

1. Preamble

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

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

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

2. Definitions

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

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

2.1. Standard Definitions

- I. **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- II. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.
- III. **AYUSH Hospital:**

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

 - a. Central or State Government AYUSH Hospital; or
 - b. Teaching Hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council of Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative
- IV. **Associated Medical Expenses** shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.
- V. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
- VI. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to

- form, structure or position.
- a. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
 - b. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.
- VII. Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum Insured.
- VIII. Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
- IX. Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up within a Hospital and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all the following minimum criteria:
- a. has Qualified Nursing staff under its employment;
 - b. has qualified Medical Practitioner(s) in charge;
 - c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
- X. Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:
- a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and
 - b. which would have otherwise required a Hospitalization of more than 24 hours.
- Treatment normally taken on an Out patient basis is not included in the scope of this definition.
- XI. Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
- XII. Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.
- XIII. Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
- a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - b. the patient takes treatment at home on account of non availability of room in a Hospital.
- XIV. Emergency** means a medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
- XV. Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to Renew or continue a policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.
- XVI. 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.
- XVII. Hospitalization or Hospitalized** means the admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
- XVIII. Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
- XIX. Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- XX. ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
- XXI. Illness** means sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
- (a) Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / illness / injury which leads to full recovery
- (b) Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 2. It needs ongoing or long-term control or relief of symptoms
 3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 4. It continues indefinitely
 5. It recurs or is likely to recur
- XXII. Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
- XXIII. Maternity Expense shall mean:**
- a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
 - b. Expenses towards lawful medical termination of pregnancy during the Policy Period.
- XXIV. Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.
- XXV. Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
- XXVI. Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.
- XXVII. Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

- a. is required for the medical management of the Illness or Injury suffered by the insured;
 - b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - c. must have been prescribed by a Medical Practitioner;
 - d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- XXVIII. Migration:** "Migration" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
- XXIX. Network Provider** means Hospital or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
- XXX. Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- XXXI. Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the network.
- XXXII. OPD Treatment** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.
- XXXIII. Pre-existing Disease** means any condition, ailment, Injury or disease
- a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
 - b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the insurer or its reinstatement
- XXXIV. Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
- a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- XXXV. Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital, provided that:
- a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
 - b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- XXXVI. Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
- XXXVII. Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- XXXVIII. Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.
- XXXIX. Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time bound exclusions and for all Waiting Periods.
- XL. Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.
- XLI. Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.2. Specific Definitions

- I. **Age** means age last birthday.
- II. **Base Sum Insured** means the amount stated in the Schedule of Insurance Certificate.
- III. **Bone Marrow Transplant** is a condition where the Insured Person needs necessary medical treatment to replace malignant or defective bone marrow with normal bone marrow from healthy donors to stimulate the production of formed blood cells.
- IV. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
- V. **Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.
- VI. **Complementary & Alternative Medicine** means Alternative Treatments done alone or along with conventional/modern medicine.
- VII. **Diagnostic Tests** means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.
- VIII. **Diagnostic Services** means a broad range of Diagnostic Tests and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.
- IX. **Evidence Based Clinical Practice** means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.
- X. **Family Floater Policy** means a Policy described as such in the Schedule of Insurance Certificate where the family members (two or more) named in the Schedule of Insurance Certificate are insured under this Policy. Only the following family members can be covered under a Family Floater Policy:
 - a. Insured Person; and/or
 - b. Insured Person's legally married spouse (for as long as they continue to be married); and/or
 - c. Insured Person's children who are less than 21 years of Age on the commencement of the Policy Period (maximum 4 children can be covered).
- XI. **Family First Policy** means a Policy described as such in the Schedule of Insurance Certificate where You and Your family members named in the Schedule of Insurance Certificate are insured under this Policy. Only the following family members can be covered under a Family First Policy:
 - a. Your legally married spouse for as long as Your spouse continues to be married to You;
 - b. Son;
 - c. Daughter-in-law as long as Your son continues to be married to Your Daughter-in-law;
 - d. Daughter;
 - e. Son-in-law as long as Your daughter continues to be married to Your Son-in-law;
 - f. Father;
 - g. Mother;
 - h. Father-in-law as long as Your spouse continues to be married to You;
 - i. Mother-in-law as long as Your spouse continues to be married to You;
 - j. Grandfather;
 - k. Grandmother;
 - l. Grandson;
 - m. Granddaughter;
 - n. Brother;
 - o. Sister;
 - p. Sister-in-law;
 - q. Brother-in-law;

- r. Nephew;
- s. Niece.
- XII. First Policy** means the Schedule of Insurance Certificate issued to the Policyholder at the time of inception of the Policy mentioned in the Schedule of Insurance Certificate with Us.
- XIII. Information Summary Sheet** means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.
- XIV. Individual Policy** means a Policy described as such in the Schedule of Insurance Certificate where the individual named in the Schedule of Insurance Certificate is insured under this Policy.
- XV. Insured Person** means person named as insured in the Schedule of Insurance Certificate.
- XVI. IRDAI** means the Insurance Regulatory and Development Authority of India.
- XVII. Medical Devices** are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.
- XVIII. Medical Record** means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by Medical Practitioners who has knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.
- XIX. No Claim Bonus** means an increase to the Base Sum Insured in accordance with the provisions of Section 3.11 in respect of claim free Policy Years.
- XX. Policy** means these terms and conditions, the Schedule of Insurance Certificate (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.
- XXI. Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Schedule of Insurance Certificate or the date of cancellation of this Policy, whichever is earlier.
- XXII. Policy Year** means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.
- XXIII. Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy which specifies the Plan applicable, the Benefits available to the Insured Persons and any sub-limits applicable to each Benefit.
- XXIV. Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.
- XLII. Schedule of Insurance Certificate** means a certificate issued by Us, and, if more than one, then the latest in time. The Schedule of Insurance Certificate contains details of the Policyholder, Insured Persons and the Benefits applicable under the Policy.
- XLIII. Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.
- XLIV. Standby Services** are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.
- XLV. Suite Room means**
 - a. a space available for boarding in a Hospital which contains two or more rooms; Or
 - b. a space available for boarding in a Hospital which contains an extended living/dining/kitchen area
- XLVI. Sum Insured:** In case of Individual Policy, Sum Insured means the total of the Base Sum Insured, re-fill amount as per Section 3.12 and No Claim Bonus as per Section 3.11 which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of the Insured Person. However in case of a single claim, Our maximum liability for that claim during the Policy Year in respect of the Insured Person shall be the total of the Base Sum Insured and No Claims Bonus as per Section 3.11.
In case of Family Floater Policy, Sum Insured means the total of the Base Sum Insured, re-fill amount as per Section 3.12 and No Claim Bonus as per Section 3.11 which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Persons.
In case of Family First Policy, Sum Insured means the total of the Base Sum Insured for each Insured Person,

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

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

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

XXV. Waiting Period means a time-bound exclusion period related to condition(s) specified in the Schedule of Insurance Certificate or the Policy which shall be served before a claim related to such condition(s) becomes admissible.

XXVI. We/Our/Us means Niva Bupa Health Insurance Company Limited.

XXVII. You/Your/Policyholder means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us

3. Benefits covered under the Policy

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

I. Inpatient Care

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

- a. The Hospitalization is Medically Necessary and advised and follows Evidence Based Clinical Practices and Standard Treatment Guidelines.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:
 - i. Room Rent;

- ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
 - iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
 - iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
 - v. Medicines, drugs as prescribed by the treating Medical Practitioner;
 - vi. Intravenous fluids, blood transfusion, injection administration charges, consumables and/or enteral feedings;
 - vii. Operation theatre charges;
 - viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
 - ix. Intensive Care Unit charges.
- c. If the Insured Person is admitted in the Hospital in a room category higher than the eligibility as specified in the Product Benefits Table, then We shall be liable to pay only a pro-rated proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the entitled room category to the Room Rent actually incurred.
 - d. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless such:
 - i. Medical Practitioner's treatment or advice has been sought by the Hospital; and
 - ii. Visiting fees or consultation charges are included in the Hospital's bill; and
 - iii. Visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

II. Pre-hospitalization Medical Expenses

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

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

III. Post-hospitalization Medical Expenses

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

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

IV. Alternative Treatments

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

Pre-hospitalization Medical Expenses incurred for upto 30 days prior to the Alternative Treatments being commenced and Post-hospitalization Medical Expenses incurred for up to 60 days following the Alternative Treatment being concluded will also be indemnified under this Benefit provided that these Medical Expenses relate only to Alternative Treatments only and not Allopathy.

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

V. Day Care Treatment

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

- a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.
- b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.
- c. The following procedures will be covered as Day Care Treatment under this benefit as they each require a period of specialized observation or care after completion of the procedure:
 - i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
 - ii. Renal dialysis (Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)
- d. We will not cover any OPD Treatment and Diagnostic Services under this Benefit.

VI. Domiciliary Hospitalization

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

- a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
- b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.

VII. Living Organ Donor Transplant

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

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

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

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

VIII. Emergency Ambulance

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

- a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to the nearest Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another nearest Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
- b. This benefit is available for one transfer per Hospitalization.

- c. The ambulance service is offered by a healthcare or ambulance Service Provider.
- d. We have accepted a claim under Section 3.1 (Inpatient Care) above.
- e. We will cover expenses upto the amount specified in the Product Benefits Table.
- f. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic centre for evaluation purposes only.

IX. Vaccination for Animal Bite

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

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

X. Health Checkup

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

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

XI. No Claim Bonus

- a. For an Individual Policy or Family Floater Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable) and no claim has been made in the immediately preceding Policy Year, each Policy Year We will increase the Sum Insured applicable under the Policy by 20% of the Base Sum Insured of the immediately preceding Policy Year; subject up to maximum of 100% of the expiring Base Sum Insured. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.
- b. For a Family First Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable) and no claim has been made in the immediately preceding Policy Year, each Policy Year We will increase the Sum Insured applicable under the Policy by 20% of the Base Sum Insured of each individual Insured Person only and the increase shall not apply to the Floater Sum Insured stated in the Schedule of Insurance Certificate as applicable under the Policy; subject up to maximum of 100% of the expiring Base Sum Insured of each individual Insured Person. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.
- c. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated No Claim Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We shall not provide any credit for the accumulated No Claim Bonus to the Family Floater Policy.
- d. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated No Claim Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family First Policy, then the accumulated No Claim Bonus to be carried forward for credit in the Renewing Policy would be the accumulated No Claim Bonus for that Insured Person only.
- e. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated No Claim Bonus for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy with same or higher Base Sum Insured, then the accumulated No Claim Bonus to be carried forward for credit in the Renewing Policy would be the least of the accumulated No

Claim Bonus amongst all the Insured Persons.

- f. If the Insured Persons in the expiring Policy are covered under Family First Policy and have an accumulated No Claim Bonus for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on an Individual Policy with same or higher Base Sum Insured, then the accumulated No Claim Bonus to be carried forward for credit in the Renewing Policy would be the accumulated No Claim Bonus for that Insured Person.
- g. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Schedule of Insurance Certificate in to two or more floater / individual / Family First Policy, then We shall not provide any credit of the accumulated No Claim Bonus to the split Policy.
- h. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated No Claim Bonus shall also be reduced in proportion to the Base Sum Insured.
- i. In case the Base Sum Insured under the Policy is increased at the time of Renewal, the applicable accumulated No Claim Bonus shall be carried forward.
- j. If a claim has been made in the immediately preceding Policy Year, We will not increase or decrease the Sum Insured due to this benefit for the Policy Year. Whereas, if a reported claim has been denied by Us, the Insured Persons will be eligible for this benefit.

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

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

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

XIII. Modern Treatments

The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1 and Section 3.4 respectively, in a Hospital:

- i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- ii. Balloon Sinuplasty
- iii. Deep Brain stimulation
- iv. Oral chemotherapy
- v. Immunotherapy- Monoclonal Antibody to be given as injection
- vi. Intra vitreal injections
- vii. Robotic surgeries
- viii. