A. Preamble

This is a contract of insurance between You and Us which is subject to the receipt of the full premium in advance and the terms, conditions, and exclusions of this Policy. This Policy has been issued on the basis of the information provided by You in the Proposal Form or accompanying documents.

All treatments in this policy will be considered if they are taken in India.

B. Definitions

B.1. Standard Definitions:

1. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Deductible** means 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.
3. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
4. **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.
5. **Hospital** means any institution established for Inpatient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
   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.
6. **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.
7. **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.
8. **Illness** means a 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:

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

9. **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.
10. **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.
11. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
12. **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.
13. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.
14. **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.
15. **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.
16. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized **modes of communication.**
17. **Non-Network Provider** means any Hospital, Day Care Center or other provider that is not part of the network.
18. **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.
19. **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.
    c.
20. **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.
21. **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.

22. **Specific Waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

B.2. Specific Definitions:

1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
2. **Base Sum Insured** means the amount stated in the Policy Schedule.
3. **Diagnostic Services** means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.
4. **Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:
    a. Primary Insured Person; and/or
    b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or
    c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).
5. **First Policy** means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.
6. **Individual Policy** means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.
7. **Insured Person** means person(s) named as insured persons in the Policy Schedule.
8. **IRDAI** means the Insurance Regulatory and Development Authority of India.
9. **Policy** means these terms and conditions, the Policy Schedule (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.
10. **Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
11. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
12. **Policy Schedule** means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.
13. **Primary Insured Person** means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.
14. **Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.
15. **Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.
16. **Sum Insured** means the total of the Base Sum Insured which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person(s) which is specified in the Policy Schedule.
17. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.
18. **We/Our/Us** means Niva Bupa Health Insurance Company Limited.
19. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

C. Benefits Covered under the Policy

- All benefits mentioned below are optional in nature and can be chosen in any combination by the Policyholder.
- The Policy Schedule/Certificate of Insurance will specify which Benefits are in force and available for the Insured Person for the operative time as shown in the Policy Schedule/ Certificate of Insurance.
- Premium charged for the Policy would be according to opted benefits and as mentioned in the Policy Schedule/ Certificate of Insurance.
- All expenses should be Reasonable and Customary in nature and can be availed by either Cashless or Reimbursement methods as mentioned in the Policy Schedule/ Certificate of Insurance.

1. Out Patient Consultations

We do NOT take any responsibility for correctness of medical advice given or for any disputes arising between the Insured Person and the Service Provider.

1.1. Video Consultations

We will cover Video Consultations with certified General Practitioners for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year.

1.2. Tele Consultations

We will cover Tele Consultations with certified General Practitioners for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year.

1.3. Physical Consultations

We will cover Physical Consultations with certified General Practitioners for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year.

1.4. Video Consultations with specialists

We will cover Video Consultations with Specialists doctors for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year. Indicative list of specialists is mentioned in Annexure 2.

1.5. Tele Consultations with specialists

We will cover Tele Consultations with Specialists Doctors for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year. Indicative list of specialists is mentioned in Annexure 2

1.6. Physical Consultations with specialists

We will cover Physical Consultations with Specialists Doctors for the Insured and it will be subject to the limits mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year. Indicative list of specialists is mentioned in Annexure 2.

1.7. What is not covered under Outpatient Consultations:

a. Consultation for Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.

1.8. Claims Process & Requirements:

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Section, then as a Condition Precedent to Our liability under this Section the following procedure shall be complied with:

1.8.1. Claims Documentation:

a. Claim form duly completed and signed by the claimant.
b. Original Bills with detailed breakup of charges (including but not limited to pharmacy, purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
c. Original payment receipts
d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries, OPD treatment card, consultation notes.

1.8.2. Claims Assessment & Repudiation:

All admissible claims under this Policy shall be assessed by Us; Co-Payment (if applicable) as specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the amount payable by Us.

2. Diagnostic Tests and Investigations

We will provide diagnostic test and investigation services and it will be subject to the limits/conditions mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year.

The indicative list of diagnostic tests covered under this benefit is mentioned in Annexure 3.

3. Pharmacy Services

We will provide pharmacy services and it will be subject to the limits/conditions mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year.

