatient Care** or as part of **Day Care Treatment** as per Section 3.1 and Section 3.4 respectively, 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. Bronchical Thermoplasty
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.

a. 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 Sections 3.2 and 3.3 within the overall benefit sub-limit.

4. Optional Benefits

The following optional benefit shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if the optional benefit is selected by **You**. This optional benefit can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**, on payment of the corresponding additional premium. If a loading applies to the premium for the main **Policy**, such loading will also apply to the premium for this optional benefit selected. The Optional Benefit covers **Reasonable and Customary Charges** incurred towards the medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness**, **Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**.
All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 7.2 (XIII) (Claim process & Requirements).

4.1. Hospital Cash

If **We** have accepted an **Inpatient Care Hospitalization** claim under Section 3.1 (**Inpatient Care**), **We** will pay the Hospital Cash amount specified in the **Product Benefits Table** 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** provided that:

a. The **Insured Person** has been admitted in a **Hospital** for a minimum period of 48 hours continuously.
b. **We** will not make any payment under this option for Section 3.6 (**Domiciliary Hospitalization**).

4.2. Personal Accident

4.2.1 Accidental Death (AD)

In event of unfortunate demise of the insured within 365 days from the date of the Accident, within the Policy Period, we will pay the Sum Insured.

The Personal accident benefit will terminate after the Accidental Death benefit is paid for.

4.2.2 Permanent Total Disability

If the Insured Person suffers Permanent Total Disability, within 365 days from the date of the Accident, within the Policy Period, we will pay the benefit as per the below Table

Condition for Permanent Total Disability	% of Accidental Death Sum Insured
Complete & Irrecoverable loss of : • Any 2 Limbs • Sight of both eyes • Speech & hearing of both Ears • Combination of One Limb & Sight of One Eye	125%
Complete & Irrecoverable loss of : • 1 Limb • Sight of 1 Eye	50%

a. Complete & Irrecoverable loss of limb means physical separation or complete loss of functionality of the limb, within 365 days from the date of the Accident. This will include Paralysis including Paraplegia, Quadriplegia with loss of functional use of limb.

The Personal accident benefit will terminate after the Permanent Total Disability benefit is paid for.

4.2.3 Permanent Partial Disability

a. If the Insured Person suffers a Permanent Partial Disability, within 365 days from the date of the Accident, within the Policy Period, we will pay the benefit as per the below Table.

Condition for Permanent Partial Disability	% of Accidental Death Sum Insured
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	50%
Each hand at the wrist	50%
Each Thumb	20%
Each Index Finger	10%
Each other Finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%

b. If a Permanent Partial Disability loss is not mentioned in the table above, then we will internally assess the degree of disablement and determine the amount of payment to be made.

c. If there is more than one Permanent Partial Disability loss, then the total claim amount put together for all losses will not exceed the total Accidental Death Sum Insured opted. Once Total Sum Insured is paid, the policy will lapse.

5. Claim Cost Sharing Options

The following claim cost sharing options shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if such options are selected by **You**. These claim cost sharing options can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**.

5.1. Treatment only in Tiered Network (Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy)

By selecting this cost sharing option, **Insured Person** can avail **Cashless Facility** in **Our Network Providers** in locations except Delhi (NCR), Mumbai including Suburbs, Chennai, Bengaluru, Hyderabad, Kolkata, Pune, Ahmedabad and Surat. **Insured Person** can also avail treatment (on **Reimbursement** basis) in Delhi (NCR), Mumbai including Suburbs, Chennai, Bengaluru, Hyderabad, Kolkata, Pune, Ahmedabad, Surat **Hospitals** with 20% **Co-payment**.

Co-payment will not apply to any claim under Section 3.10(Health Checkup) and Section 4.1 (Hospital Cash).

5.2. Annual Aggregate Deductible

The **Insured Person** shall bear on his/her own account an amount equal to the **Deductible** specified in the **Schedule of Insurance Certificate** for any and all admissible claim amounts **We** assess to be payable by **Us** in respect of all claims made by that **Insured Person** under the **Policy** for a **Policy Year**. It is agreed that **Our** liability to make payment under the **Policy** in respect of any claim made in that **Policy Year** will only commence once the **Deductible** has been exhausted.

