Health Recharge – Prospectus cum Sales Literature

Health Recharge - Start a healthy relationship

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

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

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

Policy Design

- Niva Bupa's 'Health Recharge' product can be issued to an individual customer or to a family with up to 4 children (refer to as family floater).
- The family floater policy is available in any of the following combinations:
  - 1 Adult + 1 Child
  - 1 Adult + 3 Children
  - 2 Adults
  - 2 Adults + 2 Children
  - 2 Adults + 4 Children
  - 1 Adult + 2 Children
  - 1 Adult + 4 Children
  - 2 Adults + 1 Child
  - 2 Adults + 3 Children
- The family includes spouse and dependent children and can comprise up to a unit of 6 insured persons of which up to 4 can be children.
- The premium for family floater policies depends on the age of the eldest insured person.
- The range of entry ages for Adults under the policy is from 18 years (last birthday) to 65 Years (last birthday). The range of entry ages for dependent children is from 91 days to 25 years.

Please note if any Insured Person who is a child and has completed 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on our underwriting guidelines, as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

- **Term discount:** The default policy term for all plans is one year. Two year and three year policy term options are also available under the product. The level of discount is as below:
  - **2 year term:** 7.5% on the premium for second policy year
  - **3 year term:** 15% on the premium for third policy year + 7.5% on the premium for second policy year
- **Staff discount:** A staff discount of 15% on the policy premium will be given for the first policy year and on every renewal of such policy. However, if the policy is also purchased online, then online discount of 12% will not be applicable

- **Online discount:** A discount of 12% on premium will be given for the first policy year and on every renewal of such policy provided if the policy is purchased online.

Coverage Options

Sum Insured ranges from Rs. 2 lacs to Rs. 95 lacs. You have to mandatorily choose an annual aggregate claim deductible amount, options of these deductible amounts are provided in the 'Product Benefit Table'. The details of the benefits/ limits/ amounts basis Sum Insured are available in the product benefits table.

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

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

1. **Inpatient Care**

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

i. Room Rent;
ii. Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;
iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
iv. Investigative tests or diagnostic procedures directly related to the Insured Event which lead to the current Hospitalization;
v. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;
vi. Intravenous fluids, blood transfusion, injection administration charges and /or allowable consumables;
vii. Operation theatre charges;
viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
ix. Intensive Care Unit Charges.

Conditions:

a. The Hospitalization is for Medically Necessary Treatment and advised in writing by a Medical Practitioner.
b. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to 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 for Hospitalization as an Inpatient excluding private nursing charges, Medical Practitioners' fees excluding any charges or fees for Standby Services, investigation and diagnostics procedures directly related to the current admission, operation theatre charges, ICU Charges.
c. We will pay the consultation charges for any Medical Practitioner visiting the Insured Person only if:
   i. The Medical Practitioner's treatment or advice has been specifically sought by the Hospital; and
   ii. The consultation charges are included in the Hospital's bill

2. **Pre-hospitalization Medical Expenses**

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

Conditions:

a. We have accepted a claim under Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments.
b. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments claim.
c. The expenses are incurred after the inception of the First Policy with Us. If any portion of these expenses is incurred before the inception of the First Policy with Us, then We shall be liable only for those expenses incurred after the commencement date of the First Policy, irrespective of the initial waiting period.
d. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
e. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments claim has been incurred.

Sub-limit:

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

3. **Post-hospitalization Medical Expenses**

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

Conditions:

a. We have accepted a claim under Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments.
b. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care, Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments claim.
c. The expenses incurred shall be as advised in writing by the treating Medical Practitioner.
d. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
e. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments claim has been incurred.

Sub-limit:

a. We will pay Post-hospitalization Medical Expenses only for up to 90 days immediately following the Insured Person's discharge from Hospital or Day Care Treatment or Domiciliary Hospitalization or Alternative Treatments.

4. **Day Care Treatment**

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

Conditions:

a. The Day Care Treatment is advised in writing by a Medical Practitioner as Medically Necessary Treatment.
b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with respective sections mentioned.

What is not covered:

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

5. **Domiciliary Hospitalization**

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

Conditions:

a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.
c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with respective sections mentioned.

6. **Alternative Treatments**

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

Conditions:

a. The treatment should be taken in AYUSH Hospital. An AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or state government AYUSH Hospital; or
   ii. Teaching Hospital attached to AYUSH college recognized by the Central Government / Central Council of Indian Medicine / Central Council of Homeopathy; or
   iii. 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:
      a) Having at least five in-patient beds;
      b) Having qualified AYUSH Medical Practitioner in charge round the clock;
      c) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      d) 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).

b. Pre-hospitalization Medical Expenses incurred for up to 60 days immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days immediately following the Insured Person's discharge will also be indemnified under this benefit in accordance with respective sections mentioned, provided that these Medical Expenses relate only to Alternative Treatments and not Allopathy.
c. Any non-allopathic treatment taken by the Insured Person shall only be covered under Section (Alternative Treatments) as per the applicable terms and conditions, except for treatment under Section 3.12 (Mental Disorders Treatment) and Section 3.13 (HIV / AIDS).

What is not covered:

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

7. **Living Organ Donor Transplant**

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

Conditions:

a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.
c. We have accepted the recipient Insured Person's claim under Inpatient Care.

What is not covered:

a. Stem cell donation whether or not it is Medically Necessary Treatment except for Bone Marrow Transplant.
b. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalization for organ transplant.
d. Transplant of any organ/tissue where the transplant is Unproven / experimental treatment or investigational in nature.
e. Expenses related to organ transportation or preservation.
f. Any other medical treatment or complication in respect of the donor, which is directly or indirectly consequence to harvesting.

8. **Emergency Ambulance**

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

Conditions:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a

Hospital where appropriate medical treatment can be obtained or;

b. The medical condition of the Insured Person requires immediate ambulance services from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
c. This benefit is available for only one transfer per Hospitalization.
d. The ambulance service shall be offered by a healthcare or ambulance Service Provider.
e. We have accepted a claim under Inpatient Care above.
f. We will cover expenses up to the amount specified in Your Policy Schedule.

What is not covered:

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

9. **e-Consultation**

What is covered:
If the Insured Person is diagnosed with an Illness or is planning to undergo a planned Surgery or a Surgical Procedure, the Insured Person can, at the Insured Person's sole direction, obtain an e-Consultation from Our Service Provider during the Policy Period.

Conditions:

a. e-Consultation shall be requested through Our call centre or website.
b. e-Consultation will be arranged by Us (without any liabilities) and will be based solely only on the information provided by the Insured Person.
c. e-Consultation must not be considered a substitute to medical opinion or advice nor shall be same pursued over a medical advice or opinion given by treating physician or doctor.
d. By seeking e-Consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
e. The Insured Person is free to choose whether or not to obtain the e-Consultation, and if obtained then whether or not to act on it in whole or in part.
f. e-Consultation under this benefit shall not be valid for any medico-legal purposes.
g. We do not represent correctness of e-Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

10. **Pharmacy and Diagnostic Services**

What is covered:
You may purchase medicines or avail diagnostic services from Our Service Provider through Our website or mobile application.

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

a. The cost for the purchase of the medicines or for availing diagnostic services shall be borne by You.
b. Further it is made clear that purchase of medicines from Our Service Provider is Your absolute discretion and choice.

11. **Loyalty Additions (applicable only for Base Sum Insured up to Rs. 25** Lac)

What is covered:
If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year / 3 year Policy Period respectively (if applicable), We will provide Loyalty Additions in the form of Cumulative Bonus by increasing the Sum Insured applicable under the Policy by 5% of the Base Sum Insured of the immediately preceding Policy Year subject to a maximum of 50% of the Base Sum Insured. There will be no change in the sub-limits applicable to various benefits due to increase in Sum Insured under this benefit.

Conditions:

a. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Cumulative Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We will provide the credit for the accumulated Cumulative Bonus to the Family Floater Policy.
b. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Policy Schedule in to two or more floater / individual, then We will provide the credit of the accumulated Cumulative Bonus to each of the split Policy.
c. If the Insured Persons covered on a Family Floater Policy are reduced at the time of Renewal, the applicable accumulated Cumulative Bonus shall remain same under the policy.

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

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

f. This benefit is not applicable for e-Consultation and Optional benefits (if opted for) such as Personal Accident Cover and Critical Illness Cover. Enhancement of Sum Insured due to Loyalty Additions benefit cannot be utilized for the aforementioned benefits.

g. This benefit is not applicable for Policy with Base Sum Insured greater than Rs. 25 Lac.

12. **Mental Disorders Treatment**

What is covered:
We will indemnify the expenses incurred by the Insured Person for Inpatient treatment for Mental Illness up to the limit as specified in Your Policy Schedule.

Conditions:

a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist or a professional registered with the concerned State Authority or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

b. The Hospitalization is for Medically Necessary Treatment.

c. The treatment should be taken in Mental Health Establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friend.

d. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit as per respective sections mentioned.

What is not covered:

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

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

c. Mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by subnormality of intelligence

Sub-limit:

a. The following disorders / conditions shall be covered only up to 10% of Base Sum Insured or Rs. 50,000, whichever is lower. This sub-limit shall apply for all the following disorders / conditions on cumulative basis.

Disorder / Condition	Description
Severe Depression	Severe depression is characterized by a persistent feeling of sadness or a lack of interest in outside stimuli. It affects the way one feels, thinks and behaves.
Schizophrenia	Schizophrenia is mental disorder, that distorts the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. Schizophrenia result in combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning,
Bipolar Disorder	Bipolar disorder is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior. It includes periods of extreme mood swings with emotional highs and lows.
Post traumatic stress disorder	Post-traumatic stress disorder is an anxiety disorder caused by very stressful, frightening or distressing events. It includes flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.
Generalized anxiety disorder	Generalized Anxiety Disorder is a mental health disorder characterized by a perpetual state of worry, fear, apprehension, inability to relax.

ICD codes for the above disorders / conditions are provided in Annexure II.

b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

13. **HIV / AIDS**

What is covered:
We will indemnify the expenses incurred by the Insured Person for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS.

Conditions:

a. The Hospitalization or Day Care Treatment is Medically Necessary and the Illness is the outcome of HIV / AIDS. This needs to be prescribed in writing by a registered Medical Practitioner.
b. The coverage under this benefit is provided for opportunistic infections which are caused due to low immunity status in HIV / AIDS resulting in acute infections which may be bacterial, viral, fungal or parasitic.
c. The patient should be a declared HIV positive.
d. Pre-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 90 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified will also be indemnified under this benefit as per respective sections mentioned.

What is not covered:

a. Chronic health conditions including ischemic heart disease, chronic liver disease, chronic kidney disease, cerebro-vascular disease/ stroke, bronchial asthma and neoplasms which are not directly related to the patient's immunity status would not be covered under this benefit.
b. Lifestyle diseases like diabetes, hypertension, heart diseases and dyslipidemia which are not related to HIV / AIDS would not be covered under this benefit.

14. **Artificial Life Maintenance:**

What is covered:
We will indemnify the expenses incurred by the Insured Person for Artificial life maintenance, including life support machine used to sustain the Insured Person who is not brain dead, up to the limit as specified in Your Policy Schedule

Conditions:

a. Artificial life maintenance is Medically Necessary and prescribed by the treating Medical Practitioner.

What is not covered:
Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

15. **Modern Treatments**

What is covered:
The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment in a hospital up to the limit as specified in Your Policy Schedule.

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy- Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. BronchicalThermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Sub-limit:

a. The following procedures / treatments shall be covered only up to the sub-limit as specified for each procedure / treatment in the below table:

Disorder / Condition	Sub-limit* (Rs.)
Deep Brain Stimulation	5 Lac
Immunotherapy- Monoclonal Antibody to be given as injection	5 Lac
Intra vitreal injections	5 Lac
Robotic surgeries	2.5 Lac
Stereotactic radio surgeries	3.5 Lac
BronchicalThermoplasty	2 Lac
Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	2 Lac

*Maximum payout will be the sub-limit specified or Base Sum Insured, whichever is lower.

b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

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

II. **Optional Benefits**

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

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

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

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

A. **Personal Accident Cover**

What is covered:
This optional benefit is available either to the Primary Insured Person or Primary Insured Person along with his/her spouse, which is specified in the Policy Schedule.

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

1. **Accident Death (AD)**

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

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

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

1. Loss of use of limbs or sight

   The Insured Person suffers from total and irrecoverable loss of:

   a) The use of two limbs (including paraplegia and hemiplegia) OR
   b) The sight in both eyes OR
   c) The use of one limb and the sight in one eye

2. Loss of independent living

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

   a) Washing: the ability to maintain an adequate level of cleanliness and personal hygiene.
   b) Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary.
   c) Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available.
   d) Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene.
   e) Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.
   f) Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

   Conditions:

   i. The Permanent Total Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
   ii. We will admit a claim under this optional benefit only if the Permanent Total Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Total Disability unless it is irreversible, such as in case of amputation/loss of limbs etc; and
   iii. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Accident Death subject to terms and conditions mentioned therein; and
   iv. We will not make payment under Accident Permanent Total Disability more than once in the Insured Person's lifetime for any and all Policy Periods.
   v. If a claim under this optional benefit is admitted, then coverage for the Insured Person will immediately and automatically cease under Personal Accident Cover and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

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

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

   Conditions:

   a) The Permanent Partial Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
   b) We will admit a claim under this optional benefit only if the Permanent Partial Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Partial Disability, unless it is irreversible; and
   c) If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Accident Death subject to the terms and conditions mentioned therein.
   d) If a claim under this optional benefit has been admitted, then no further claim in respect of the same condition will be admitted under this optional benefit.
   e) If a claim under this optional benefit is paid and the entire Personal Accident Sum Insured specified in the Policy Schedule does not get utilized, then the balance Personal Accident Cover Sum Insured shall be available for further claims under Personal Accident Cover until the entire Personal Accident Cover Sum Insured is consumed. The Personal Accident Cover Sum Insured specified in the first Policy Schedule shall be a lifetime limit for the Insured Person and once this limit is exhausted, coverage for the Insured Person will immediately and automatically cease under Personal Accident Cover and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person

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

B. **Critical Illness Cover**

What is covered:
IThis optional benefit is available either to the Primary Insured Person or Primary Insured Person along with his/her spouse, which is specified in the Policy Schedule.

If the Insured Person covered under this optional benefit is diagnosed for the first time with any of the following listed Critical Illnesses or if any of the following Critical Illnesses occurs or manifests itself in the Insured Person during the Policy Period for the first time, We will pay the Critical Illness Sum Insured specified in the Policy Schedule provided that the Insured Person survives the Survival Period of 30 days from the diagnosis of the Critical Illness during the Policy Period.

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 behaviour, 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 be low and with mitotic count of less than or equal to 5/50 HPFs;

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
   iii. 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.

3. **Open Chest3 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

4. **Open Heart Replacement or Repair of Heart Valves**

I. 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.

5. **Coma of Specified Severity**

I. 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:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded

6. **Kidney Failure requiring Regular Dialysis**

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

7. **Stroke resulting in Permanent Symptoms**

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **Major Organ /Bone Marrow Transplant**

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

9. **Permanent Paralysis of Limbs**

I. 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.

10. **Motor Neuron Disease with Permanent Symptoms**

I. Motor neuron 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.

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

12. **Deafness**

I. 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.

13. **End Stage Lung Failure**

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
   iv. Dyspnea at rest.

14. **End Stage Liver Failure**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

15. **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.

16. **Third Degree Burns**

I. 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.

17. **Fulminant Viral Hepatitis**

I. 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:
   i. rapid decreasing of liver size; and
   ii. necrosis involving entire lobules, leaving only a collapsed reticular framework; and
   iii. rapid deterioration of liver function tests; and
   iv. deepening jaundice; and
   v. hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria

18. **Aplastic Anemia**

I. 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:
   i. Absolute neutrophil count of less than 500/mm^3
   ii. Platelets count less than 20,000/mm^3
   iii. 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

19. **Muscular Dystrophy**

I. 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 electromyography 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:

a. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene
b. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary
c. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available

d. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
e. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence
f. 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

20. **Bacterial Meningitis**

I. 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.

Conditions applicable to 'Critical Illness cover':

a. We will not make payment under Critical Illness Cover more than once in the Insured Person's lifetime for any and all Policy Periods
b. The diagnosis of a Critical Illness must be verified in writing by a Medical Practitioner.
c. The Waiting Periods specified below shall be applicable to the Insured Person and claims shall be assessed accordingly. On Renewal, if the Critical Illness Cover Sum Insured specified in the Policy Schedule is enhanced, the Waiting Periods would apply afresh to the extent of the increase in benefit amount limit, subject to Underwriting Guidelines and in accordance with the existing guidelines of the IRDAI.

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

i. **Pre-existing Diseases:**

a. All the listed Critical Illnesses under the optional benefit, which occurs or manifests itself as a result of any Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with Us.
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 (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under this optional benefit after the expiry of 48 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

Pre-existing Disease waiting period shall be applicable only if the pre-existing medical condition is the direct cause of any Critical Illness and confirmed by the Medical Practitioner.

ii. **90-day waiting pe+riod:**

a. All the listed Critical Illnesses under the optional benefit, which occurs or manifests itself within 90 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.
d. If the Insured Person is diagnosed / undergoes a Surgical Procedure or any medical condition occurs falling under the definition of Critical Illness as specified above that may result in a claim, then We shall be given written notice immediately and in any event within 7 days of the aforesaid Illness/ condition/ Surgical Procedure.
e. We shall not be liable to make any payment under this optional benefit if the Insured Person does not survive the Survival Period.
f. If diagnosis of the Critical Illness takes place on or before the Policy expiry date specified in the Policy Schedule, but the Survival Period expires after the Policy expiry date, such claims would be admissible if the Insured Person survives the Survival Period.
g. In the event of death of the Insured Person post the Survival Period, the immediate family member/relative of the Insured Person claiming on Insured Person's behalf must inform Us in writing immediately and send a copy of all the required documents to prove the cause of death within 30 days of the death. We upon acceptance of the admission of claim under the Policy shall make payment to the Nominee/ legal heirs of the Insured Person.
h. If We have admitted a claim under this optional benefit for an Insured Person in any Policy Year, this optional benefit shall not be renewed in respect of that Insured Person for any subsequent Policy Year, but the cover for this optional benefit will be renewable for other Insured Persons.

C. **Modification in Room Rent**

If this optional benefit is in force under the Policy, then the maximum eligibility for a room category in case of Hospitalization of the Insured Person payable by Us will be limited to stay in a Single Private Room.

III. **Claim Cost Sharing**

The following claim cost sharing options shall apply under the Policy if specified in the Policy Schedule and shall apply to all Insured Persons. These claim cost sharing options can be selected only at the time of issuance of the First Policy and cannot be altered at Renewal by You unless as specified below:

1. **Annual Aggregate Deductible**

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

It is further agreed that:

a. Deductible will not apply to any claim under e-Consultation, Personal Accident Cover and Critical Illness Cover.

b. Deductible option can be altered without any medical underwriting or pre policy medical check-up, subject to the following conditions:
   i. This option can be availed only once in a lifetime and at the time of Renewal, post completion of 5 Policy Years; and
   ii. The eldest member's Age in the Policy has not crossed 50 years.
   iii. In case of waiver of Deductible, We will offer an option, at the time of renewal, to opt for an equivalent indemnity health insurance Policy (without any Deductible) offered by Us for same Sum Insured. Your current Policy will lapse in case You exercise the option of waiver of Deductible.

IV. **Waiting Periods**

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if the Sum Insured is enhanced, the Waiting Periods would apply afresh to the extent of the increased Sum Insured only. The Waiting Periods set out below shall not apply to e-Consultation, Personal Accident Cover and Critical Illness Cover.

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

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

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

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 (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.

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

2. **Specified disease/procedure waiting period- Code- Excl02**

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

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

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures:
   i. Pancreatitis and stones in biliary and urinary system
   ii. Cataract, glaucoma and other disorders of lens, disorders of retina
   iii. Hyperplasia of prostate, hydrocele and spermatocele

iv. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
vi. Hernia of all sites,
vii. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
viii. Chronic kidney disease and failure
ix. Varicose veins of lower extremities
x. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
xi. Ulcer, erosion and varices of gastro intestinal tract
xii. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
xiii. Internal Congenital Anomaly
xiv. Surgery of Genito-urinary system unless necessitated by malignancy
xv. Spinal disorders

3. **30-day waiting period (Code- Excl03):**
   a. Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
   c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

4. **Personal Waiting Periods:**

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

V. **Permanent Exclusions:**

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

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy. Exclusions 1 to 27 are not applicable to Personal Accident Cover.

The permanent exclusions applicable to Personal Accident Cover have been specified separately under exclusion 28.

1. **Investigation & Evaluation (Code-Excl04)**
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

   Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a. Surgery to be conducted is upon the advice of the Doctor
   b. The surgery/Procedure conducted should be supported by clinical protocols.
   c. The member has to be 18 years of age or older and;

d. Body Mass Index (BMI);
   i. greater than or equal to 40 or
   ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      1. Obesity-related cardiomyopathy
      2. Coronary heart disease
      3. Severe Sleep Apnea
      4. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. **Birth control, Sterility and Infertility (Code-Excl17)**

    Expenses related to Birth Control, sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization

15. **Maternity Expenses (Code-Excl18)**
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
    b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

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

17. **Circumcision**:

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

18. **Conflict & Disaster:**

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

19. **External Congenital Anomaly:**

    Screening, counseling or treatment related to external Congenital Anomaly.

20. **Dental/oral treatment:**

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

21. **Hormone Replacement Therapy:**

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

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

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

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

24. **Sleep disorders:**

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

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

26. Any expenses incurred on OPD treatment

27. **Unrecognized Physician or Hospital:**
    a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
    b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
    c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

28. **Permanent Exclusions for Personal Accident Cover**

    We shall not be liable to make any payment under any benefits under Personal Accident Cover if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:
    1. Suicide or self inflicted Injury, whether the Insured Person is medically sane or insane.
    2. 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.

3. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time.
4. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule.
5. Committing an assault, a criminal offence or any breach of law with criminal intent.
6. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.
7. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.
8. Engaging in or taking part in professional/adventure sports or any hazardous pursuits, speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, polo, snow and ice sports, hunting.

VI. Claims Process & Requirements

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

1. Claims Administration:

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

a. We advise You to submit all claims related documents, including documents for claims within the Deductible amount, once the Deductible limit has been exhausted.
b. We/Our Service Provider must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
c. We and Our Service Provider must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.
d. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of such change will be considered on merits where the change has been proven to be for reasons beyond the claimant's control.

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

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

i. Process for Obtaining Pre-Authorization

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

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

All final authorization requests, if required, shall be sent at least six hours prior to the Insured Person's discharge from the Hospital.

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

I. The health card We have issued to the Insured Person at the time of inception of the Policy (if available) supported with KYC document;
II. The Policy Number;
III. Name of the Policyholder;
IV. Name and address of Insured Person in respect of whom the request is being made;
V. Nature of the Illness/Injury and the treatment/Surgery required;
VI. Name and address of the attending Medical Practitioner;
VII. Hospital where treatment/Surgery is proposed to be taken;
VIII. Date of admission;
IX. First and any subsequent consultation paper / Medical Record since beginning of diagnosis of that treatment/Surgery;
X. Admission note;
XI. Treating Medical Practitioner certificate for Illness / Insured Event history with justification of Hospitalization.

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

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

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

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

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

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

b. **For Reimbursement Claims:**

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

i. The Policy Number;
ii. Name of the Policyholder;
iii. Name and address of the Insured Person in respect of whom the request is being made;
iv. Nature of Illness or Injury and the treatment/Surgery taken;
v. Name and address of the attending Medical Practitioner;
vi. Hospital where treatment/Surgery was taken;
vii. Date of admission and date of discharge;
viii. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

3. **Claims Documentation:**

For medical claims – Reimbursement Facility:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Event giving rise to a claim or within 30 days from the date of occurrence of an Insured Event or completion of Survival Period (in case of Critical Illness Cover).

For medical claims – Cashless Facility:

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

Necessary information and documentation for medical claims

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

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

c. Age / Identity proof document of Insured Person in case of claim approved under Cashless Facility (not required if submitted at the time of pre-authorization request) and Policyholder in case of Reimbursement claim.
   i. Self attested copy of valid age proof (passport / driving license / PAN card / class X certificate / birth certificate);
   ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);
   iii. Recent passport size photograph

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

e. Original discharge summary.

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

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

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

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

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

j. For Medico-legal cases (MLC) or in case of Accident
   i. MLC/ Panchnama / First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);
   ii. Original self-narration of incident in absence of MLC / FIR.

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

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

For Personal Accident claims

Additional claim documentation for Personal Accident Cover:

1. Accident Death
   i. Copy of death certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
   ii. Copy of post mortem report wherever applicable

2. Accident Permanent Total Disability or Accident Permanent Partial Disability
   i. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government.

For Critical Illness claims

Additional claim documentation for Critical Illness Cover:

1. Treating Medical Practitioner's certification for insured person's survival post survival period.

4. **Claims Assessment & Repudiation:**

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

b. We shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim has fallen due.

c. Payment for Reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

d. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.

e. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-
   i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Inpatient benefit.
   ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per policy terms and conditions exceeds the Deductible limit within the same Policy Year.

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

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

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

6. **Claims process for e-Consultation:**

After validation of Insured Person and Policy details, We will evaluate the information of the Insured Person from the perspective to check eligibility of cover only and if the request is approved, We will facilitate arrangement as per the conditions specified under respective benefits admissible to the Insured Person.

VII. Portability and Migration

Portability:

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the premium due date of his / her existing Policy as per extant guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General / Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per extant guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

Migration

The Insured Person will have the option to migrate the Policy to other health insurance products / plans offered by the Company policy by applying for migration of the policy 30 days before the premium due date of his / her existing Policy as per extant guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product / plan offered by the Company, the proposed insured person will get the accrued continuity benefits in waiting periods as per extant guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

VIII. General Terms and Conditions

1. **Free Look Period**

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days (thirty days for policies with a term of 3 years, if sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges

2. **Cancellation**

a. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

1 year		2 year		3 year	
Policy in-force up to	**Refund Premium (%)**	**Policy in-force up to**	**Refund Premium (%)**	**Policy in-force up to**	**Refund Premium (%)**
Up to 30 days	75%	Up to 30 days	87.5%	Up to 30 days	90%
31 to 90 days	50%	31 to 90 days	75%	31 to 90 days	87.5%
91 to 180 days	25%	91 to 180 days	62.5%	91 to 180 days	75%
exceeding 180 days	0%	181 to 365 days	50%	181 to 365 days	60%
		366 to 455 days	25%	366 to 455 days	50%
		456 to 545 days	12%	456 to 545 days	25%
		Exceeding 545 days	0%	545 to 720 days	12%
				Exceeding 720 days	0%

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

In case of death of an Insured, pro-rate refund of the premium for the deceased insured will be refunded, provided there is no history of claim

3. **Automatic Cancellation:**

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

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

iii. Refund:
A refund in accordance with the table above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and e-Consultation has not been availed under the Policy by or on behalf of any Insured Person. We will pay the refund of premium to the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

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

i. The table below indicates where a medical checkup is initially required with the proposal form, based on the age. The validity of medical tests would be; for medical tests reports with test result within normal range, the validity is for 6 months from the date of tests done, whereas for medical tests reports with test result not within the normal range, validity is for 3 months from the date of tests done.

Underwriting Grid			
Age Band (Completed years)	**E-saver** (Annual Aggregate Deductible – Rs, 10,000/ Rs. 25,000 / Rs. 50,000)	**Super Top-up** (Annual Aggregate Deductible - Rs. 1 lac to Rs. 10 lac)	**Additional Considerations**
Birth to < 1 year	Birth Discharge summary or/and MER #	Birth Discharge summary or/and MER #	Medical underwriting may be triggered based on health declaration by the proposer or based on BMI or BMI for Age value*
1 to 44 years	Nil	Nil	
45 to 54 years	Pre-policy Medical Checkup (PPMC)	Nil	
55 years and above	Pre-policy Medical Checkup (PPMC)	Pre-policy Medical Checkup (PPMC)	

- A health declaration will result in referral to the underwriter. Based on the assessment and information available, the medical underwriter may trigger a PPMC.
- Ported policies will be referred for underwriting and necessary risk assessment.
- # In case of non-availability of discharge summary or incomplete information therein, underwriter will exercise the discretion to trigger appropriate medical test(s) or decline proposed life in view of potential medical risk(s).
- * For less than 18 years of age, BMI for age will be considered and for above 18 years of age BMI will be considered.
- Entry age for Adults is 18 years to 65 Years and from 91 days to 25 years for children (Dependent children). New born children can be added to existing policies post 90 days of birth
- Critical Illness benefit can be offered subject to acceptance of base cover under 'E-saver' or 'Super Top-up'.
- Acceptance of Critical Illness is not automatic and will be independently assessed even if indemnity cover is offered

The medical checkups are spread in levels depending on the age, type of plan and sum insured.

Standard Tests under PPMC may include tests such as (but not limited to): MER, RUA, T Cholesterol, LDL, HbA1c, ECG, SGPT, SGOT, S Creatinine, GGT.

The underwriter may seek additional medical tests or past medical records if required for making an informed underwriting assessment and decision.

The following grid of cost of tests sharing will be applicable on costs incurred towards PPMC:

Accepted Proposal	Decline Proposal
100% of cost to be borne by Niva Bupa	100 % to be borne by Proposer

For all the plans under this product in case customer requests for cancellation of an accepted proposal, Proposer will bear 100% of the cost incurred towards PPMC.

During the underwriting process, each individual's medical history will be evaluated for risk and upon full assessment of facts, based on the severity and prognosis of the condition(s), it will be ascertained whether the proposed insured's declared condition presents a future medical risk.

Three potential options will be determined as per the underwriting guidelines.

1. Standard risk – accept application with no condition exclusion(s)
2. Sub-standard risk – Such proposals are accepted by applying pertinent waiting periods of 24 months to the proposed insured(s), as applicable.
3. Risk outside of Niva Bupa's risk appetite – decline the proposal. We may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. We will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

Where proposals are not accepted due to unacceptable risk then they too will receive communications from Us advising of the same and specific reasons for the cover denied.

5. Loading on Premium

There is no premium loading applicable basis the health status of the Insured under the Policy.

6. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
V. No loading shall apply on renewals based on individual claims experience

7. **Other Renewal Conditions**

a. **Continuity of benefits on Timely Renewal:**

i. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period

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

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

B. You change any coverage provision

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

b. **Reinstatement:**

i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting policy and no continuing benefits shall be available from the expired Policy.

ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your Policy.

iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. **Disclosures on Renewal:**

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

d. **Renewal for Insured Persons who have achieved Age 26:**

If any Insured Person who is a child and has completed Age 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

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

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

f. **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 shall apply afresh for this enhanced limit from the effective date of such enhancement.

8. **Change of Policyholder**

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

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

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

9. **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.

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

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

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

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

12. **Fraud**

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy: a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact; c) any other act fitted to deceive; and d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer

13. **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.

14. **Territorial Jurisdiction**

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

15. **Notices**

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

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

b. Us at the following address:
Niva Bupa Health Insurance Company Limited
2nd Floor, Plot No D-5, Sector 59,
Noida, Gautam Budhnagar – 201301
Fax No.: +91 11 41743397

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

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

16. **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.

17. **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.

18. **Withdrawal of Policy**

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. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

19. **Redressal of Grievances:**

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

Website: www.nivabupa.com
Toll free: 1860-500-8888
E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)
Fax: 011-4174-3397
Courier: Customer Services Department
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:
Head – Customer Services
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,Uttar Pradesh, 201301
Contact No: 1860-500-8888
Fax No: 011-4174-3397
Email ID: Email our Grievance officer through our Grievance Redressal platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx
For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx
If the Insured Person is not satisfied with the above, they can escalate to our Grievance Redressal officer through our platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx.
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 (Refer below Annexure).

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

20. **Assignment**

The Policy can be assigned subject to applicable laws.

21. **Moratorium Period**

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

22. **Multiple 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 insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

b) Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

c) If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

d) Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

23. **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.

24. **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.

If you wish to know more about Niva Bupa's Health Recharge and/ or would like a personal quote, speak to our specially trained sales team or your local advisor. They'll take time to fully understand your requirements and help you to select the right plan for you.

Phone 1860-500-8888 (Toll Free)

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. (2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

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

Base Sum Insured (SI) per Policy Year (in Lacs)	2 L	3 L / 4 L	5 L / 7.5 L / 10L / 15L / 25L / 40L / 45L / 65L / 70L / 90L / 95L
Annual aggregate Deductible	E-saver: 10k, 25k, 50k Super Top-up: 1L to 10L in multiples of 1L		
Baseline cover benefits			
In-patient treatment			
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges	Covered up to Sum Insured		
Medical Practitioners' fees, excluding any charges or fees for Standby Services			
Physiotherapy, investigation and diagnostics procedures directly related to the current admission			
Medicines, drugs and consumables as prescribed by the treating Medical Practitioner			
Intravenous fluids, blood transfusion, injection administration charges and /or consumables			
Operation theatre charges			
The cost of prosthetics and other devices or equipment if implanted internally during Surgery			
Intensive Care Unit charges			
Room Rent (per day)	Up to 1% of Base Sum Insured per day		Single private room; up to Sum Insured
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured		
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured		
Day Care Treatment	Covered up to Sum Insured		
Domiciliary treatment	Covered up to Sum Insured		
Alternative treatment	Covered up to Sum Insured		
Living Organ Donor Transplant	Covered up to Sum Insured		
Emergency Ambulance	Up to Rs.1,500 per hospitalization		
e-Consultation	Unlimited tele / online consultations		
Pharmacy and diagnostic services	Available through our empanelled service provider		
Loyalty Additions	Increase of 5% of expiring Base Sum Insured in a Policy Year; maximum up to 50% of Base Sum Insured; no increase in sub-limits (This benefit is applicable only for Base Sum Insured up to Rs. 25 Lac)		
Mental Disorders Treatment	Covered up to Sum Insured (sub-limit applicable on few conditions)		
HIV / AIDS	Covered up to Sum Insured		
Artificial Life Maintenance	Covered up to Sum Insured		
Modern Treatments	Covered up to Sum Insured (sub-limit applicable on few conditions)		

OPTIONAL BENEFITS (which may be added at customer level at an additional premium)		
Personal Accident cover - Accident Death - Accident Permanent Total Disability - Accident Permanent Partial Disability	Options available: 1Lac, 2Lacs, 5Lacs to 50Lacs (in multiple of 5Lacs)	
Critical illness cover	Options available: 1Lac to 10Lacs (in multiple of 1 Lac)	
Modification in room rent	Single private room; covered up to Sum Insured (optional available only for deductible more than 50,000)	Not applicable

E-saver				
Ded \ SI	200,000	300,000	400,000	500,000
10,000	Y	Y	Y	Y
25,000	Y	Y	Y	Y
50,000	Y	Y	Y	Y

Super Top-up														
Ded \ SI	2Lac	3Lac	4Lac	5Lac	7.5Lac	10Lac	15Lac	25Lac	40Lac	45Lac	65Lac	70Lac	90Lac	95Lac
100,000	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N
200,000	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
300,000	N	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N
400,000	N	N	Y	Y	Y	Y	Y	N	N	N	N	N	N	N
500,000	N	N	N	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y
600,000	N	N	N	N	Y	Y	Y	Y	N	N	N	N	N	N
700,000	N	N	N	N	Y	Y	Y	Y	N	N	N	N	N	N
800,000	N	N	N	N	N	Y	Y	Y	N	N	N	N	N	N
900,000	N	N	N	N	N	Y	Y	Y	N	N	N	N	N	N
1,000,000	N	N	N	N	N	Y	Y	Y	Y	N	Y	N	Y	N

Annexure II
ICD codes for the specified disorders / conditions

Disorder / Condition	ICD Codes
Severe Depression	F33- F33.9 O90.6, F34.1, F32.0 - F32.9, F30.0 - F30.9, F43.21
Schizophrenia	F20.0 - F20.8, F21 - F24, F25 - F25.9
Bipolar Disorder	F31.0 - F31.9
Post traumatic stress disorder	F43.0, F43.1, F43.2, F43.8, F43.9
Generalized anxiety disorder	F40.1, F41- F41.8, F40.8- F40.9, F60.7, F93.0- F94.0

Annexure III
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
1	Baby Food	35	Oxygen Cylinder (For Usage Outside The Hospital)
2	Baby Utilities Charges	36	Spacer
3	Beauty Services	37	Spirometre
4	Belts/ Braces	38	Nebulizer Kit
5	Buds	39	Steam Inhaler
6	Cold Pack/Hot Pack	40	Armsling
7	Carry Bags	41	Thermometer
8	Email / Internet Charges	42	Cervical Collar
9	Food Charges (Other Than Patient's Diet Provided By Hospital)	43	Splint
10	Leggings	44	Diabetic Foot Wear
11	Laundry Charges	45	Knee Braces (Long/ Short/ Hinged)
12	Mineral Water	46	Knee Immobilizer/Shoulder Immobilizer
13	Sanitary Pad	47	Lumbo Sacral Belt
14	Telephone Charges	48	Nimbus Bed Or Water Or Air Bed Charges
15	Guest Services	49	Ambulance Collar
16	Crepe Bandage	50	Ambulance Equipment
17	Diaper Of Any Type	51	Abdominal Binder
18	Eyelet Collar	52	Private Nurses Charges- Special Nursing Charges
19	Slings	53	Sugar Free Tablets
20	Blood Grouping And Cross Matching Of Donors Samples	54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
21	Service Charges Where Nursing Charge Also Charged	55	Ecg Electrodes
22	Television Charges	56	Gloves
23	Surcharges	57	Nebulisation Kit
24	Attendant Charges	58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	59	Kidney Tray
26	Birth Certificate	60	Mask
27	Certificate Charges	61	Ounce Glass
28	Courier Charges	62	Oxygen Mask
29	Conveyance Charges	63	Pelvic Traction Belt
30	Medical Certificate	64	Pan Can
31	Medical Records	65	Trolly Cover
32	Photocopies Charges	66	Urometer, Urine Jug
33	Mortuary Charges	67	Ambulance
34	Walking Aids Charges	68	Vasofix Safety

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

Sl. No.	Item	Sl. No.	Item
1	Baby Charges (Unless Specified/Indicated)	20	Luxury Tax
2	Hand Wash	21	Hvac
3	Shoe Cover	22	House Keeping Charges
4	Caps	23	Air Conditioner Charges
5	Cradle Charges	24	Im Iv Injection Charges
6	Comb	25	Clean Sheet
7	Eau-De-Cologne / Room Freshners	26	Blanket/Warmer Blanket
8	Foot Cover	27	Admission Kit
9	Gown	28	Diabetic Chart Charges
10	Slippers	29	Documentation Charges / Administrative Expenses
11	Tissue Paper	30	Discharge Procedure Charges
12	Tooth Paste	31	Daily Chart Charges
13	Tooth Brush	32	Entrance Pass / Visitors Pass Charges
14	Bed Pan	33	Expenses Related To Prescription On Discharge
15	Face Mask	34	File Opening Charges
16	Flexi Mask	35	Incidental Expenses / Misc. Charges (Not Explained)
17	Hand Holder	36	Patient Identification Band / Name Tag
18	Sputum Cup	37	Pulseoxymeter Charges
19	Disinfectant Lotions		

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

Sl. No.	Item	Sl. No.	Item
1	Hair Removal Cream	13	Surgical Drill
2	Disposables Razors Charges (For Site Preparations)	14	Eye Kit
3	Eye Pad	15	Eye Drape
4	Eye Sheild	16	X-Ray Film
5	Camera Cover	17	Boyles Apparatus Charges
6	Dvd, Cd Charges	18	Cotton
7	Gause Soft	19	Cotton Bandage
8	Gauze	20	Surgical Tape
9	Ward And Theatre Booking Charges	21	Apron
10	Arthroscopy And Endoscopy Instruments	22	Torniquet
11	Microscope Cover	23	Orthobundle, Gynaec Bundle
12	Surgical Blades, Harmonicscalpel,Shaver		

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

Sl. No.	Item	Sl. No.	Item
1	Admission/Registration Charges	10	Hiv Kit
2	Hospitalisation For Evaluation/ Diagnostic Purpose	11	Antiseptic Mouthwash
3	Urine Container	12	Lozenges
4	Blood Reservation Charges And Ante Natal Booking Charges	13	Mouth Paint
5	Bipap Machine	14	Vaccination Charges
6	Cpap/ Capd Equipments	15	Alcohol Swabes
7	Infusion Pump– Cost	16	Scrub Solution/Sterillium
8	Hydrogen Peroxide\Spirit\ Disinfectants Etc	17	Glucometer & Strips
9	Nutrition Planning Charges - Dietician Charges- Diet Charges	18	Urine Bag

Benefit Illustration

Benefit Illustration (25 Lac Sum Insured with 5 Lac Deductible, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
Illustration 1										
18	1,267.00	25,00,000	NA	NA	NA	NA	1,267.00	1,595.00	5,141.00	25,00,000
21	1,267.00	25,00,000	NA	NA	NA	NA	1,267.00			
39	1,641.00	25,00,000	NA	NA	NA	NA	1,641.00			
45	2,561.00	25,00,000	NA	NA	NA	NA	2,561.00			
Total premium for all members of the family is **Rs.6,736**, when each member is covered separately.			Total premium for all members of the family is **Rs.NA**, when they are covered under a single policy.				Total premium when the policy is opted on floater basis is **Rs.5,141**.			
Sum Insured available for each individual is **Rs.2,500,000.**			Sum Insured available for each family member is **Rs.NA**.				Sum Insured of **Rs.2,500,000** is available for the entire family.			
Illustration 2										
55	5,320.00	25,00,000	NA	NA	NA	NA	5,320.00	1,994.00	10,573.00	25,00,000
63	7,247.00	25,00,000	NA	NA	NA	NA	7,247.00			
Total premium for all members of the family is **Rs.12,567**, when each member is covered separately.			Total premium for all members of the family is **Rs.NA**, when they are covered under a single policy.				Total premium when the policy is opted on floater basis is **Rs.10,573**.			
Sum Insured available for each individual is **Rs.2,500,000**.			Sum Insured available for each family member is **Rs.NA**.				Sum Insured of **Rs.2,500,000** is available for the entire family.			
Illustration 3										
65	7,247.00	25,00,000	NA	NA	NA	NA	7,247.00	3,101.00	12,279.00	25,00,000
70	8,133.00	25,00,000	NA	NA	NA	NA	8,133.00			
Total premium for all members of the family is **Rs.15,380**, when each member is covered separately.			Total premium for all members of the family is **Rs.NA**, when they are covered under a single policy.				Total premium when the policy is opted on floater basis is **Rs.12,279**.			
Sum Insured available for each individual is **Rs.2,500,000**.			Sum Insured available for each family member is **Rs.NA**.				Sum Insured of **Rs.2,500,000** is available for the entire family.			

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