4. Home Health Care Services

We will provide home health care services and it will be subject to the limits/conditions mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year. Indicative list of specialists is mentioned in Annexure 4

Conditions:

a. The medical condition of the Insured Person must be such that the treating Medical Practitioner expects the condition to improve in a reasonable and generally predictable period of time.
b. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
c. The amount, frequency and time period of the services under this Benefit shall be reasonable, and in agreement between treating Medical Practitioner and the Insured Person availing the service.

5. Vaccination Cover

We will provide vaccination services and it will be subject to the limits/conditions mentioned in the Policy Schedule/ Certificate of Insurance. Any unutilized amount will not be carried forward to the next Policy Year. Indicative list of specialists is mentioned in Annexure 5

6. Annual Health Check-up

The Insured may avail any of the following:

a. Set of Health check-up tests during the Policy Period as per policy schedule/certificate of insurance
b. Up to the limit specified in the Policy Schedule/Certificate of Insurance

Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

The indicative list of tests covered under this benefit is mentioned in Annexure 6

7. Daily Cash Benefit

If an Insured Person due to illness or injury is hospitalized, then we will pay the amount as specified in the Policy Schedule/Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization.

Optional Benefit (can be opted only if Daily Cash Benefit is opted)
ICU Daily Cash Benefit – In case of hospitalization in intensive care unit we will pay twice the Daily Cash specified in the Certificate of Insurance for each continuous and completed period of 24 hours of admission in the Intensive Care Unit.

Optional Conditions:

a. The Policyholder may opt for franchise option under the above benefit subject to limits as mentioned in Policy Schedule/Certificate of Insurance. Franchise means minimum specified period for which the Insured Person is hospitalized, following which the benefit amount is payable from the first completed day of hospitalization.
b. The Policyholder may opt for deductible option under the above benefit subject to limits as mentioned in Policy Schedule/Certificate of Insurance.

Conditions:

We shall not be liable to make any payment under this Benefit in respect Domiciliary Hospitalization or Maternity Expenses or New Born Baby coverage.

7.1. Claims Documentation:

a. Claim form duly completed and signed by the claimant.
b. Original Bills with detailed breakup of charges (including but not limited to pharmacy, purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
c. Original payment receipts
d. All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries, OPD treatment card, consultation notes.

8. Accident Cover

The Benefits offered under this Section shall be available to the Insured Person up to the Accidental Cover Sum Insured subject to any specific limits stated in the Policy Schedule/Certificate of Insurance as per the eligibility under the opted Benefits.

8.1. Death

If the Insured person dies within 365 days from the date of the Accident, we will pay the Sum Insured.

Disappearance: If the Insured person disappears, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, It shall be deemed after 365 days, subject to all other terms and conditions of this Policy that such Insured Person shall have died as the result of an Accident. If at an time, after the payment of the Death benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to the Company.

The policy will terminate after the Death benefit is paid for.

8.2. Permanent Total Disability (PTD)

a. If the Insured Person suffers a Permanent Total Disability, within 365 days from the date of the Accident, we will pay the benefit as per the Table 1.

Table 1:

Condition for Permanent Total Disability	**% of 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	100%
Complete & Irrecoverable loss of : • 1 Limb • Sight of 1 Eye	50%

b. 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.

Any claim made under this benefit will not terminate the policy.

8.3. Permanent Partial Disability (PPD)

a. If the Insured Person suffers a Permanent Partial Disability, within 365 days from the date of the Accident, we will pay the benefit as per the Table 2.

Table 2:

Condition for Permanent Partial Disability	**% of 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 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.

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 Sum Insured opted.

8.4. Temporary Total Disability (TTD)

If an Insured Person suffers a Temporary Total Disability and is unable to go to work and perform his/her duties then:

a. We will pay the amount mentioned in the Policy Schedule/ Certificate of Insurance per week to the Insured Person.
b. If the Insured is disabled for part of a week, then proportionate amount will be paid.
c. TTD caused due to Coma & Burns will also be considered.
d. TTD is not applicable for Dependent Children

8.5. Accidental Medical Reimbursement

In case the Insured is admitted in a hospital (for more than 24 hours) solely and directly due to an injury sustained during the policy period, then we will pay for hospitalization expenses up to opted Sum Insured
We will pay the expenses incurred on treatment (Naturally this excludes expenses not linked to treatment like food, beverage, toiletries and cosmetics) if Insured were admitted for more than 24 hours post an Accident.

