ReAssure 3.0
Policy Wordings

1. **Preamble**

   This Policy covers Allopathic and AYUSH treatments taken in **India ONLY.**

2. **Definitions**

   It is IMPORTANT You should go through the definition of some words used in the policy. Definition of these may vary from the common understanding and colloquial meaning. If a word is not specifically defined in the following section, it's common meaning will apply.

   2.1. **Standard Definitions:**

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

   2.1.2. **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 five 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.

   AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

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

   2.1.4. 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

   2.1.5. **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.

2.1.6. **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.

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

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

2.1.9. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:

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.

2.1.10. **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.

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

2.1.12. 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.

2.1.13. **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.

2.1.14. **Emergency care** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

2.1.15. **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.

2.1.16. **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 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.

2.1.17. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

2.1.18. **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:

    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

    b. it needs ongoing or long-term control or relief of symptoms

    c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

    d. it continues indefinitely

    e. it recurs or is likely to recur

2.1.19. **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.

2.1.20. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.21. **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 considerable more sophisticated and intensive than in the ordinary and other wards.

2.1.22. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

2.1.23. **Maternity Expenses shall include:**

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 Policy Period.

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

2.1.25. **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.

2.1.26. **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.

2.1.27. **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.

2.1.28. **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.

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

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

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

2.1.32. **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.

2.1.33. **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.

2.1.34. **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.

2.1.35. **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.

2.1.36. **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.

2.1.37. **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.

2.1.38. **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.

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

2.1.40. **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.

2.1.41. **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

2.1.42. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

2.2. **Specific Definitions**

2.2.1. **Base Sum Insured** means the coverage amount for which the premium is computed and charged for this policy.

2.2.2. **Insured Person** is the one for whom the company has received full premium (including additional premium if any), completed the risk assessment and issued the policy. The names of the Insured persons covered in the policy are specified in the policy document, who are also referred as You/ Your/Policyholder in this policy.

2.2.3. **Partner Network** means Hospital, Diagnostic Centers, Clinics, Doctors, Health Care Workers, empanelled by the Insurer and/or by a consolidated organization to provide health related medical services.

2.2.4. **Policy Year** means the period of one year from the date of commencement of the policy.

2.2.5. **Brain Death means** the permanent, irreversible cessation of all brain function, including the brainstem, leading to the death of the person.

3. **Sum Insured(s)**

The product offers you so much more! More benefits, More options and More Sum Insured. Sum Insured will be utilized as per following sequence in event of any claim:

1. Base Sum Insured
2. Booster+ Sum Insured
3. ReAssure+

4. **Benefits available under the policy.**

Different benefits have different limits or Sum Insured. A limit or Sum Insured is our maximum liability (basically this is the maximum claim we will pay) under the benefit. These limits & Sum Insured will be mentioned in your Policy Schedule.

4.1. **Expenses in reaching a Hospital**

4.1.1. Road Ambulance: We will pay you up to the mentioned limit in your policy.

4.1.2. Air Ambulance: Only in case of Emergency per hospitalization.

Note: This will be paid only if claim for Expenses during hospitalization is paid by us. You must always use a registered ambulance / air ambulance provider.

4.2. **Expenses during Hospitalization**

4.2.1. We will pay the expenses incurred by you on treatment (Naturally this excludes expenses not linked to treatment like food, beverage, toiletries and cosmetics). Basis the plan you choose; the hospital room (like single private room, general ward, twin sharing) you are eligible for will get fixed. Choose the option that matches your lifestyle, pocket and comfort needs.

- Admitted for 2 hours or more (minimum 24 hours for AYUSH treatment in a AYUSH Hospital)

Note:

- Cataract: Classic & Select Variant covers only Mono-focal Lens.
- We will NOT pay, even if you were hospitalized, if there was no treatment and only investigations were done. Examples: MRI, CT Scan, Endoscopy, Colonoscopy etc.
- We will NOT pay for Automation machine for peritoneal dialysis
- If you choose a room outside your plan's category, the Copayment (as per Annexure V) will apply on the entire claim.

4.2.2. **We** pay for the below specified **Modern treatments,** up to what your plan covers,

1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	2. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	3. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	4. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5. Balloon Sinuplasty	6. Oral Chemotherapy	7. Robotic surgeries	8. Stereotactic radio Surgeries
9. Deep Brain stimulation	10. Intra vitreal injections	11. Bronchical Thermoplasty	12. IONM - (Intra Operative Neuro Monitoring)

4.3. **Expenses** before and after hospitalization **(Pre & Post hospitalization)**

We will pay expenses incurred on consultations, medicines, physiotherapy, diagnostic tests for 60 days before the date of admission and 180 days after date of discharge **IF these are related** to the condition for which hospitalization claim is paid.

4.4. **Home Care / Domiciliary Treatment**

Home Care Treatment means treatment availed by the insured person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

4.4.1. The medical practitioner advices the insured person to undergo treatment at home

4.4.2. There is continuous active line of treatment with monitoring of health status by a medical practitioner for each day through the duration of the home care treatment

4.4.3. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

Note:

- We will pay for Pre & Post hospitalization benefit as per section 4.3 for Home Care / Domiciliary Treatment.
- **We pay for peritoneal dialysis, Chemotherapy taken at home.**
- **We do NOT pay for any Medical & ambulatory devices used at home** (like Pulse Oxymeter, BP monitors, Sugar monitors, automation device for peritoneal dialysis, CPAP, BiPAP, Crutches, wheel chair etc.)

4.5. **Organ donor**

If you ever undergo an organ transplant, we will pay the hospitalization expenses of the donor for harvesting the organ, **ONLY** when your Hospitalization claim is paid.

If you donate any of your organs, we will pay for the expenses for harvesting the organ from you. We respect this noble deed. Remember, **organ donation saves many lives.**

4.6. **ReAssure Forever**

The first paid claim in the life of the policy triggers ReAssure “Forever”. Once Triggered it stays for life, provided that the policy is renewed without break.

Note:

- **Maximum amount ReAssure Forever pays for any single claim is up to Base Sum Insured.**
- We will consider a claim, if it is paid under the following: **Expenses in reaching a Hospital, Expenses during Hospitalization**, Expenses before and after hospitalization, **Home Care / Domiciliary Treatment, Organ Donor.**
- Expenses in reaching a Hospital and Expenses before and after hospitalization for the 1st ever hospitalization will be treated as the 1st claim itself.
- Applies only for policies where "Unlimited Sum Insured" option is not opted.

Year 1: Once the Policy is bought.

Base Sum Insured	1st paid Claim	ReAssure+ is triggered (Equal to Base Sum Insured)	Balance Base Sum Insured	2nd payable claim	Claim amount paid	Balance Base Sum Insured	3rd Payable claim	Claim amount paid
10 Lakh	7 Lakh		3 Lakh	12 Lakh	12 Lakh (3 Lakh from Base Sum Insured and 9 Lakh from **ReAssure+ Forever**	Nil	11 Lakh	10 Lakh from **ReAssure+ Forever**

Year 2: Once the policy is renewed:

Base Sum Insured	ReAssure+ is already triggered	1st Claim Paid	Balance Base Sum Insured	2nd payable claim	Claim amount paid	Balance Base Sum Insured	3rd Payable claim	Claim amount paid
10 Lakh	10 Lakh	15 Lakh	Nil	12 Lakh	10 Lakh	Nil	10 Lakh	10 Lakh from **ReAssure+ Forever** (this 10 Lakh will trigger unlimited times)
		10 Lakhs from Base Sum Insured and 5 Lakhs from **ReAssure+ Forever**			**ReAssure+ Forever**		**ReAssure+ Forever**	

4.7. **Lock the Clock:** Your age is locked at entry when you buy the policy, till a claim is paid.

E.g. if you buy the policy at 25 years, you will keep paying the premium applicable for a 25 year old at each renewal, till a claim is paid in the policy. Post the claim is paid, the premium charged will be as per your current age and will continue to change as per the age slabs at each renewal.

Note:

- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age. If a claim is taken in the middle, the age will unlock for the remainder of the tenure and additional premium will be charged. This additional premium will be adjusted from the claim payout. If no claim is taken, then at renewal the premiums will be charged as per the entry age and & pre-existing waiting periods completed. Additional premium will be charged for the remaining one year tenures left. For example, for a 3 year policy, if a claim is incurred in first year, additional premium will only be charged for year 2 and year 3.
- If you add a member to the floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If you add a member to an individual plan and convert it into a Floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member in the policy amongst the remaining members and lock at that age, till a claim is paid.
- If a floater plan, splits into multiple policies, then we will carry forward the locked age at which the floater policies were taken by individuals (as per the claim history) in the policies carried forward, till a claim is paid.
- In a multi individual policy, the age will unlock only for the individuals who claim.
- In a floater policy, if a claim is paid for anyone in the plan then we will unlock the age for the entire policy.
- We will consider a claim, if a claim is paid under the following: **Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Home Care / Domiciliary Treatment, Organ Donor, Borderless, Borderless for Specified Illness.**

4.8. **Booster+**

Don't lose what you don't use.

Unutilized Base Sum Insured carries forward. Maximum it will accumulate up 10 times (based on the plan you have chosen) of the Base Sum Insured.

Example: If you have chosen Base Sum Insured of INR 10 lakh and Elite Variant, then at the end of 10 years (if you have made no claims in these years) you will have

1.10 Crore Sum Insured (that is 10 Lakh base + 1 Crore Booster+). Don't forget that you would have the ReAssure "Forever" (in case of claim) over and above the 1.10 Crore.

That's 11 times of Sum Insured than what you paid for.

Note:

- If you convert an Individual Sum Insured policy in any manner, into a floater plan, then the least of the Booster+ Sum Insured of individual insured members will be carried forward to the floater plan.
- If a floater plan, splits into multiple policies, then the Booster+ Sum Insured of floater plan will be carried forward to the split policies, provided the Base Sum Insured is not reduced.
- If you reduce the Base Sum Insured, Booster+ Sum Insured will be proportionately reduced. Let's say if you reduce the current INR 10 lakh Sum Insured to INR 5 lakh, your Booster+ Sum Insured will be halved.

- You can and should regularly increase Sum Insured of your Health insurance policy. Medical inflation is a reality and current Sum Insured will fall short in future for advanced treatments. When you enhance your Sum Insured, the accumulated Booster+ Sum Insured will continue and grow even more (remember Booster+ is up to maximum 10 times of the Base Sum Insured. Higher the Base Sum insured higher the Booster+ Sum Insured).

4.9. **Live Healthy**

Simply walk and earn up to 30% discount at renewal, by downloading the recommended mobile App and get your **Health points.** 1000 steps will help you earn one health point!

Note: Discount is on the individual's premium in Individual plan and on Floater Policy Premium in Floater plans. Discount will be considered only for Insured's 18 years and above.

Renewal discount is computed based on the health score on 90 days before the due date of renewal. These points are not lost and will be considered for the next policy year.

Policy Period: 1 year

Policy Start Date	End of 9 months	Points at the end of 9 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2025) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2023	Up to 1500			0%	0%
		1501 –2250			5%	2.5%
		2251 – 3000			15%	7.5%
		3001 – 3750			20%	10%
		>=3751			30%	15%

Policy Period: 2 years

Policy Start Date	End of 21 months	Points at the end of 21 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2026) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2024	Up to 3000			0%	0%
		3001 – 4500			5%	2.5%
		4501 – 6000			15%	7.5%
		6001 – 7500			20%	10%
		>=7501			30%	15%

Policy Period: 3 years

Policy Start Date	End of 33 months	Points at the end of 33 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2027) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2025	Up to 4500			0%	0%
		4501 – 6750			5%	2.5%
		6751 – 9000			15%	7.5%
		9001 – 11250			20%	10%
		>=11251			30%	15%

Policy Period: 4 years

Policy Start Date	End of 45 months	Points at the end of 45 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2028) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2026	Up to 6000			0%	0%
		6001 – 9000			5%	2.5%
		9001 – 12000			15%	7.5%
		12001 – 15000			20%	10%
		>=15000			30%	15%

Policy Period: 5 years

Policy Start Date	End of 57 months	Points at the end of 57 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2029) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2027	Up to 7000			0%	0%
		7501 – 11250			5%	2.5%
		11251 – 15000			15%	7.5%
		15001 – 18750			20%	10%
		>=18751			30%	15%

4.10. **Surprise Benefit**

Buy the plan, download the app. and unlock a HEALTH SURPISE! Use this for a variety of health related services and benefits like specialist consultations, ambulance booking, condition management programs, health risk assessments, diagnostics, pharmacies available right on the app

Note: Download Niva Bupa App or Approved partner apps by Niva Bupa

4.11. **Second Medical Opinion**

You can take a second medical opinion from our panel of specialists & super specialists for any condition diagnosed and / or treatment prescribed. We will facilitate this through our empaneled partner and we will pay for it. You can take second medical opinion for unlimited number of conditions / prescribed treatments in a policy year.

4.12. **e-Consultation**

You can take Unlimited e-consultations from our Partners.

Optional Benefit:

4.13. **Hospital Daily Cash**

We will pay for an Insured, an additional fixed amount for each day's hospitalization for maximum up to 30 days. One day is considered as 24 continuous hours of continuous hospitalization. We will pay this if we have paid for Expenses during hospitalization in the policy.

4.14. **Personal Accident**

4.14.1. **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.

4.14.2. **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.

4.14.3. **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.

4.15. **Personal Accident (Lite)**

4.15.1. **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 (Lite) benefit will terminate after the Accidental Death benefit is paid for.

4.16.Personal Accident (Pro)

4.16.1. **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 (Pro) benefit will terminate after the Accidental Death benefit is paid for.

4.16.2. **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%

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.

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

4.16.3. **Permanent Partial Disability**

d. 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%

e. 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.

f. 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.

4.16.4. **Accidental OPD**

If the Insured Person sustains an Accidental Injury then we will cover expenses incurred on Outpatient (OPD) treatment of the Insured.

Outpatient Expenses includes ONLY:

- Procedures that require less than 24 hours of hospitalization. This excludes day care treatment.
- Diagnostic Tests for Accident related injury or procedure
- Vaccinations/Vaccinations for Animal Bites
- Plaster cast and/or crutches

4.17. **Claim Safeguard+**

We will cover non-payable items mentioned in **'List I, II, III, IV of Annexure I.** Clause 2.1.37 for Reasonable and Customary Charges will still apply.

4.18. **Annual Aggregate Deductible**

This is an aggregate amount in a year that is incurred by you on Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Home Care / Domiciliary Treatment, Organ Donor, which we will **NOT** pay. Once the total expense exceeds this amount, balance we will pay.

Note:

- Deductible amount borne by you should also be payable as per policy terms and conditions.
- Deductible will NOT apply to Annual Health Check-up, Live Healthy, Second Medical Opinion, Shared Accommodation Cash, e-consultation, Personal Accident, Hospital Daily Cash benefits.
- **Co-Payment & Annual Aggregate Deductible cannot be opted together.**

4.19. **Co-Payment:**

It is the percentage of admissible claim amount You would have to bear for every claim, Rest we will pay.

Note: Co-payment will NOT apply to Annual Health Check-up, Live Healthy, Second Medical Opinion, Shared Accommodation Cash, e-consultation, Personal Accident, Hospital Daily Cash benefits

Co-Payment & Annual Aggregate Deductible cannot be opted together

4.20. **Pre-Existing Disease Waiting Time Modification**

You can choose to reduce or increase the Pre-Existing Disease waiting time.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

4.21. **Specific Disease Waiting Time Modification**

You can choose to reduce or increase the Specific Disease waiting time.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

4.22. **Annual Health Checkup (Cashless Only)**

Available once every Policy Year, from day 1 of the policy. The tests MUST be booked through our digital assets (e.g. Mobile App). This benefit is available ONLY on cashless and no re-imbursement is allowed.

Note:

- If you undergo multiple tests, make sure that all these are done within 7 days.
- All Packages as per variant are mentioned in Annexure III
- Annual Health Checkup (Cashless Only), Annual Health Checkup (Cashless + Reimbursement), and NivaBupaOne cannot be opted together.

4.23. **Annual Health Checkup (Cashless + Reimbursement)**

Available once every Policy Year, from day 1 of the policy. The tests MUST be booked through our digital assets (e.g. Mobile App). This benefit is available on cashless and re-imbursement basis.

Note:

- If you undergo multiple tests, make sure that all these are done within 7 days.
- All Packages as per variant are mentioned in Annexure III
- Annual Health Checkup (Cashless Only), Annual Health Checkup (Cashless + Reimbursement), and NivaBupaOne cannot be opted together.

4.24. **Cash-Bag+:**

For each claim free year get an amount equal to 10% of the premium to be paid on 1st Renewal and 5% thereafter on each renewal from 2nd renewal onwards.