It is further agreed that:

a. The provisions in Section 5.1 on **Co-payment** (if applicable) will apply to any amounts payable by **Us** in respect of a claim made by the **Insured Person** after the **Deductible** has been exhausted.

b. **Deductible** will not apply to any claim under Section 3.10 (Health Checkup) and Section 4.1 (Hospital Cash).

6. Exclusions

6.1. Standard Exclusions

I. **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**.

II. **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-day 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:
    i. Pancreatitis and Stones in Biliary and Urinary System,
    ii. Cataract, Glaucoma and other disorders of lens, disorders of Retina,
    iii. Hyperplasia of Prostate, Hydrocele and spermatocele,
    iv. Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy,
    v. Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,
    vi. Hernia of all sites,
    vii. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders,
    viii. Chronic kidney disease and failure,
    ix. Varicose veins of lower extremities,
    x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,
    xi. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
    xii. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,
    xiii. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,
    xiv. Internal Congenital Anomaly.

III. **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.

IV. **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.

V. **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.

VI. **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

VII. **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.

VIII. **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.

IX. **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.

X. **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.

XI. **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.

The complete list of excluded providers can be referred to on our website.

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

XIII. 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)**

XIV. 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)**

XV. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

XVI. **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.

XVII. **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

XVIII. **Maternity (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.

6.2. Specific Exclusions

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

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

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

IV. 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.

V. External Congenital Anomaly:
Screening, counseling or treatment related to external Congenital Anomaly.

VI. 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.

VII. Hormone Replacement Therapy:
Treatment for any condition / illness which requires hormone replacement therapy.

VIII. Sexually transmitted Infections & diseases (other than HIV / AIDS):
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

IX. Sleep disorders:
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

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

XI. 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.

XII. 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.

XIII. AYUSH Treatment
Any form of AYUSH Treatments, except as mentioned under Section 3.4.

XIV. OPD Treatment:
OPD Treatment is not covered except for animal bite vaccinations to the extent stated in Section 3.9.

7. General Terms and Clauses

7.1. Standard General Terms and Clauses

I. Free Look Period

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.

a. 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

II. 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

III. 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.

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I. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
II. 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.
III. Coverage is available during the grace period.
IV. 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.
V. 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.

IV. 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. 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.

V. Fraud

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** and the premium paid shall be forfeited.

Any amount already paid against claims made under this **Policy** but which are found fraudulent later shall be repaid by all recipient(s)/**Policyholder(s)**, who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the **Insured Person** or by his agent or the **Hospital**/doctor/any other party acting on behalf of the **Insured Person**, 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 claim and / or forfeit the policy benefits 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

VI. **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.

VII. Withdrawal of Policy

a. In the likelihood of this product being withdrawn in future, the **Company** will intimate the **Insured Person** about the same 90 days prior to expiry of the **Policy**.
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 **Cumulative Bonus**, waiver of waiting period as per IRDAI guidelines, provided the **Policy** has been maintained without a break.

VIII. **Redressal of Grievances**:

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 Annexure I).

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

IX. 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 to the policyholder from the date of receipt of claim intimation till the date of payment of claim at a rate of 2% above the bank rate.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

X. 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 moratorium 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.

XI. Multiple Policies

I. 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.

II. Benefit Based Policies:

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

III. Disclosure of Information

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

(Explanation: “Material facts” for the purpose of this **Policy** shall mean all relevant information sought by the **Company** in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

IV. Condition Precedent to Admission of Liability

The terms and conditions of the **Policy** must be fulfilled by the **Insured Person** forthe **Company** to make any payment for claim(s) arising under the **Policy**.

V. Complete Discharge

Any payment to the **Policyholder**, **Insured Person** or his/ her nominees or his/ her legal representative or assignee or to the **Hospital**, as the case may be, for any benefit under the **Policy** shall be a valid discharge towards payment of claim by the **Company** to the extent of that amount for the particular claim.

XV. 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

XVI. 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

7.2. Specific Terms and Clauses

I. **Loading on Premium**

a. Based on **Our** discretion, 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 150% of the premium.

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**.

II. **Automatic Cancellation:**

i. **Individual Policy**:
The **Policy** shall automatically terminate in the event of death of the **Insured Person**.

ii. For **Family Floater Policies** and **Family First Policies**:
The **Policy** shall automatically terminate in the event of the death of all the **Insured Persons**. .

iii. Refund:
A refund in accordance with Section 7.1 (II) shall be payable if there is an automatic cancellation of the **Policy** provided that no claim has been made under the **Policy** by or on behalf of any **Insured Person**. **We** will pay the refund of premium to the **Nominee** named in the **Schedule of Insurance Certificate** or **Your** legal heirs or legal representatives holding a valid succession certificate.

III. **Other Renewal Conditions:**

a. Continuity of Benefits on Timely Renewal:

i. The **Renewal** premium is payable on or before the due date and in any circumstances before the expiry of **Grace Period**, at such rate as may be reviewed and notified by **Us** before completion of the **Policy Period**.
ii. **Renewal** premium rates for this **Policy** may be further altered by **Us** including in the following circumstances:
   A. **You** proposed to add an **Insured Person** to the **Policy**
   B. **You** change any coverage provision
   C. **You** change **Your** residence to different zip code
iii. **Renewal** premium will alter based on individual **Age**. The reference of **Age** for calculating the premium for **Family Floater Policies** shall be the **Age** of the eldest **Insured Person**, and for **Family First Policies** it shall be the individual **Age** of each **Insured Person** of the family.

b. Reinstatement:
i. The **Policy** shall lapse after the expiration of the **Grace Period**. If the **Policy** is not **Renewed** within the **Grace Period** then **We** may agree to issue a fresh **Policy** subject to **Our** underwriting criteria, as per **Our** Board approved underwriting policy and no continuing benefits shall be available from the expired **Policy**.
ii. **We** will not pay for any **Medical Expenses** which are incurred happen between the date the **Policy** expires and the date immediately before the reinstatement date of **Your Policy**.
iii. If there is any change in the **Insured Person's** medical or physical condition, **We** may add exclusions or charge an extra premium from the reinstatement date.

c. 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.

d. Renewal for Insured Persons who have achieved Age 21:
If any **Insured Person** who is a child and has completed **Age**21 years at the time of **Renewal**, 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 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**.

e. 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**.

f. Changes to Sum Insured on Renewal:
i. Wherever the **Sum Insured** is reduced on any **Policy Renewals**, the **Waiting Periods** shall be waived only up to the lowest **Sum Insured** of the last 48/36 consecutive months as applicable to the relevant **Waiting Periods** of the Plan opted.
ii. Any enhanced **Sum Insured** applied on **Renewal** will not be available for an **Illness** or **Injury** already contracted under the preceding **Policy Periods**. All **Waiting Periods** shall apply afresh for this enhanced limit from the effective date of such enhancement.

IV. **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 plan 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. Coverage of Benefits in such scenario will be limited to current **Policy Year**.
c. **Renewal** of such **Policies** will be according to terms and conditions of existing **Policy**.

V. **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**.

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

As a **Condition Precedent** to the 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**.

VII. **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.

VIII. **Territorial Jurisdiction**

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

IX. **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 **Schedule of Insurance Certificate** 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.: 011-4174-3397

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 **YourPolicy** from time to time.

X. **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**.

XI. **Zonal pricing**

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

- Zone 1: Delhi, Gurgaon, Faridabad, Gautam Buddha Nagar, Ghaziabad, Noida, Surat, Kolkata, Mumbai, Thane
- Zone 2: Pune, Nasik, Ludhiana, Jaipur, Baghpat, Bulandshahr, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak and Sonipat
- Zone 3: Rest of India

XII. **Assignment**

The **Policy** can be assigned subject to applicable laws.

XIII. **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 **Schedule of Insurance Certificate**) 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 **Our** liability under this **Policy**.