NOTE: Admission in a hospital happens in what is called wards or rooms of various categories, ICUs, CCUs, NICU etc.

8.6. Benefit amount

If for Section 8.1 (Death) or Section 8.2(Permanent Total Disability) or Section 8.3 (Permanent Partial Disability) or Section 8.4 (Temporary Total Disability) or Section 8.5 (Medical Reimbursement) the benefit amount in the policy is linked to any of the following (as mentioned in the Policy Schedule/Certificate of Insurance). The insured will be asked for documents as proof for the specified benefit amount category at the time of issuance of the policy or/and claims.

a. Based on Weekly, Monthly, Quarterly Salary: The take home Salary of the Insured will be considered as the declared Salary at the time of buying the policy. We will not consider bonus and other payouts as part of the Salary. Salary has to be in the name of the Insured Proposer.
b. Based on Fixed Deposit (FD) Amount: The amount deposited as FD by the Insured at the time of buying the policy will be considered. The FD has to be in the name of the Insured Proposer. The Interest earned on the fixed deposit will not be considered at the time of payment of benefit.
c. Based on Balance of the Savings Account: The Average quarterly balance maintained as confirmed by the bank or the balance on the day of issuance of policy (for new accounts), in the said Savings Account in the name of the Insured will be considered. The Savings Account has to be in the name of the Insured Proposer.
d. Based on Credit Card Limit: The set Credit Card limit on the said card (as declared by the insured) in the name of the Insured, on the day of buying the policy will be considered. Change in the limits of the Card post policy issuance will not be considered.

e. Based on Loan Amount: The principal outstanding amount on the said loan (the loan basis which the policy was issued) on the day of the event giving rise to the claim. We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The loan has to be in the name of the Insured Proposer.

f. Based on EMIs on Loan Amount: The EMI amount for up to 24 months will be considered as pay out. The Actual EMI amount on the said Loan (the loan basis which the policy was issued) will be considered at the time of payment of the benefit. . We will not consider any top ups and/or upgrades post policy issuance as part of the said loan. The EMI has to be in the name of the Insured Proposer.

g. Based on payment of Utility Bills: The amount paid towards utility bills- up to past 180 days, or/and up to last 24 bills paid- will be considered as the base amount for payout. Utility bills will include all or any of the following bills: telephone bills, mobile recharge and top ups, electricity bill, gas bill, water bill, broadband/internet bill or any other category of bill as defined by us at the time of Policy issuance. The utility bills paid should be in the name of the Insured Proposer.

h. The maximum payout will be as per the Maximum Sum Insured mentioned in the Product Benefit Table (Annexure 7). This maximum cap will be applicable even when the amount is liked to any category as mentioned in points 'a' to 'g' above.

8.7. Claims Process and Requirements:

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. Claims Procedure:

a. Written notice of any occurrence which may give rise to a claim under this Policy must be given to Us as soon as practicable. Written notice of claim must be given to Us immediately in the case of death.

b. All certificates, information and evidence required by Us shall be furnished at no expense to Us and shall be in such form and of such nature as We may prescribe. When required by Us, at its own expense, You/Insured Person shall submit to medical examination in respect of any alleged claim that may give rise to a Benefit being paid.

c. 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.

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. 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.

a. **Accidental Death**

i. Duly filled and signed claim form and Age / identity proof documents

ii. Copy of Death Certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)

iii. Copy of First Information Report (FIR) /Panchnama, if applicable

iv. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.
v. Copy of Hospital record, if applicable
vi. Copy of post mortem report wherever applicable

b. **Accident Permanent Total Disability and Accident Permanent Partial Disability**
i. Duly filled and signed claim form and Age / identity proof documents
ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
iii. Final Hospital bill (in original) / self-attested copies if the originals are submitted with another insurer.
iv. Medical consultations and investigations done from outside the Hospital.
v. Certificate of Disability issued by a Medical Board duly constituted by the Central and/or the State Government.
vi. Copy of First Information Report (FIR) / Panchnama if applicable
vii. Copy of Medico Legal Certificate duly attested by the concerned Hospital, if applicable.

c. **Accidental Temporary Total Disability**
i. Duly filled and signed claim form
ii. Hospital discharge summary (in original) / self-attested copies if the originals are submitted with another insurer.
iii. Copy of First Information Report (FIR) /Panchnama / Inquest report duly attested by the concerned police station
iv. Copy of Medico Legal Certificate duly attested by the concerned hospital.
v. Attendance record of employer / Certificate of employer confirming period of absence
vi. Latest salary certificate with grade and designation
vii. Newspaper cuttings / news articles covering the Accident(if available)

d. **Accidental Medical Reimbursement**
1. In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability Benefits
2. Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them.
3. Original bills with supporting prescriptions and reports for investigations done outside the Hospital/ copies attested by other insurer if the originals are submitted with them.
4. Original bills with supporting prescriptions for medicines purchased from outside the Hospital / copies attested by other insurer if the originals are submitted with them.

C. Claims Assessment & Repudiation:

All admissible claims under this Section shall be assessed by Us in the following progressive order:-
The claim amount assessed as mentioned above would be deducted from the amount mentioned against each Benefit and Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

9. Wellness Benefit

The Insured Person may avail wellness services as mentioned in the Policy Schedule/Certificate of Insurance.
The services include:
a. Access to Fitness Centers
b. Access to Digital Fitness Coaching
c. Access to AI Fitness Coaching
d. Access to Nutritionist/Wellness Coach
e. Diagnostics/Pharmacy/Home Health Care Services

The access to above mentioned services 9a/9b/9c/9d would be available for:

i. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with no limits on the visit/consultation
ii. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with 1 visit/consultation per week
iii. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with 1 visit/consultation per month
iv. Any of the combination above

The services availed would be subject to the conditions below:

a. The services will be provided through an empanelled Service Provider. It is entirely for the Insured Person to decide whether to obtain these services.
b. We shall not be responsible for any disputes arising between the Insured Person and the Service Provider.
c. The services provided under this benefit, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

D. General Exclusions (applicable to all Sections under the Policy unless specified otherwise):

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy or in Policy Schedule/Certificate of Insurance.

i. 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).
ii. 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.
iii. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military, para-military or air force operation during peace time.
iv. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12
v. Inhaling any gas or fumes, accidentally or otherwise, except in the course of duty.
vi. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.
vii. 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.
viii. 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.

ix. 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.

x. Any exclusion mentioned in the Policy Schedule/Certificate of Insurance or the breach of any specific condition mentioned in the Policy Schedule/Certificate of Insurance.

xi. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule or Certificate of Insurance.

D.1 Waiting Periods and Exclusions Specific to Benefit 1/Benefit 2/Benefit 3/ Benefit 4/ Benefit 5/ Benefit 6/ Benefit 7

All the Waiting Periods as specified in Policy Schedule/ Certificate of Insurance shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied for, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following, except if any Insured Person suffers an Accident;

A. Waiting Periods

(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 the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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).

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, arthroscopic surgeries for ligament repair

VIII. Chronic kidney disease and failure

IX. Varicose veins of lower extremities

X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump

XI. Ulcer, erosion and varices of gastro intestinal tract

XII. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

XIII. Internal Congenital Anomaly

XIV. Surgery of Genito-urinary system unless necessitated by malignancy

XV. Spinal disorders

(iii) **30-day waiting period (Code- Excl03):**

a. Expenses related to the treatment of any Illness up to 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.

B. Permanent Exclusions:

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

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

I. **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.

II. **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.

III. **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:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

IV. **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.

V. **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.

VI. **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.

VII. **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.

VIII. **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.

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

X. 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)**

XI. 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)**

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

XIII. **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.

XIV. **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

XV. **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.

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

XVII. **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.

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

XIX. **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.

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

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

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

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

XXIV. Any expenses incurred on OPD treatment

D.2 Exclusions Specific to Accidental Cover (Benefit 8):

We shall not be liable to make any payment under this Benefit directly or indirectly for, caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy or in Policy Schedule/Certificate of Insurance.

I. Death or any disablement resulting from, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy.

II. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.

III. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Policy Schedule/Certificate of Insurance.

IV. Body or mental infirmity or any disease except where such condition arises directly due to an Accident occurring during the Policy Period.

V. Death or disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

E. General Terms and Clauses:

E.1. Standard General Terms and Clauses

1. Disclosure to 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)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. 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 maybe be, for any benefits 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.

4. 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.

5. 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.

6. 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.

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

7. 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.

i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Automatic Cancellation:

i. **Individual Cover**:
The Certificate of Insurance coverage shall automatically terminate in the event of death of the Insured Person.

ii. **For Family Floater Cover**
The cover under the Policy coverage shall automatically terminate in the event of the death of all the Insured Persons under the Family Floater Cover.

9. Renewal of Policy

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

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

a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.
c. Coverage is available during the grace period.
d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.
e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

10. 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.

11. 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 pa(y 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.

12. Claim Settlement (Provision for Penal Interest)

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

II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim intimation until 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)

13. 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.

14. Withdrawal of Policy

I. 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.

II. Insured Person will have the option to either renew (up to 90 days from renewal date) same product or to migrate to 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.

15. Redressal of Grievance:

a. In case of any grievance the insured person may contact the company through:

Website: www.nivabupa.com

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

Fax No.: +91 11 41743397

Customer Helpline No: 1860-500-8888

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

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

b. 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

Head – Customer Services

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

Customer Helpline No: 1860-500-8888

Fax No.: +91 11 41743397

Email ID: 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

c. If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.com.
d.
e. 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 III).
f.
g. Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in

16. 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.

17. 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.

E.2. Specific General Terms and Clauses

18. Cancellation in case of Credit Linked Cases:

In cases the Policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure subject to maximum tenure of 5 years, closure of the loan or Policy Period/ Coverage Period Term whichever is

earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy.

19. 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 provided that all such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.

ii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:

A. You/Insured Person proposed to add an Insured Person to the Policy

B. You/Insured Person change any coverage provision

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.

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 between the date the Policy expires and the date immediately before the reinstatement date of Your/Insured Person's 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/Insured Person 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. 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 and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy for that newly added individual with Us.

e. Changes to Sum Insured on Renewal:

You/Insured Person may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. 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 as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

20. Assignment

The Benefits under this Policy are assignable subject to applicable Law.

21. Territorial Jurisdiction

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

22. Role of Group Administrator

The role of Group Policyholder as an administrator will only be to facilitate the insurance cover to its members. Any subsequent Policy servicing or claims related assistance shall directly be done by Us.

23. 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.

24. Notices

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

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

b. Us at the following address:

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301 Fax No.: +91 11 41743397

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

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

25. Alteration to the Policy

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

26. Notification of Claim and Delay in Intimation:

The notification of all claims should be sent to Us via one of the following:

By calling Us at 1860-500-8888

By registered post sent to:
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 Fax No.: +91 11 41743397

By writing an email to customercare@nivabupa.com.

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.

If You/Insured Person holds multiple sections (Indemnity & Benefit) under this Policy with Us, a single notification for claim will apply to all the sections of the Policy.

27. Obligations in case of a minor

If an Insured Person is less than 18 years of Age, You/ Insured Person or another adult Insured Person or legal guardian (in case of the Insured Person's 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.

28. Records to be maintained:

As a Condition Precedent, You/Insured Person shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You/Insured Person shall furnish such information as We may require under this Policy at any time during the Policy Period/ Coverage Period.

29. 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.

ANNEXURE 1

LIST OF INSURANCE OMBUDSMEN

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh 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@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava 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@ecoi.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma 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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).

Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	
DELHI - Shri Sudhir Krishna 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@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra 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@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.

Email: bimalokpal.kolkata@ecoi.co.in	
LUCKNOW -Shri Justice Anil Kumar Srivastava 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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat 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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.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 - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah 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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email:inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

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

ANNEXURE 2
LIST OF SPECIALISTS

This is an indicative List.

S.No	List
1	Dietician
2	Gynaecologist
3	Psychologist
4	Psychiatrist
5	Paediatrician
6	Health Coach
7	ENT
8	Ophthalmologist

ANNEXURE 3

LIST OF DIAGNOSTIC TESTS

This is an indicative list of diagnostic tests.

