ReAssure 2.0
Policy Wordings

1. Preamble

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

2. Definitions

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

2.1. Standard Definitions:

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

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

a. Central or state government AYUSH Hospital; or

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

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

i. Having at least five in-patient beds;

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

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

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

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

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

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

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

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

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

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

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

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

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

a. has Qualified Nursing staff under its employment;

b. has qualified Medical Practitioner(s) in charge;

c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and

b. which would have otherwise required a Hospitalization of more than 24 hours.

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

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

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

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

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

b. the patient takes treatment at home on account of non availability of room in a Hospital.

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

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

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

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

a. has Qualified Nursing staff under its employment round the clock;

b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;

c. has qualified Medical Practitioner(s) in charge round the clock;

d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

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

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

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

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

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

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

d. it continues indefinitely

e. it recurs or is likely to recur

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

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

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

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

2.1.23. **Maternity Expenses shall include:**

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization)

b. Expenses towards lawful medical termination of pregnancy during Policy Period.

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

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

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

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

a. is required for the medical management of the Illness or Injury suffered by the insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a Medical Practitioner;

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

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

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

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

2.1.33. **Pre-existing Disease** means any condition, ailment, injury or disease

a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer, or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2. Specific Definitions

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

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

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

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

3. Sum Insured(s)

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

1. Base Sum Insured
2. Booster+ Sum Insured
3. Safeguard/Safeguard+ Sum Insured
4. ReAssure+/ReAssureX

4. Benefits available under the policy.

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

4.1. Expenses in reaching a Hospital

4.1.1. **Road Ambulance:** We will pay you up to Sum Insured.

4.1.2. **Air Ambulance:** Only in case of Emergency. Maximum INR 2,50,000 per hospitalization.

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

4.2. Expenses during Hospitalization

4.2.1. We will pay the expenses incurred by you on treatment (Naturally this excludes expenses not linked to treatment like food, beverage, toiletries and cosmetics). We don't limit your choice. Choose the room you like, but choose judiciously to protect your Sum Insured.

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

Note:

- **We will NOT pay, even if you were hospitalized, if there was no treatment and only investigations were done. Examples: MRI, CT Scan, Endoscopy, Colonoscopy etc.**
- **We will NOT pay for Automation machine for peritoneal dialysis**

4.2.2. **We** pay for **Modern treatments** as specified below:

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

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

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

4.4. Home Care / Domiciliary Treatment

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

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

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

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

Note:

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

4.5. Organ donor

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

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

4.6. Annual Health Checkup

Available once every Policy Year, from day 1 of the policy. You can choose any test(s) from the list specified below up to your eligibility limit. The tests MUST be booked through our digital assets (e.g. Mobile App). This benefit is available ONLY on cashless and no re-imbursement is allowed.

List of tests covered:		
Complete blood count (CBC)	Complete Physical Examination by Physician	Serum Electrolytes
Urine Routine & Microscopic	Post prandial/lunch blood sugar (PPBS / PLBS)	HbA1C
Erythrocyte Sedimentation Rate (ESR)	Uric Acid	Thyroid function test
Fasting Blood sugar (FBS)	Lipid Profile	Liver Function Test (LFT)
Electrocardiogram (ECG)	Kidney function test	Treadmill test (TMT) OR 2 D ECHO
X Ray chest	Serum Vitamin D	Ultrasound test (USG)
Mammogram	Colonoscopy (for >50 year olds)	Serum calcium
PAP smear		

Note:

If you undergo multiple tests, make sure that all these are done within 7 days. Unutilized amount will not be carried forward to next policy year.

4.7. ReAssure+

4.7.1. **ReAssure "Forever":** Enjoy unlimited Sum Insured. The first paid claim in the life of the policy triggers ReAssure "Forever". Once Triggered it stays for life, provided that the policy is renewed without break.

Note:

- **Maximum amount ReAssure+ pays for any single claim is up to Base Sum Insured.**
- We will consider a claim, if it is paid under the following: **Expenses in reaching a Hospital, Expenses during Hospitalization,** Expenses before and after hospitalization, **Home Care / Domiciliary Treatment, Organ Donor.**
- Expenses in reaching a Hospital and Expenses before and after hospitalization for the 1st ever hospitalization will be treated as the 1st claim itself.

Illustration:

Year 1: Once the Policy is bought.

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

Year 2: Once the policy is renewed:

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

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

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

Note:

- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age. No additional premium will be charged In the middle of the tenure in case of claims.

  At the time of renewal (in case of a claim), the premium will be charged as per the current age of the consumer at renewal.
- If you add a member to the floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If you add a member to an individual plan and convert it into a Floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member in the policy amongst the remaining members and lock at that age, till a claim is paid.
- If a floater plan, splits into multiple policies, then we will carry forward the locked age at which the floater policies were taken by individuals (as per the claim history) in the policies carried forward, till a claim is paid.
- In a multi individual policy, the age will unlock only for the individuals who claim.
- In a floater policy, if a claim is paid for anyone in the plan then we will unlock the age for the entire policy.
- We will consider a claim, if a claim is paid under the following: **Expenses in reaching a Hospital, Expenses during Hospitalization,** Expenses before **and after hospitalization, Home Care / Domiciliary Treatment, Organ Donor.**

4.8. ReAssureX

Enjoy unlimited Sum Insured. The first paid claim in the life of the policy triggers ReAssure "Forever". Once Triggered it stays for life, provided that the Policy is renewed without break.

Note:

- **Maximum amount ReAssureX pays for any single claim is up to Base Sum Insured.**
- We will consider a claim, if it is paid under the following: **Expenses in reaching a Hospital, Expenses during Hospitalization,** Expenses before and after hospitalization, **Home Care / Domiciliary Treatment, Organ Donor.**
- Expenses in reaching a Hospital and Expenses before and after hospitalization for the 1st ever hospitalization will be treated as the 1st claim itself.

Illustration:

Year 1: Once the Policy is bought.

Base Sum Insured	1st paid Claim		Balance Base Sum Insured	2nd payable claim	Claim amount paid	Balance Base Sum Insured	3rd Pay-able claim	Claim amount paid
10 Lakh	7 Lakh	**ReAssureX is triggered (Equal to Base Sum Insured)**	3 Lakh	12 Lakh	12 Lakh (3 Lakh from Base Sum Insured and 9 Lakh from **ReAssureX**	Nil	11 Lakh	10 Lakh from **ReAssureX**

Year 2: Once the policy is renewed:

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

4.9. Booster+

Don't lose what you don't use.

Unutilized Base Sum Insured carries forward. Maximum it will accumulate up to 3/5/10 times (based on the plan you have chosen) of the Base Sum Insured.

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

1.10 Crore Sum Insured (that is 10 Lakh base + 1 Crore Booster+). Don't forget that you would have the Safeguard / Safeguard+ (this is a great benefit. You must choose it) and ReAssure "Forever" (in case of claim) over and above the 1.10 Crore.

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

Note:

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

Insured will fall short in future for advanced treatments. When you enhance your Sum Insured, the accumulated Booster+ Sum Insured will continue and grow even more (remember Booster+ is up to maximum 3/5/10 times (based on the plan you have chosen) of the Base Sum Insured. Higher the Base Sum insured higher the Booster+ Sum Insured).

4.10. Live Healthy

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

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

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

Policy Period: 1 year

Policy Start Date	End of 9 months	Points at the end of 9 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2024) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2023	Up to 1500			0%	0%
		1501 –2250			5%	2.5%
		2251 – 3000			15%	7.5%
		3001 – 3750			20%	10%
		>=3751			30%	15%

Policy Period: 2 years

Policy Start Date	End of 21 months	Points at the end of 21 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2025) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2024	Up to 3000			0%	0%
		3001 – 4500			5%	2.5%
		4501 – 6000			15%	7.5%
		6001 – 7500			20%	10%
		>=7501			30%	15%

Policy Period: 3 years

Policy Start Date	End of 33 months	Points at the end of 33 months (A) This will be considered for discount on the first renewal.	Points in next 3 months (B)	Total points considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st April 2026) NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater	
					Individual sum insured policy and Floater policies with 1 Adult	Floater policies with more than 1 Adult
1 April 2023	31st December 2025	Up to 4500			0%	0%
		4501 – 6750			5%	2.5%
		6751 – 9000			15%	7.5%
		9001 – 11250			20%	10%
		>=11251			30%	15%

4.11. Shared accommodation Cash Benefit

If you opt for a shared room (for which hospitalization claim is paid), we will pay an additional amount for each day's hospitalization. One day is considered as 24 continuous hours of hospitalization.

4.12. Second Medical Opinion

Once in a Policy year, you can choose to take a second medical opinion from any Medical Practitioner for which we have paid a claim under expenses during hospitalization.. Through our partners we can help you get a second opinion from some of the most reputed doctors in the country.

4.13. e-Consultation

You can take Unlimited e-consultations from our Partners.

Optional Benefit:

4.14. Hospital Cash

We will pay for an Insured, an additional fixed amount for each day's hospitalization for maximum up to 30 days. One day is considered as 24 continuous hours of hospitalization.

Note: we will pay if you were hospitalized for 48 hours or more continuously.

4.15. Personal Accident

4.15.1. Accidental Death (AD)

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

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

4.15.2. Permanent Total Disability

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

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

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

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

4.15.3. **Permanent Partial Disability**

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

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

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

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

4.16. Safeguard

4.16.1. **Claim Safeguard:** We will cover non-payable items mentioned in **'List I – Expenses not covered' of Annexure I'**. Clause 2.1.37 for Reasonable and Customary Charges will still apply.

4.16.2. **Booster+ Safeguard:** Booster+ will not be impacted if the total claim in a policy year is up to INR 50,000

4.16.3. **Sum Insured Safeguard:** Preserves the value of Sum Insured. Safeguards it against inflation. We will increase the Base Sum Insured on cumulative basis at each renewal by the rate of inflation in the previous year. Inflation rate would be the average consumer price index (CPI) of the entire calendar year published by the Central Statistical Organization (CSO).

Note: You will lose all accumulated Sum Insured Safeguard if you opt out of this benefit at any point in time.

4.17. Safeguard+

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

4.17.2. **Booster+ Safeguard+:** Booster+ will not be impacted if the total claim in a policy year is up to INR 1,00,000.

4.17.3. **Sum Insured Safeguard+:** Preserves the value of Sum Insured. Safeguards it against inflation. We will increase the Base Sum Insured on cumulative basis at each renewal by the rate of inflation in the previous year. Inflation rate would be the average consumer price index (CPI) of the entire calendar year published by the Central Statistical Organization (CSO).

Note: You will lose all accumulated Sum Insured Safeguard+ if you opt out of this benefit at any point in time.

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

4.18. Annual Aggregate Deductible

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

Note:

a. Deductible amount borne by you should also be payable as per policy terms and conditions.

b. Deductible will **NOT** apply to Annual Health Check-up, Live Healthy, Second Medical Opinion, Shared Accommodation Cash, e-consultation, Personal Accident, Hospital Daily Cash benefits.

4.19. Co-Payment:

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

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

4.20. Pre-Existing Disease Waiting Time Modification

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

4.21. Room Type Modification

You can as per your lifestyle, choose to change the room category we are offering, and opt for what suits you best!

You can choose between a Single Private Room and a Sharing Room. Irrespective of the Room type you choose, ICU admission will always be paid up to Base Sum Insured.

5. Exclusions

5.1. Standard Exclusions

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

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

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

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

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

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

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

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

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

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

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

f. List of specific diseases/procedures:

i. Pancreatitis and stones in biliary and urinary system

ii. Cataract, glaucoma and retinal detachment

iii. Hyperplasia of prostate, hydrocele and spermatocele

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

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

vi. Hernia of any site or type,

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

viii. Varicose veins of lower extremities

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

x. Ulcer, erosion or varices of gastro intestinal tract

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Body Mass Index (BMI);

   i. greater than or equal to 40 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

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

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

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

5.2. Specific Exclusions

5.2.1. **Personal Waiting Period**

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

5.2.2. **Conflict & Disaster:**

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

5.2.3. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

5.2.4. **Dental treatment:**

All dental treatments other than due to accidents and cancers.

5.2.5. **Unrecognized Physician or Hospital:**

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

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

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

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

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

6. General Terms and Clauses

6.1. Standard General Terms and Clauses

6.1.1. Free Look Period

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

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

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

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

Simplified for you

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

6.1.2. Cancellation

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

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

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

Simplified for you

You can cancel your policy whenever you wish.

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

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

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

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

6.1.3. Renewal of Policy

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

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

Simplified for you

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

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

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

c. Coverage is available during the grace period.

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

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

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

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

6.1.5. **Nomination**

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

6.1.6. **Fraud**

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

Any amount already paid against claims made under this 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

Simplified for you

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

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

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.

Note: Non standard decisions are:

- Loading – We ask for additional premium
- Exclusions – We apply a additional waiting period for health conditions or treatments
- Rejection – We hate to do this. But sometimes are compelled to say no to a customer

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

- Cause fraud of any kind

6.1.7. **Withdrawal of Policy**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to either renew (up to 90 days from renewal date) same product or to migrate to a similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

6.1.8. **Redressal of Grievance**:

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

Website:	www.nivabupa.com
Toll- Free:	1860-500-8888
E-mail:	Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)
Fax :	011-41743397
Courier:	Customer Services Department Niva Bupa Health Insurance Company Limited D-5, 2nd Floor, Logix Infotech Park opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Grievance Redressal Officer

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park

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

Contact No: 1860-500-8888

Fax No.: 011-41743397

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

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

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

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

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

6.1.9. **Claim settlement (Provision for Penal interest)**

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

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

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

Simplified for you

We will provide our decision on claim within 15 days from submission of all necessary claim documents. For any delay in payment of claim, we will pay interest on the claim amount at a rate 2% above bank rate.

6.1.10. **Moratorium Period**

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

Simplified for you

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

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

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

6.1.11. **Multiple Policies**

A. Indemnity Based Policies:

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

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

B. Benefit Based Policies:

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

Simplified for you

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

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

6.1.12. **Migration**

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

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

Simplified for you

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

6.1.13. **Portability**

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

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

Simplified for you

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

6.1.14. **Disclosure of Information**

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

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

6.1.15. **Condition Precedent to Admission of Liability**

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

6.1.16. **Complete Discharge**

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

6.1.17. **Premium Payment in Instalments**

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

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

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

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

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

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

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

6.2. Specific Terms and Clauses

6.2.1. **Automatic Cancellation:**

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

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

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

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

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

6.2.3. **Other Renewal Conditions:**

a. Renewal Premium:

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

b. Addition of Insured Persons on Renewal:

If a new member is added in the Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable afresh for that member.

c. Changes to Sum Insured on Renewal:

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

6.2.4. **Claims**

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

b. Documents required with claim form:

Hospital / Medical records:

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

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

- KYC documents
- Cancelled cheque

IMPORTANT:

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

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

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

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

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

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

Please Note:

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

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

6.2.5. **Policy Disputes**

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

6.2.6. **Territorial Jurisdiction**

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

6.2.7. **Alteration to the Policy**

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

6.2.8. **Zonal pricing**

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

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

b. Zone 2: Rest of India

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

6.2.9. **Assignment**

The Policy can be assigned subject to applicable laws.

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

List I – Expenses not covered

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	BABY FOOD	24	ATTENDANT CHARGES	47	LUMBO SACRAL BELT
2	BABY UTILITIES CHARGES	25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	48	NIMBUS BED OR WATER OR AIR BED CHARGES
3	BEAUTY SERVICES	26	BIRTH CERTIFICATE	49	AMBULANCE COLLAR
4	BELTS/ BRACES	27	CERTIFICATE CHARGES	50	AMBULANCE EQUIPMENT
5	BUDS	28	COURIER CHARGES	51	ABDOMINAL BINDER
6	COLD PACK/HOT PACK	29	CONVEYANCE CHARGES	52	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES
7	CARRY BAGS	30	MEDICAL CERTIFICATE	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	31	MEDICAL RECORDS	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	32	PHOTOCOPIES CHARGES	55	ECG ELECTRODES
10	LEGGINGS	33	MORTUARY CHARGES	56	GLOVES
11	LAUNDRY CHARGES	34	WALKING AIDS CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
13	SANITARY PAD	36	SPACER	59	KIDNEY TRAY
14	TELEPHONE CHARGES	37	SPIROMETRE	60	MASK
15	GUEST SERVICES	38	NEBULIZER KIT	61	OUNCE GLASS
16	CREPE BANDAGE	39	STEAM INHALER	62	OXYGEN MASK
17	DIAPER OF ANY TYPE	40	ARMSLING	63	PELVIC TRACTION BELT
18	EYELET COLLAR	41	THERMOMETER	64	PAN CAN
19	SLINGS	42	CERVICAL COLLAR	65	TROLLY COVER
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		

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

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

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

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

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

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

Annexure II - List of Insurance Ombudsmen

Office Details	Jurisdiction
AHMEDABAD Shri Collu Vikas Rao Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: oiooio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Ms. Neerja Kapurs Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oiooio.bengaluru@cioins.co.in	Karnataka
BHOPAL Shri Ajay Kumar Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: oiooio.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh

BHUBANESWAR Shri Bimbadhar Pradhan Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: oiooio.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Ms. Alka Jha Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oiooio.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh
CHENNAI Shri K. Vinayak Rao Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: oiooio.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
DELHI Ms. Sunita Sharma Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: oiooio.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
GUWAHATI Shri Ajay Kumar Sharma Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

HYDERABAD Ms. G Shobha Reddy Office of the Insurance Ombudsman, 6-2-46, 1st floor, “Moin Court”, Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR Shri Satyajeet Rajan Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: oio.jaipur@cioins.co.in	Rajasthan
KOCHI Shri Pradeep Kumar Jain 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja’s College Ground ,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA Ms. Kiran Sahdev Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW Shri Atul Sahai Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: oio.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar

MUMBAI Ms. Sarojini S Dikhale Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: oio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumba
NOIDA Shri Bimbadhar Pradhan Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: oio.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Ms. Susmita Mukherjee Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in	Bihar, Jharkhand
PUNE Shri Sunil Jain Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Shri Umesh Sinha Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

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