A. **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. The directions, advice and guidance of the treating **Medical Practitioner** shall be strictly followed. **We** shall not be obliged to make any payment that arises out of wilful failure to comply with such directions, advice or guidance.

b. **We**/**Our** representatives 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** representatives 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 change will beat **Our** discretion.

B. **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 **Our** 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**. The complete list of **Network Providers** is 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

7.2.1.1. 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**.

7.2.1.2. 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**.

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.

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** and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, **Hospital** and locations, match with the details of the actual treatment received. For cashless **Hospitalization**, **We** will make the payment of the amount assessed to be due, directly to the **Network Provider**.

We reserve the right to modify, add or restrict any **Network Provider** for **Cashless Facility** in **Our** sole discretion. Before availing **Cashless Facility**, please check the applicable updated list of **Network Providers**.

ii. Reauthorization

Cashless Facility will not be provided where re-authorization is not requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding, unless required due to **Emergency**.

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** have not been pre-authorized or for which treatment has not been taken at a **Network Provider**, **We** shall be informed 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**.

C. **Claims Documentation: 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 (in the case of **Pre-hospitalization Medical Expenses** and **Hospitalization Medical Expenses**) or within 30 days of the completion of the **Post-hospitalization Medical Expenses** period (in the case of **Post-hospitalization Medical Expenses**). For those claims for which the use of **Cashless Facility** has been authorised, **We** will be provided these documents by the **Network Provider** immediately following the **Insured Person's** discharge from **Hospital**:

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

Please provide mandatorily following information if applicable

i. Current diagnosis and date of diagnosis;
ii. Past history and first consultation details;
iii. Previous admission/**Surgery** if any.

b. Age/Identity proof document: Of **Insured Person** in case of cashless claim (not required if submitted at the time of pre-authorization request) and Proposer in case of **Reimbursement** claim.
   i. Self attested copy of 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);
c. 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**).
d. Original discharge summary.
e. Additional documents required in case of **Surgery**/**Surgical Procedure**.
   i. Bar code sticker and invoice for implants and prosthesis (if used);
f. Original final bill from **Hospital** with detailed break-up and paid receipt.
g. 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.)
h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside **Hospital** with reports and requisite prescriptions.
i. Copy of death certificate(in case of demise of the **Insured Person**).
j. For Medico-legal cases(MLC) or in case of **Accident**
   i. MLC/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 &pathological reports with supporting prescriptions.
l. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

*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**.*

D. **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. Payment for **Reimbursement** claims will be made to **You**. In the unfortunate event of **Your** death, **We** will pay the Nominee named in the **Schedule of Insurance Certificate** or **Your** legal heirs or legal representatives holding a valid succession certificate.
c. If a claim is made which extends in to two **Policy Periods**, then such claim shall be paid taking into consideration the available **Sum Insured** in these **Policy Periods** including the **Deductible** for each **Policy Period**. Such eligible claim amount will be paid to the **Policyholder/Insured Person** after deducting the extent of premium to be received for the **Renewal**/due date of premium of the **Policy**, if not received earlier.
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 **Schedule of Insurance Certificate**, then the **Associated Medical Expenses** payable shall be pro-rated as per the applicable limits in accordance with Section 3.1c.
    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 **Schedule of Insurance Certificate** shall be applicable on the amount payable by **Us**.
e. The claim amount assessed above would be deducted from the amount mentioned against each benefit and **Sum Insured** as specified in the **Schedule of Insurance Certificate**. The re-fill amount will be applied only once the **Base Sum Insured** and **No Claim Bonus** is exhausted in the **Policy Year**.

E. **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.

F. **Claims process for Section 3.10 (Health Checkup)**

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**.

Annexure I - List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, UT of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).

DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of Lakshadweep, Mahe-a part of UT of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.

LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS
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Mumbai - 400 054.
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Shri B. C. Patnaik, Secretary General
Smt Poornima Gaitonde, Secretary

Ombudsmen details are subject to change. Please refer this link for the updated details: CIO (cioins.co.in)"

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
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