S.No	Tests
1	CBC- (Hemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholesterol
6	Lipid Profile
7	Serum Creatinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray (Chest)
15	Ultra sound (USG Abdomen, Pelvis)
16	PAP Smear (For Female)
17	PSA-Male
18	ECG
19	Serum Electrolytes
20	Uric Acid
21	Calcium
22	Vitamin B-12
23	Total Vitamin D (25 hydroxyvitamin D)
24	Bone Densitometry Test (Dexa Scan)
25	2D ECHO
26	Treadmill Test (TMT)
27	Mammography & Female hormones (for Female)
28	Erythrocyte Sedimentation Rate (ESR)
29	Dental Consultation
30	Physician Consultation
31	Blood Group & RH Factor

ANNEXURE 4

LIST OF HOME HEALTH CARE SERVICES

This is an indicative list of services.

S.No	Service
1	Doctor at home
2	Nurse at home
3	Physiotherapist at home
4	Attendant at home
5	Diagnostic Tests at Home
6	ICU at home
7	Chemotherapy
8	Blood Transfusion
9	Dialysis at home

ANNEXURE 5

LIST OF VACCINATIONS

This is an indicative list of services.

S.No	List
1	Influenza
2	Pneumonia
3	Cervical Cancer
4	Hepatitis B
5	Typhoid
6	BCG/Tuberculosis
7	DPT
8	Diphtheria, Tetanus, Pertussis, Hepatitis B, Haemophilus influenza type b
9	Tetanus
10	Rota
11	Rotavirus - Rotasure Oral Vaccine
12	MMR
13	Hepatitis A

ANNEXURE 6

LIST OF TESTS UNDER ANNUAL HEALTH CHECK-UP

This is an indicative list.

S.No	Tests
1	CBC- (Hemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholesterol
6	Lipid Profile
7	Serum Creatinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray (Chest)
15	Ultra sound (USG Abdomen, Pelvis)
16	PAP Smear (For Female)
17	PSA-Male
18	ECG
19	Serum Electrolytes
20	Uric Acid
21	Calcium
22	Vitamin B-12
23	Total Vitamin D (25 hydroxyvitamin D)
24	Bone Densitometry Test (Dexa Scan)
25	2D ECHO
26	Treadmill Test (TMT)
27	Mammography & Female hormones (for Female)
28	Erythrocyte Sedimentation Rate (ESR)
29	Dental Consultation
30	Physician Consultation
31	Blood Group & RH Factor

ANNEXURE 7

PRODUCT BENEFIT TABLE

Policy Tenure	Non- loan linked - 1 year; Loan linked- Upto 5 years		
Entry Age	Adult- 18yrs to 65 Yrs Child- 0 day to 30 Yrs		
Plans	Individual Or Floater Or Combination of the two which includes following relationships- Self, Legally married spouse , up to 4 children (Son/Daughter), Daughter-in-law, Father, Mother, Father-in-law , Mother-in-law , Grandfather,Grandmother,Grandson,Granddaughter,Son-in-law, Brother, Sister, Sister-in-law, Brother-in-law, Nephew, Niece and any other relationship having insurable interest		
Waiting Periods	**Initial Waiting Period**	Range between 0 to 90 days	
	PED	Range between 0 to 48 months	
	Specific Illness	Range between 0 to 24 months	
S.No	**Main Benefit**	**Details**	**Options within the benefit**
1	**Video Consultation (GP)**	>>Video consultations with doctors >> Digital, on-call & in-center booking and service	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 per policy Option 3: Lump sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Any combination of the above Available on Only Network or combination of network and non-network both.
2	**Tele Consultations (GP)**	>>Tele consultations with doctors. >> Digital, on-call & in-center booking and service	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Lump Sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Any Combination of the above

			Available on Only Network or combination of network and non-network both.
3	**Physical Consultations (GP)**	>> Physical face to face consultations with doctors. >> Can be booked digitally, on-call or at the center	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Lump Sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Co-payment up to 50% Option 6: Any Combination of the above Available on Only Network or combination of network and non-network both.
4	**Physical Consultations (Specialist)**	>> Physical face to face consultations with doctors. >> Can be booked digitally, on-call or at the center	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Lump Sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Co-payment up to 50% Option 6: Any Combination of the above Available on Only Network or combination of network and non-network both.
5	**Video Consultations with Specialists (List of Specialists- Annexure 2)**	>>Video consultations with doctors. >> Digital booking, on-call booking or in-center booking	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Lump Sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Any Combination of the above

			Available on Only Network or combination of network and non-network both.
6	**Tele Consultations with Specialists (List of Specialists- Annexure 2)**	>>Tele consultations with doctors. >> Digital booking, on-call booking or in-center booking	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Lump Sum of up to Rs. 1L in multiple of Rs. 500 Option 4: Up to Rs. 5000 per Visit in multiple of Rs. 50 Option 5: Any Combination of the above Available on Only Network or combination of network and non-network both.
7	**Diagnostic Tests and Investigations**	>>Prescription based, Non Prescription based or a combination of both. >> Digital booking, on-call booking or in-center booking >> Conducted at-home or at facility	Option 1: Services through Company's empanelled Provider (Cost to be borne by the Customers) Option 2: Up to 10 tests per Insured basis indicative list Option 3: Basis select combination of tests Option 4: Up to Rs. 1L in multiple of Rs. 250 Option 5: Unlimited Diagnostic tests and Investigations Option 6: Any Combination of the above
8	**Pharmacy**	>>Prescription based, Non Prescription based or a combination of both. >> Online booking, booking on-call & delivery	**Prescription Based, Non Prescription Based or Both** Option 1: Services through Company's empanelled Provider (Cost to be borne by the customers) Option 2: Up to Rs. 1L in multiple of Rs. 250
9	**Home Health Care Service (Indicative List- Annexure 4)**	Service offers nurse, physiotherapist, doctors & attendants at home	Option 1: Services through Company's empanelled Provider (Cost to be borne by the customers) Option 2: Basis select combination of Services Option 3: Up to Rs. 1L in multiple of Rs. 500 Option 4: Services up to Rs. 10,000 per service Option 5: Fixed number of services ranging between 1 to 50 Option 6: Any Combination of Above

10	**Vaccinations (Annexure 5)**	Appointment for at home and at facility vaccinations	Option 1: Services through Company's empanelled Provider (Cost to be borne by the customers) Option 2: Up to 10 vaccinations per Insured basis indicative list (Annexure 5) Option 3: Basis select combination of Vaccines Option 4: Up to Rs. 1L in multiple of Rs. 500 Option 5: Any Combination of the Above
11	**Annual Health Check-up**	Health Check-up facility Option 1: Per Insured Adult Option 2: Per Insured Adult+ One non Insured related Adult	Option 1: Up to 10 tests per Insured basis indicative list (Annexure 6) Option 2: Basis select combination of tests Option 3: Up to Rs. 1L in multiple of Rs. 250 Option 4: Any Combination of the above
12	**Hospital Daily Cash**	>> Maximum coverage up to 90 days >> 'ICU Cash Benefit' can be opted when Hospital Daily Cash is opted >> Total Maximum Coverage of 90 days (including Hospitalization Daily Cash)	Option 1: up to Rs. 10,000 per day Option 2: up to Rs. 10,000 per day with Franchise of 1/2/3/4/5/6/7 days Option 3: up to Rs. 10,000 per day with deductible of 1/2/3/4/5/6/7 days Option 4: Any Combination of the Above Option 5: For ICU Daily Cash will be double the Hospital Daily Cash Benefit
13	**Personal Accident**	**Benefits under Personal Accident** 1. Accidental Death 2. Permanent Total Disability 3. Partial Total Disability 4. Temporary Total Disability 5. Accidental Medical Reimbursement (Can offer this alone or with AD)	Option 1: Lump sum benefit up to Rs. 1 0Cr. Option 2: Benefit Up to 100X of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, wallet , Utility bills of the consumer, loan. Option 3: Benefit Up to 150% of the amount linked to the salary (monthly, quarterly or annually), income, bank account, credit card limit, credit card bill, wallet, Utility bills of the consumer, loan Option 4: Any combination of the above options.

14	**Wellness Benefit**	**Benefits under Wellness Benefit** 1. Access to Fitness Center/ Digital Fitness Coaching/ AI Fitness Coaching. 2. Access to Nutritionist/Wellness Coach	Option 1. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with no limits on the visit/consultation Option 2. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with 1 visit/consultation per week Option 3. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with 1 visit/consultation per month Option 4. Any of the combination above