Get an additional 10% on the Accumulated Cash-Bag+ amount in a block of every 3 years.

Now, refer your friends and family, and with every conversion into Niva Bupa Policy, earn 10% (only on one time purchase) of the premium your friend has paid, as Cash-bag+!

All this Accumulated amount can be used for OPD, pay for deductibles, pay for co-payment, Non-payable items and pay premiums. This optional benefit can be accessed through our Mobile App.

Note:

- Deductibles, Co-Payments can only be paid for claims under ReAssure 3.0 Product.
- Only ReAssure 3.0 Product premium can be paid for using this Cash-Bag+
- Claims under Cash-Bag+ will not impact Booster+, Lock the Clock

4.25. **NivaBupaOne**

Your access to NivaBupaOne- Our Premium Club. The membership enables you to get access to an executive health check-up (Annexure III) and get fast-track priority for claims and policy services- because your time matters.

Annual Health Checkup (Cashless Only), Annual Health Checkup (Cashless + Reimbursement), and NivaBupa One cannot be opted together.

4.26. **HeadsUp**

You Call We Guide.

Reach us 48 hours before for any hospitalization and get treated for the informed illness/surgery at our recommended network provider (For emergency: inform us within 24 hrs of admission).

A 20% Co-payment will apply if either the treatment is taken for some other illness/surgery as informed earlier, or/and treatment is taken outside the recommended network provider, and/or if not informed within 24hr of admission.

Note: This will ONLY apply to Expenses in reaching a hospital, Expenses During Hospitalization, Expenses Before & After Hospitalization, Home Care/Domiciliary & Organ Donor.

You can either opt for Tiered network or HeadsUp Benefit in the plan.

4.27. **Tiered Network**

If you choose this optional benefit, then a specific list of hospitals (within our network) are only applicable for you in this policy. If any treatment is taken outside this network, then a flat 20% co-payment will be applicable to the admissible claim amount. This co-payment you would have to bear for every claim which is out of this network. Rest we will pay.

Note: This will ONLY apply to Expenses in reaching a hospital, Expenses During Hospitalization, Expenses Before & After Hospitalization, Home Care/Domiciliary & Organ Donor.

You can find the updated list of tiered network applicable to you on our website and on our Mobile App: https://rules.nivabupa.com/hospital-network/?list_id=RA301202

You can either opt for Tiered network or HeadsUp Benefit in the plan.

4.28. **Borderless**

Get emergency or planned treatments anywhere in the world. Choose from a range of co-payments options 0%, 20%, 30%, 40% & 50%

Note:

- The consumer can be diagnosed anywhere in the world and can go for treatments anywhere in the world.
- This benefit is available under cashless and reimbursement.
- The following benefits will be considered for Borderless also: Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Organ Donor.
- Lock the clock Benefit will be impacted, if a claim is paid under this benefit.
- This optional benefit is not available to Non-Indian citizens & people who are not permanent residents of India.
- We will cover up to standard private room only.
- Borderless and Borderless for Specific Illness cannot be opted together.

4.29. **Borderless for Specific Illness**

Get planned treatments for these specific list of illnesses anywhere in the world.

S. No.	Specified Illness
1	Cancer
2	Myocardial Infarction (First Heart Attack of specific severity)
3	Open Chest CABG
4	Major Organ/Bone Marrow Transplant
5	Stroke Resulting in Permanent Symptoms
6	Surgery of Aorta
7	Angioplasty
8	Primary (Idiopathic) Pulmonary Hypertension
9	Brain Surgery

Choose from a range of co-payments options 0%, 20%, 30%, 40% & 50%

Note:

- The symptoms of the Specified Illness should first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- The Specified Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- This benefit is available under cashless and reimbursement.
- The following benefits will be considered for Borderless Specified Illness also: Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Organ Donor.
- Lock the Clock Benefit will be impacted, if a claim is paid under this benefit.
- Borderless and Borderless for Specific Illness cannot be opted together.

- We will cover up to standard private room only.
- This optional benefit is not available to Non-Indian citizens & people who are not permanent residents of India.

4.30. **Wellconsult+**

Opt for Complete wellness and Out-patient benefits.

- **Tele/Video Consultation** with General Practitioners.
- **Physical Consultations** with Specialists & General Practitioner.
- **Prescribed Diagnostics**
- **Prescribed Pharmacy**
- **Dental Procedures**.
- **Ophthalmological Consultations**
- **Prescribed Physiotherapy Consultations**
- Online sessions on **Emotional Wellness.** Can be availed only through our Partner network.
- **Diet and Nutrition Coaching.** Can be availed only through our Partner network.
- Artificial Intelligence lead Smart Fitness Coaching. Can be availed only through our Partner network.
- Access to Global online content on wellness through our Partner network
- Access to **Gym memberships** on our Partner network.

Note:

- All benefits are as per limits mentioned in your policy schedule.
- Claims under WellConsult+ will not impact Booster+, Lock the Clock
- We will not pay for specialist consultation for Maternity and OPD Procedures.
- Any cosmetic Dental (like and not limited to Dentures- Removable (complete/partial), Fixed partial dentures, Invisible Aligners (Without retainers), Removable Retainers, Fixed Retainers, Essix retainer, Space maintainers) & Ophthalmological (like and not limited to cataract, eye surgery, biometry, laser, eyesight correction surgery) procedures are not covered.
- All waiting periods and exclusions will apply to this benefit.
- Reimbursement is also allowed for Tele/Video Consultations, Physical Consultations, Prescribed Diagnostics, Prescribed Pharmacy, Dental Procedures, Ophthalmological Consultation, Prescribed Physiotherapy Consultations. Flat 20% co-payment will apply in case of Reimbursement.
- This benefit is applicable only in India.

4.31. **ElderOne**

From friendly check-ins to helping with life's little needs. Opt for benefits for Senior Citizens.

- Regular virtual check-ins
- Community engagement (Virtual) - webinars, sessions, activities.
- Dedicated elder care relationship manager: your one stop for all Elder needs.
- Regular virtual updates to family members
- Complete assessment of the Senior Citizen premise for "Fall risk assessments"

- Regular check-ins (in-person)
- Virtual mental health sessions
- Cognitive Health Screening
- On call/virtual Support in curating travel plans and booking assistance
- "Care Concierge Desk" which will help provide discounts on services like, arrange for Bedside care taker, Home Nursing services, Doctor Home Visits, Wound Dressing Services, Medical Equipment's at Home - Medical bed, oxygen, wheelchair, airbed etc.

Note:

- This benefit is applicable only through our network.
- This benefit can be opted for seniors (anyone 56 years and above) insured within the policy or parents/parents-in laws of the proposer not insured in the policy.
- Visit by Care managers will be for up to 1 hour
- **All waiting periods and exclusions will apply to this benefit.**
- **This benefit is applicable only in India.**

4.32. **Third Medical Opinion**

If you are not satisfied with the second medical opinion, should you want a third medical opinion from another specialist or super specialist in the panel, we will facilitate the same through our empaneled partner. We will pay for it. You can take the third medical opinion for as many conditions as you want in a policy year.

4.33. **Second Medical Opinion-Expres**s

Once in a Policy year, you can choose to take a second medical opinion from any Medical Practitioner. Through our partners we can help you get a second opinion from some of the most reputed doctors in the country.

Note: This benefit is applicable, only if the second medical opinion is asked for within 48 hours of hospitalization.

4.34. **Medical Equipment**

If you opt for this benefit, we will pay for medically necessary equipment needed for you to resume normal living post injury due to Accident.

Note:

- The Accident has to occur within the policy period.
- The devices must be Medically Necessary for Treatment and prescribed by a Medical Practitioner.
- **We will cover this, if we have paid a claim under Expenses in reaching the hospital, Expenses During Hospital, Expenses Before and After a Hospitalization, Home Care/Domiciliary, Personal Accident, Personal Accident (Lite), Personal Accident (Pro).**
- For the purpose of this benefit, Medical Equipment means artificial devices replacing body parts including but not limiting to artificial limbs or eyes, orthopedic braces, intra-ocular lenses, spectacles, hearing aids, dentures, artificial teeth and durable medical equipment such as wheelchair, crutches, hospital beds, traction equipment, Walkers, tri-cycles.

4.35. **Emotional Wellness for Adults**

Online sessions on Emotional Wellness. Can be availed only through our Partner network

4.36. **Mind Wellness Counselling**

Online sessions on Emotional, Mental and Mind Wellness. Can be availed only through our Partner network

4.37. **Sexual Health Wellness**

Online sessions on Sexual Health Wellness can be availed. only through our Partner network. This benefit is only for Adults in the policy.

4.38. **Health Risk Assessment**

You can take an overall online health assessment on our App, and be updated about your lifestyle and health.

4.39. **Wellness for Women**

Wellness that understands a woman's need.

1. Personalized Content on our Mobile App
2. Community you can interact with in a safe environment
3. Trackers, toolkits and health monitoring
4. Stress Management sessions
5. Access to Special Sections like Ayurvedic Setu for fertility, Garbh Sanskar for pregnancy, parenting tool kit, Stress management for PCOS/menopause.
6. Medical repository
7. Recorded sessions and webinars
8. Live Webinars
9. Dedicated Personal Coach
10. Special Courses like Ayurvedic tool-kit for fertility, Labour and birth for pregnancy, Parenting at different ages for Parents, Breast feeding for new born care, Coping stress management across all ages.
11. Online consults with our specialists
12. Online Yoga, Dance, Strength Training

Note:

- **All waiting periods and exclusions will apply to this benefit**
- This benefit is applicable only in India.
- This benefit is applicable only through our network.

4.40. **EyeGuard**

Opt for benefits for eye care and vision protection.

1. Prescription Glasses
2. Non-Prescription Sunglasses
3. Basic eye checkup on our partner network
4. Ophthalmologist consultations on our partner network
5. Additional discounts on eye surgeries on our partner network.

Note:

- **All waiting periods and exclusions will apply to this benefit**
- This benefit is applicable only through our Partner network.
- Benefits on eyewear can be availed only once during the policy year. Unused benefits would not be carried forward
- Non- Prescription glasses can only be availed if Prescription Glasses are not availed. Contact lenses are not covered.
- This benefit is applicable only in India.

4.41. **Live-Fit**

Optional benefits, that keep you fit, active and healthy!

1. Diet and Nutrition Coaching.
2. Artificial Intelligence lead Smart Fitness Coaching.
3. Access to workout classes across the Globe.
4. Access to Gym memberships.
5. Access to in –App activity Tracking (Steps, Meals, wearable integration), Health and Wellness content.

Note:

- This benefit is applicable only through our Partner network.
- This benefit is applicable only in India.
- All waiting periods and exclusions will apply to this benefit

4.42. **Accident Care**

The Insured Person may avail below services, from Our Partner network by reaching us through our mobile application/website or call center.

1. **ICU @Home:** In case of Permanent Total Disability, Permanent Partial Disability, and if recommended by the treating doctor, we will cover expenses for ICU at home. This includes services like General Nurse, Nursing Attendant, Physiotherapy, e-monitoring, Medical Equipment like syringe pumps, Oxygen concentrator, IV stand, DVT pump.
2. **Nursing Care at Home:** In case of Permanent Total Disability, Permanent Partial Disability. We will cover 12 hour/day and/or 24hr/day nursing services as prescribed by the treating doctor. This includes services of General Nurse or Nursing Attendant.
3. **Blood Transfusion:** In case of Permanent Total Disability, Permanent Partial Disability, and if recommended by the treating doctor, we will cover expenses for Blood Transfusion at home.
4. **Physiotherapy:** In case of Permanent Total Disability, Permanent Partial Disability, and if recommended by the treating doctor, we will cover expenses for Physiotherapy at home.
5. **Single nurse procedural visit:** In case of Permanent Total Disability, Permanent Partial Disability, and if recommended by the treating doctor, we will cover expenses for nurse visits for following procedures: Injection administration visit – Subcut/IM, Large Wound Dressing, Suppository application, RT insertion, Enema application, VACC dressing, Cannula Insertion, Urinary Catheterization, Small Wound Dressing.

6. **Financial Guidance:** in case of Accidental Death, we will offer one session with financial expert to provide investment guidance.

Note:

- We will pay for this if a claim is paid under Personal Accident, Personal Accident (Pro), Personal Accident (Lite), or claim for Accident is paid under Expenses for Reaching Hospital, Expenses During Hospitalization, Expenses Before and After a Hospitalization, Home Care/Domiciliary, Organ Donor.

4.43. **Health Vouchers**

Opt for Vouchers and download the app! Use this for a variety of health related services and benefits like condition management programs, consultations with specialists, access to health content etc. available right on the app.

Note: Download Niva Bupa or Approved partner apps by Niva Bupa

4.44. **Critical Illness**

We will pay if you get any of the critical illness mentioned in Annexure IV

Note:

- The Critical Illness first occurs and is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- The Insured Person should survive for a minimum of 30 days, post the diagnosis of critical illness.
- This benefit will only be given once in the lifetime of the consumer.

4.45. **Compassionate Visit**

If you are hospitalized for more than 10 consecutive days, we will pay for the economy class air ticket/ railway return ticket for your immediate family member.

Note:

- Ticket will be to & fro, from the place of residence of the immediate family member.
- This applies, when the place of residence of the immediate family member and the place of residence of the Insured member is different.
- "Immediate Family member" means the Insured's Spouse, Children, Parents, and Parents-in-law.

4.46. **Pre- Hospitalization Modification**

You can choose to reduce or increase the number of days under Pre-Hospitalization.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

4.47. **Post- Hospitalization Modification**

You can choose to reduce or increase the number of days under Post-Hospitalization.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

4.48. **Flight-Mode:**

If you are a traveler and travel outside India, then you can choose to pause your policy for a maximum of 30 days in a Policy year. The coverage of the policy will be extended by the number of days you paused it for.

Note:

- This optional benefit is not available to Non-Indian citizens & people who are not permanent residents of India.
- The information (like and not limited to date of travel, proof of tickets, visa) to pause the cover should be given 48 hours before the start of the travel date.
- You need to inform us if In case you return earlier.
- If the return to India is later than 30 days after the pause was activated, the coverage shall automatically resume after 30 days irrespective of actual return date.
- If out of all members who travelled, only one or some members return to India earlier than the notified date, then the coverages shall resume from the earliest date of return to India.
- This benefit cannot be offered with International Cover, Borderless or Borderless with specified illness

4.49. **Initial Wait Period Modification**

You can choose to reduce the Initial Wait Period.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

4.50. **Vaccination Cover**

We will pay for the following vaccinations through our Providers. We will pay for these vaccinations once in a policy year.

S.No	Vaccination Name
1	Influenza
2	Pneumonia
3	Cervical Cancer
4	Hepatitis B
5	Typhoid
6	BCG
7	OPV + IPV 1
8	DPT
9	Haemophilus influenzae type B
10	Tetanus
11	Rota
12	MMR
13	Hepatitis A

4.51. **Convalescence Benefit**

We will pay a fixed amount, if you are hospitalized continuously for more than 10 days

Note:

- We will pay this benefit, if we have paid for Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Home Care / Domiciliary Treatment, Organ Donor.
- This will be paid only once in the lifetime of the consumer.

4.52. **Dependent Accommodation Benefit**

If you are continuously hospitalized for more than 10 days, we will pay a per day benefit for the Immediate family member who is you get better at the hospital. This will be paid maximum up to 10 days.

Note:

- We will pay this benefit, if we have paid for Expenses in reaching a Hospital, Expenses during Hospitalization, Expenses before and after hospitalization, Home Care / Domiciliary Treatment, Organ Donor.
- "Immediate Family member" means the Insured's Spouse, Children, Parents, and Parents-in-law.
- We will pay for one immediate family member only.

4.53. **International Cover**

The following coverage under this benefit is provided outside India. The coverage under this benefit commences when the Insured Person first boards the common carrier by which it is intended that the Insured Person shall finally leave India and expires automatically on the earliest of:

- The Insured Person's return to India; or
- Policy Period end date; or
- The expiry of 45 days per trip starting from the date of journey

A. **Emergency Hospitalization**

We will pay for Hospitalization until you reach a Medically Stable Condition during the Policy Period on Cashless Facility basis only provided that:

- The Hospitalization is Medically Necessary and follows the written advice of the treating Medical Practitioner.
- The Insured Person is required to be admitted in a Hospital in an Emergency when the Insured Person is outside India, but within those regions specified in the Policy Schedule.

B. **Emergency medical evacuation:** When an adequate medical facility is not available proximate to the Insured Person, as determined by the Insured Person's attending physician and agreed by Us / Our Service Provider, We/Our Service Provider will arrange and pay for ambulance services under appropriate medical supervision on Cashless Facility basis only, by an appropriate mode of transport as decided by Us / Our Service Provider's consulting physician and patient's attending physician to the nearest medical facility capable of providing the required care.

C. **OPD cover**

We will pay for Out-patient Treatment only on reimbursement basis. A 20% co-payment will apply.

D. **Loss of Passport**

We will pay for the cost of obtaining a new or a duplicate passport, if you lose your passport in foreign land.

E. **Loss of checked-in baggage**

We will pay if you lose your entire checked-in baggage in a common carrier. Out liability is up to the maximum amount mentioned in your policy, irrespective of the number of bags lost. A 20% co-payment will apply. We will pay for this benefit only in reimbursement basis.

We will not pay, if we have already paid for delayed in checked-in baggage.

F. **Delay of checked-in baggage**

We will pay through reimbursement only, If the check-in baggage is delayed (reasons other than detention or confiscation of the baggage by the common carrier or customs or any government or other agencies) by more than 12 hours from your arrival at the place of destination.

We will not pay, if we have already paid for Loss of Checked-in baggage.

G. **Return of mortal remains:** In the unfortunate event of death, we will arrange with Only Our Providers, the return of the mortal remains to an authorized funeral home or to the legal residence of the Insured.

H. **Trip Cancellation**

We will pay you, if you cancel your trip for any of the following reason.

- Death or minimum 24Hr hospitalization of your immediate family member or traveling companion or You.
- Your presence is required by judicial authority during the period of insurance.
- You are unable to start your trip due to any natural disaster declared by the appropriate government authority
- Due to unexpected strike, riot or Civil commotion at Your destination or hometown or departure city.
- Loss of passport in case of international trips.
- Compulsory quarantine or prevention of travel by Government of India.

Note:

- We will cover only travel ticket and accommodation costs.
- Any cancellation due to Hospitalization resulting from pre-existing disease, Childbirth, Pregnancy or related medical complications to You, your immediate family or traveling companion.
- Failure to start the journey due to rejection of VISA.

I. **Trip interruption**

We will pay for additional travel costs (in the same class as original booking) if you cannot use your return ticket and/or unused accommodation costs that insured person has paid and cannot get back, if your trip was interrupted due to the following reasons, and you had to return before the trip completion.

- Death or minimum 24Hr hospitalization of your immediate family member or traveling companion or You
- You are unable to start your trip due to any natural disaster declared by the appropriate government authority.
- The common carrier which you boarded as a passenger is hijacked.
- Due to unexpected strike, riot or Civil commotion at place of visit other than your hometown.
- Due to compulsory quarantine or prevention of travel by government

Note:

- We will reimburse additional travel costs (in the same class as original booking) if you cannot use your return ticket

- We will not pay in case, any claim which was not authorized by our Medical Emergency Assistance provider before you returned home.
- Any abandonment due to Hospitalization due to a pre-existing disease, Childbirth, Pregnancy or related medical complications to You, your immediate family or traveling companion.
- Any claim for Trip interruption where there is no valid claim for Emergency In-patient medical treatment or Emergency In-patient medical treatment with OPD.

J. **Trip Delay**

We will pay you, if your trip is delayed for more than 12 consecutive hours from the later of the declared time of departure or expected time of departure due solely and directly to any one of the following:

- Delay due to bad Weather.
- Delay due to a sudden Strike or any other action by employees of the Common Carrier.
- Delay due to equipment failure of the Common Carrier.
- Delay due to operational problem at the Common Carrier end like crew/staff scheduling issues.
- Cancellation or rescheduling done by the Common carrier.

Note:

- We will not pay if any delay is due to reasons, which were made public or known to You at least 6 hours prior to the scheduled departure of the Common Carrier.
- If customer abandons the trip due to delay in departure of scheduled common carrier, then this benefit will not be payable.

K. **Compassionate visit:**

If Insured is hospitalized for a consecutive 7 days, and someone from immediate family of insured is visiting, then we will reimburse economy class travel cost for one such person

Note:

- Provided there is no other adult traveling companion with insured.
- Provided that no Adult member of your Immediate Family is present at the location of your hospitalization.
- Claim under this benefit will be applicable only if we have accepted claim under emergency inpatient medical treatment section of this policy

L. **Medical repatriation:**

We will provide through our provider's transportation under medical supervision to your residence or rehabilitation facility if our consulting physician and your medical practitioner determines that the transportation is medically necessary.

4.54. **Modern Treatments+**

If opted, we will remove the applicable sub-limit from "Modern Treatments" under the benefit "Expenses during Hospitalization" enhancing the limit for the benefit up to Sum Insured. All other conditions for the policy will remain same. This benefit can only be opted for Classic & Select Variants

4.55. **Air Ambulance+**

If opted, you can avail Air Ambulance up to the specified limit. This benefit can only be opted for Classic & Select Variants

Note: This will be paid only if claim for Expenses during hospitalization is paid by us. You must always use a registered air ambulance provider.

5. **Exclusions**

5.1. **Standard Exclusions**

5.1.1. **Pre-existing Diseases (Code–Excl01):**

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations, 2024 then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of 36 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

5.1.2. **Specified disease/procedure waiting period (Code- Excl02)**

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-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 retinal detachment

iii. Hyperplasia of prostate, hydrocele and spermatocele

iv. Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy)

v. Hemorrhoids, fissure, fistula or abscess of anal and rectal region

vi. Hernia of any site or type,

vii. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair

viii. Varicose veins of lower extremities

ix. All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump

x. Ulcer, erosion or varices of gastro intestinal tract

xi. 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

5.1.3. **30-day waiting period (Code- Excl03):**

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

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

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

5.1.4. **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.

5.1.5. **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.

5.1.6. **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

5.1.7. **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.

5.1.8. **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.

5.1.9. **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.

5.1.10. **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.

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

5.1.12. 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)

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

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

Note: Less than 7.5 Diopter means a power of eye either >7.5 Dioptre for Hypermetropia or far sightedness (say +7.75 Dioptre) or < 7.5 Dioptre for Myopia or near sightedness (say -7.75 Dioptre).

5.1.14. **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.

5.1.15. **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

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

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

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

5.2. **Specific Exclusions**

5.2.1. **Personal Waiting Period**

Conditions specified for an Insured Person under Personal Waiting Period will be subject to a Waiting Period of up to 48 months from the inception of the First Policy with Us.

5.2.2. **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.

5.2.3. **External Congenital Anomal**y:

Screening, counseling or treatment related to external Congenital Anomaly.

5.2.4. **Dental treatmen**t:

All dental treatments other than due to accidents and cancers.

5.2.5. **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.

5.2.6. Costs which are not Reasonable and Customary and treatments which are not Medically Necessary. **Refer Definition 2.1.37 for Reasonable and Customary Charges.**

5.2.7. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state.

In patients on artificial life support like ventilator, we may request for assessment to ensure the insured is not brain dead. The assessment MUST follow legally established procedure in the country. We may also recommend an independent specialist as a part of the team responsible for the assessment.

6. General Terms and Clauses

6.1. Standard General Terms and Clauses

6.1.1. 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 return 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.

Simplified for you

Free look is a 30 days period during which you can return back your policy, if you don't like what you have purchased.

6.1.2. Cancellation

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

b. 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.

a. 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

Simplified for you

You can cancel your policy whenever you wish.

Note: We will NOT refund any premium if we have paid a claim.

We will refund part of the premium depending on how many days your policy has been running for, if there is no claim.

6.1.3. Renewal of Policy

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

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

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

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

c. Coverage is available during the grace period.

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

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

6.1.4. **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.

6.1.5. **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.

6.1.6. **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

Simplified for you

If we ever cancel your policy, it will be for Fraud or Non disclosure only. Insurance contract is a legal contract too and it's based on trust.

Fraud is an action by you or anyone acting on your behalf where you receive benefits, financial or otherwise, for which you are either not eligible at all or not to the extent under the policy.

Pay your renewal premium before end of policy period to maintain continuity of benefits. A grace period is also available to pay the premium after policy expiry.

Note: You are NOT insured during the grace period.

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.

6.1.7. **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 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.

6.1.8. **Redressal of Grievance**:

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

Website: www.nivabupa.com

Toll- Free: 1860-500-8888

E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)

Fax: 011-41743397

Simplified for you

We will cancel your policy, will not pay any claim, will not refund any premium paid and have right to take all possible legal action against you including for recovery of benefits paid earlier, if

- You withheld any information from us, whole or part that would have invited any decision other than a 'standard acceptance' of your application for insurance

Note: Non standard decisions are:

o Loading – We ask for additional premium

o Exclusions – We apply a additional waiting period for health conditions or treatments

o Rejection – We hate to do this. But sometimes are compelled to say no to a customer

IMPORTANT: We understand you may not know how important is the information on your health and it's impact on your policy. Hence it's very important that you disclose all health information and we would decide how important (we call it 'material') it is.

- Cause fraud of any kind

	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 Contact No: 1860-500-8888 Fax No.: 011-41743397 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 II). Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in	
6.1.9.	**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	**Simplified for you** We will provide our decision on claim within 15 days from submission of all necessary claim documents. For any delay in payment of claim, we will pay interest on the claim amount at a rate 2% above bank rate._

Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

6.1.10. **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.

Simplified for you

After 5 years, no health insurance claim shall be contestable except for proven fraud and permanent exclusions.

6.1.11. **Multiple Policies**

A. Indemnity Based Policies:

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

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

B. **Benefit Based Policies:**

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

Simplified for you

In case you have multiple policies, you can choose the policy from which you want to claim first.

If claim amount exceeds the Sum Insured of first policy you claim from; then you can claim the balance amount from the second policy.

6.1.12. **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.

6.1.13. **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.

6.1.14. **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)

6.1.15. **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.

6.1.16. **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.

6.1.17. **Premium Payment in Instalments**

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

Simplified for you

In case you have multiple policies, you can choose the policy from which you want to claim first.

If claim amount exceeds the Sum Insured of first policy you claim from; then you can claim the balance amount from the second policy.

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

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

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

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

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

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

6.2. Specific Terms and Clauses

6.2.1. **Automatic Cancellation:**

The Policy shall automatically terminate in the event of death of the all Insured Person(s). A refund in accordance with the table in Section 6.1.2 shall be payable provided that no claim has been admitted or lodged or not benefit has been availed by the insured person under the policy.

Simplified for you

You can shift your policy to any other health insurance product / plan offered by us as per migration guidelines.

6.2.2. **Additional premium (Risk Loading)**

a. We may ask for additional premium after due risk evaluation (it's what referred to as Underwriting) based on all information provided by you. We will issue policy to you only after you pay us the additional premium and provide us consent.

b. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual.

c. Once applied, Risk loading continues even for all renewals. However, we offer discounts up to 30% under Live Healthy for maintenance and improvement in health.

6.2.3. **Other Renewal Conditions:**

a. Renewal Premium:

Renewal premium will alter based on Age (in case of claim). For Floater plan, the age of eldest insured person will be considered for calculating the premium.

Simplified for you

You can also shift your policy to any other insurer as per portability guidelines.

b. Addition of Insured Persons on Renewal:

If a new member is added in the 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 afresh for that member.

c. Changes to Sum Insured on Renewal:

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

6.2.4. **Claims**

a. Cashless claim facility is available at our network hospitals ONLY. As list of network hospitals is dynamic, for the latest list, refer to our website www.nivabupa.com.

b. Documents required with claim form:

Hospital / Medical records:

- Original Discharge summary with first and subsequent consultation papers.
- Original Final Hospital bill with detailed break-up and payment receipt (including pharmacy bills).
- Laboratory investigation reports with supporting prescriptions.
- MLC/First Information Report (FIR) (in accident cases).

Policyholder documents (Nominee in case of death of Policyholder):

- KYC documents
- Cancelled cheque

IMPORTANT:

- All documents **MUST** be submitted at the earliest possible time. .
- For any delay in submission, You **MUST** provide the reasons in writing. We will condone such delay on merits (i.e. reasons beyond your control).
- You **MUST** submit all claim related documents for expenses within the Deductible amount (if applicable).
- We reserve the right to check and investigate the hospital / medical records from any doctor, Hospital, clinic, individual or institution.

c. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are placed as Annexure I.

d. If you opt for a Hospital room which is higher than the eligible room category as specified in your Policy Schedule, then We will pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

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

e. For any hospitalization, we will pay for items included in the bill by the Hospital during the duration of hospitalization. Items not included in the bill will not be paid.

Please Note:

i. 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.

ii. 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

6.2.5. **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.

6.2.6. **Territorial Jurisdiction**

All claims shall be payable in India in Indian Rupees only.

6.2.7. **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.

6.2.8. **Zonal pricing**

For the purpose of calculating premium, the country has been divided into the following 2 zones:

a. Zone 1: Delhi, Surat, Faridabad, Gurgaon, Nashik, Ghaziabad

b. Zone 2: Surendra Nagar, Ahmedabad, Vadodara, Gandhi Nagar, Anand, Mahesana, Kheda, Hisar, Sonipat, Panipat, Rohtak, Jhajjar, Palwal, Sirsa, Mahendragarh, Kaithal, Jind, Nuh, Rewari, Kurukshetra, Karnal, Charkhi Dadri, Aligarh, Alwar, Bagpat, Bulandshahr, Gautam Buddha Nagar, Hapur, Mathura, Meerut, Muzaffarnagar, Noida, Saharanpur, Shamli, Khandwa, Jhabua, Dewas, Khargone, Indore, Ujjain, Dhar

c. Zone 3: Palghar, Mumbai, Thane, Raigarh(Mh), Agra, Bhopal, Telangana, Kolkata, Asansol

d. Zone 4: Rest Of Gujarat, Rest Of Maharastra, Rest Of Madhya Pradesh, Daman And Diu, Dadra And Nagar Haveli, Visakhapatnam, Vizianagaram, Ludhiana, Mohali, Amritsar, Dehradun, Tirupati, Vijayawada

e. Zone 5: Rest Of Haryana, Allahabad, Bengaluru, Bangalore Rural, Tumkur, Kolar, Chikkaballapur, Ramanagar, Chandigarh, Jaipur, Kerala, Lakshadweep, Chennai, North 24 Parganas, Howrah, Hooghly, South 24 Parganas, Nadia, North Presidency, South Presidency, Barasat

f. Zone 6: Rest Of Andhra Pradesh, Patiala, Rest Of Uttarakhand, Vellore, Tiruvannamalai, Villupuram, Kanchipuram, Tiruvallur, Tirupattur, Bihar, Rest Of Uttar Pradesh

g. Zone 7: Rest Of Punjab, Rest Of Karnataka, Rest Of Rajasthan, Goa, Jharkhand

h. Zone 8: Rest Of Tamilnadu, Rest Of West Bengal, Himachal Pradesh, Andaman And Nicobar Islands, Arunachal Pradesh, Assam, Chhattisgarh, Jammu And Kashmir, Orissa, Sikkim, Ladakh, Manipur, Meghalaya, Mizoram, Nagaland, Puducherry, Tripura

Your premium depends upon your residential city. Please inform us immediately in case of change in your city.

6.2.9. **Assignment**

The Policy can be assigned subject to applicable laws.

7. **Coverage Standards & Protocols**

Medicine is an 'evidence based' science. It follows protocols. Avoiding unnecessary and not indicated treatment is as important as administering the right treatment. Simply put, Unnecessary and not indicated treatment can harm, including putting life at risk.

One important principle in insurance is 'insurance or the state of being insured should not change one's healthcare purchase decision'. As a prudent & logical individual, everyone, while availing treatment for any condition, considers cost versus outcome.

A. **Medical protocols**

We will periodically publish and refresh medical protocols on our website. These protocols will be based on Textbooks, AIIMS, ICMR, Clinical Establishment Act, PMJAY, Various state schemes' protocols, Department of health research under Ministry of Health, Mayo clinic, Cleveland clinic, NICE.org etc. These protocols will provide

- Indication for hospitalization: The criteria for hospitalization in to various category of rooms (ICU, Normal room etc.)
- What is the right treatment (medicine, procedure) for the condition & severity?

  Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India will not be covered. We will also use instructions on the drug, procedure published by manufactures, approver of the drug, procedure in different countries especially the country of discovery or invention on indications, contraindications, usage etc. Extra / Off label usage (using a drug or procedure for conditions other than it was explicitly approved for) will not be covered under the policy.

  A. **Position statements**

  As a responsible insurer, we will transparently publish on our website what we refer to as 'Position Statements'. These will essentially clarify our position on coverage of various treatments. We may fully pay, part pay, suggest alternatives, investigate, or even deny certain medicines, procedures, investigations, therapies etc. If in any treatment our position, based on scientific evaluation, is not to pay or pay only a part, we will at least pay up to the cost of currently prevailing most common alternative treatments for the condition and not less. Medicine is an ever evolving world with newer technologies and treatments being introduced. Many of which may not provide cost adjusted superior outcomes as compared to other existing alternatives. These position statements will tap in to Globally available resources like AIIMS, ICMR, Clinical Establishment Act, PMJAY, Various state schemes' protocols, Department of health research under Ministry of Health, Mayo clinic, Cleveland clinic, NICE.org etc. The position statements will be based on various Health Technology Assessments, Health Economic Evaluation, Cost Benefit analysis, Cost Efficiency analysis other than various other researches done Globally and published in reputed journals. Any research data with conflict of interest will be discarded for the purpose.

  B. **Prolonged Hospitalization**

  - We encourage you to intimate to us as much earlier as possible before any hospital admission.
  - In any event if you fail to intimate to us before admission in to a hospital, please intimate as soon as possible after admission.
  - You MUST intimate to us if your hospitalization duration exceeds 7 days. In event of failure to intimate within 7 days from date of hospitalization, an additional cumulative co-payment of 10% will be levied on your final admissible amount. This duration will be relaxed to a maximum of 9 days only for road traffic accidents.

C. **Organ Transplants**

- You MUST intimate to us, even for hospitalization in Non-Network hospital, at least 7 days before live donor organ transplant
- You MUST intimate to us, even for hospitalization in Non-Network hospital, as early as feasible, not exceeding 48 hours from the date and time of admission in event of cadaveric organ transplant
- In all liver & Pancreas transplants, biopsy must be performed on the recipients' organ. We reserve the right to collect the biopsy slide & tissue block and get opinion and fresh biopsy done from other independent experts. Our final decision to honor the claim will be based on these independent expert opinions.
- If you get treated in a non-network hospital, and fail to intimate us or share the biopsy as indicated above, an additional co-payment of 20% will be applied on the admissible claim amount.

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

List I – Expenses not covered

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	BABY FOOD	24	ATTENDANT CHARGES	47	LUMBO SACRAL BELT
2	BABY UTILITIES CHARGES	25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	48	NIMBUS BED OR WATER OR AIR BED CHARGES
3	BEAUTY SERVICES	26	BIRTH CERTIFICATE	49	AMBULANCE COLLAR
4	BELTS/ BRACES	27	CERTIFICATE CHARGES	50	AMBULANCE EQUIPMENT
5	BUDS	28	COURIER CHARGES	51	ABDOMINAL BINDER
6	COLD PACK/HOT PACK	29	CONVEYANCE CHARGES	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
7	CARRY BAGS	30	MEDICAL CERTIFICATE	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	31	MEDICAL RECORDS	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	32	PHOTOCOPIES CHARGES	55	ECG ELECTRODES
10	LEGGINGS	33	MORTUARY CHARGES	56	GLOVES
11	LAUNDRY CHARGES	34	WALKING AIDS CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
13	SANITARY PAD	36	SPACER	59	KIDNEY TRAY
14	TELEPHONE CHARGES	37	SPIROMETRE	60	MASK
15	GUEST SERVICES	38	NEBULIZER KIT	61	OUNCE GLASS
16	CREPE BANDAGE	39	STEAM INHALER	62	OXYGEN MASK
17	DIAPER OF ANY TYPE	40	ARMSLING	63	PELVIC TRACTION BELT
18	EYELET COLLAR	41	THERMOMETER	64	PAN CAN
19	SLINGS	42	CERVICAL COLLAR	65	TROLLY COVER
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG

21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/ SHOULDER IMMOBILIZER		

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

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	14	BED PAN	27	ADMISSION KIT
2	HAND WASH	15	FACE MASK	28	DIABETIC CHART CHARGES
3	SHOE COVER	16	FLEXI MASK	29	DOCUMENTATION CHARGES / ADMINISTRA-TIVE EXPENSES
4	CAPS	17	HAND HOLDER	30	DISCHARGE PROCEDURE CHARGES
5	CRADLE CHARGES	18	SPUTUM CUP	31	DAILY CHART CHARGES
6	COMB	19	DISINFECTANT LOTIONS	32	ENTRANCE PASS / VISITORS PASS CHARGES
7	EAU-DE-COLOGNE / ROOM FRESHNERS	20	LUXURY TAX	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
8	FOOT COVER	21	HVAC	34	FILE OPENING CHARGES
9	GOWN	22	HOUSE KEEPING CHARGES	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EX-PLAINED)
10	SLIPPERS	23	AIR CONDITIONER CHARGES	36	PATIENT IDENTIFICATION BAND / NAME TAG
11	TISSUE PAPER	24	IM IV INJECTION CHARGES	37	PULSEOXYMETER CHARGES
12	TOOTH PASTE	25	CLEAN SHEET		
13	TOOTH BRUSH	26	BLANKET/WARMER BLAN-KET		

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

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	HAIR REMOVAL CREAM	9	WARD AND THEATRE BOOKING CHARGES	17	BOYLES APPARATUS CHARGES
2	DISPOSABLES RAZORS CHARGES (for site preparations)	10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	18	COTTON
3	EYE PAD	11	MICROSCOPE COVER	19	COTTON BANDAGE
4	EYE SHEILD	12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER	20	SURGICAL TAPE
5	CAMERA COVER	13	SURGICAL DRILL	21	APRON
6	DVD, CD CHARGES	14	EYE KIT	22	TORNIQUET
7	GAUSE SOFT	15	EYE DRAPE	23	ORTHOBUNDLE, GYNAEC BUNDLE
8	GAUZE	16	X-RAY FILM		

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

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

Annexure II - List of Insurance Ombudsmen

Office Details	Jurisdiction
AHMEDABAD Shri Collu Vikas Rao Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: oiooio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Ms. Neerja Kapurs 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: oiooio.bengaluru@cioins.co.in	Karnataka
BHOPAL Shri Ajay Kumar Insurance Ombudsman 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 Email: oiooio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh
BHUBANESWAR Shri Bimbadhar Pradhan Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: oiooio.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Ms. Alka Jha 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 Email: oiooio.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh

CHENNAI Shri K. Vinayak Rao Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: oiooio.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
DELHI Ms. Sunita Sharma Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: oiooio.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
GUWAHATI Shri Ajay Kumar Sharma Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD Ms. G Shobha Reddy 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 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR Shri Satyajeet Rajan Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: oio.jaipur@cioins.co.in	Rajasthan

KOCHI Shri Pradeep Kumar Jain 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA Ms. Kiran Sahdev Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW Shri Atul Sahai Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: oio.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 Ms. Sarojini S Dikhale Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: oio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumba
NOIDA Shri Bimbadhar Pradhan 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: oio.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

PATNA Ms. Susmita Mukherjee Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in	Bihar, Jharkhand
PUNE Shri Sunil Jain 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: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Shri Umesh Sinha Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.”

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

Annexure III – List for Annual Health Checkups & NivaBupaOne Executive Health Checkup

S.No	Test Name	Variants				NivaBupaOne
		Classic	Classic + Select	Classic + Select + Elite	Classic + Select + Elite + Black	Executive Health Assessment
1	Calcium	NA	NA	Yes	Yes	Yes
2	Complete blood count (CBC)	Yes	Yes	Yes	Yes	Yes
3	Erythrocyte Sedimentation Rate (ESR)	NA	NA	Yes	Yes	Yes
4	Fasting Blood sugar (FBS)	Yes	Yes	Yes	Yes	Yes
5	HbA1C	Yes	Yes	Yes	Yes	Yes
6	Uric Acid	NA	Yes	NA	NA	NA
7	Serum creatinine	Yes	Yes	NA	NA	Yes
8	Kidney Function Test (KFT)	NA	NA	Yes	Yes	Yes
9	SGOT / SGPT	Yes	NA	NA	NA	NA
10	Liver Function Test (LFT)	NA	Yes	Yes	Yes	Yes
11	Physical Examination (PE)	NA	NA	Yes	Yes	Yes
12	Post prandial blood sugar (PPBS)	NA	NA	NA	NA	Yes
13	Routine Urine Analysis (RUA)	NA	NA	NA	Yes	Yes
14	Sensitized Erythrocyte Lysis (SEL)	NA	NA	NA	Yes	Yes
15	Serum Cholesterol	Yes	NA	NA	NA	NA
16	Lipid Profile	NA	Yes	Yes	Yes	Yes
17	Vitamin D	NA	Yes	Yes	Yes	Yes
18	TSH	Yes	Yes	Yes	NA	NA
19	Thyroid Function Test (TFT)	NA	NA	NA	Yes	Yes
20	Electrocardiogram (ECG)	NA	NA	NA	Yes	Yes
21	X Ray chest	NA	NA	NA	Yes	Yes
22	Ultrasound Test (USG)	NA	NA	NA	Yes	Yes
23	Treadmill test (TMT)	NA	NA	NA	Yes	Yes
24	PSA	NA	NA	NA	Yes	Yes
25	Mammogram	NA	NA	NA	NA	Yes
26	PAP smear of Cervix	NA	NA	NA	NA	Yes
27	Colonoscopy*	NA	NA	NA	NA	Yes
28	Vitamin B12	NA	NA	NA	NA	Yes

*Prescription based only.

S. No.	List of Critical Illness	Definition	What Does it Mean
1	Cancer of Specified Severity	I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. II. The following are excluded - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3. ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond; iii. Malignant melanoma that has not caused invasion beyond the epidermis; iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0 v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below; vi. Chronic lymphocytic leukaemia less than RAI stage 3 vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification, viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs	Cancer (also known as a malignant tumour) is a disease where cells change and grow in an abnormal way. If left untreated, they can destroy surrounding healthy cells and eventually destroy healthy cells in other parts of the body. There are about 200 different types of cancer, varying widely in outlook and treatment.

2	Myocardial Infarction (First Heart Attack of specific severity)	I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria: i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) ii. New characteristic electrocardiogram changes Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. II. The following are excluded: i. Other acute Coronary Syndromes ii. Any type of angina pectoris iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.	A heart attack, also known as a myocardial infarction, happens when part of the heart muscle dies because it has been starved of oxygen. This causes severe pain and an increase in cardiac enzymes and troponins, which are released into the blood stream from the damaged heart muscle.
3	Open Chest CABG	I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: i. Angioplasty and/or any other intra-arterial procedures	Coronary arteries can become narrowed or blocked by the build-up of fatty deposits caused by poor lifestyle such as high fat diet, smoking and high blood pressure. This may cause symptoms including chest pain and can sometimes cause a heart attack. Coronary artery by-pass surgery is used to treat blocked arteries in the heart by diverting the blood supply around the blocked artery using a vein, usually taken from the leg, arm or chest. This definition covers surgery if it requires the heart to be reached by a surgical incision through the chest wall or sternum (breastbone), to replace the blocked arteries with a vein.

4	Open Heart Replacement or Repair of Heart Valves	The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.	Heart valve repair or replacement surgery is done when valves are damaged or diseased and do not work the way they should. When one (or more) valve(s) becomes stenotic (stiff), narrowed or diseased due to any reasons, the heart must work harder to pump the blood through the valve. If your heart valve(s) becomes damaged, you may have the following symptoms: • Dizziness • Chest pain • Breathing difficulties • Palpitations • Edema (swelling) of the feet, an kles, or abdomen (belly) • Rapid weight gain due to fluid retention This definition implies a large surgical incision made in the chest and the heart stopped for a time so that the surgeon can repair or replace the valve(s).
5	Coma of Specified Severity	A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a) no response to external stimuli continuously for at least 96 hours; b) life support measures are necessary to sustain life; and c) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.	A coma is a state of unconsciousness from which the patient cannot be aroused and has no control over bodily functions. It may be caused by illness, stroke, infection, very low blood sugar or serious accident. Recovery rates vary, depending upon the depth and duration of the coma.
6	Kidney Failure Requiring Regular Dialysis	End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.	The kidneys perform an important role filtering the body's waste to pass as urine. If the kidneys fail, there is a harmful build up of the body's waste products. In severe cases it may be necessary for the filtering to be done by a dialysis machine or, in some cases, a transplant may be needed.

7	Stroke Resulting in Permanent Symptoms	Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced. The following are excluded: i. Transient ischemic attacks (TIA) ii. Traumatic Injury of the brain iii. Vascular disease affecting only the eye or optic nerve or vestibular functions	Strokes are caused by a sudden loss of blood supply or haemorrhage to a particular part of the brain. The symptoms and how well a person recovers will depend on which part of the brain is affected and the extent of the damage. A transient ischaemic attack, sometimes referred to as a 'mini-stroke', does not result in any permanent neurological deficit. These are not covered by this definition, because symptoms aren't permanent and will disappear within 24 hours.
8	Major Organ/ Bone Marrow Transplant	The actual undergoing of a transplant of: • One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or • Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following are excluded: • Other stem-cell transplants • Where only islets of langerhans are transplanted	An organ may become so diseased that it needs to be replaced.
9	Permanent Paralysis of Limbs	Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.	Paralysis is the complete loss of use. It may be caused by injury or illness. A limb is an arm or leg.

10	Motor Neurone Disease with Permanent Symptoms	Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.	Motor neurone disease (MND) is a gradual weakening and wasting of the muscles, usually beginning in the arms and legs. This may cause difficulty walking or holding objects. As the disease develops, other muscle groups may be affected, such as those involving speech, swallowing and breathing. Eventually, 24 hour care may be needed.
11	Multiple Sclerosis with Persisting Symptoms	I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:: i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months. II. Neurological damage due to SLE is excluded.	Multiple sclerosis (MS) is the most common disabling neurological disease among young adults and is usually diagnosed between the ages of 20 and 40.
12	Aplastic Anaemia	Aplastic Anemia is chronic persistent bone marrow failure. A certified hematologist must make the diagnosis of severe irreversible aplastic anemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following: a) Absolute neutrophil count of less than 500/ mm^3 b) Platelets count less than 20,000/mm^3 c) Reticulocyte count of less than 20,000/mm^3 The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anemia is excluded and not covered under this Policy.	Aplastic anaemia is a serious condition where bone marrow fails to produce sufficient blood cells or clotting agents. Symptoms include shortness of breath, excessive bleeding and an increased chance of catching infections.

13	Bacterial Meningitis	Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction. There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis and culture of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.	Bacterial meningitis causes inflammation to the meninges, which is the protective layer around the brain and spinal cord. It's caused by a bacterial infection and needs prompt medical treatment. Initial symptoms include headache, fever and vomiting.
14	Loss of Speech	I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.	The total loss of the ability to speak. It's often caused when the vocal cords need to be removed because of a tumour or a serious injury.
15	End Stage Liver Disease	Permanent and irreversible failure of liver function that has resulted in all three of the following: a) Permanent jaundice; and b) Ascites; and c) Hepatic Encephalopathy. Liver failure secondary to drug or alcohol abuse is excluded.	The liver is an important organ, which carries out several of the body's vital functions such as helping with digestion and clearing toxins. This definition covers liver failure at an advanced stage. This type of liverfailure leads to permanent jaundice (yellow discolouration of the skin), ascites (build up of fluid in the abdomen), and encephalopathy (brain disease or damage).
16	Deafness	Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.	This means permanent loss of hearing in both ears, measured by using an audiogram across different frequencies, which vary from low to high pitch.

17	End-stage Lung Disease	End stage lung disease, causing chronic respiratory failure, as evidenced by all of the following: a) FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and b) Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2< 55mmHg); and d) Dyspnea at rest. This diagnosis must be confirmed by a respiratory physician.	The lungs allow us to breathe in oxygen and get rid of harmful carbon dioxide. The definition of End Stage Lung Disease covers advanced lung failure when breathing is severely affected and regular oxygen therapy is required.
18	Fulminant Viral Hepatitis	A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following: a) rapid decreasing of liver size; and b) necrosis involving entire lobules, leaving only a collapsed reticular framework; and c) rapid deterioration of liver function tests; and d) deepening jaundice; and e) hepatic encephalopathy. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.	Appearance of severe systemic complications like sepsis, gastro-intestinal bleeding, cerebral oedema, renal and cardiac failure, rapidly after the first signs of liver disease (such as jaundice), and indicates that the liver has sustained severe damage.
19	Third Degree Burns	There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.	

20	Muscular Dystrophy	Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of Muscular Dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence. The disease must result in the permanent inability of the Insured Person to perform (whether aided or unaided) at least three (3) of the six (6)"Activities of Daily Living". Activities of Daily Living are defined as: i. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene ii. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary iii. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available iv. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene v. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence vi. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.	

Annexure V – Co-payments for Room Category:

Varaint	Category Claimed for	Co-Payment
Classic	General Ward	0%
Classic	Twin Sharing Room	20%
Classic	All Room Categories except deluxe and Suite	40%
Classic	All Room Categories	50%
Select	General Ward	0%
Select	Twin Sharing Room	0%
Select	All Room Categories except deluxe and Suite	20%
Select	All Room Categories	40%
Elite	General Ward	0%
Elite	Twin Sharing Room	0%
Elite	All Room Categories except deluxe and Suite	0%
Elite	All Room Categories	20%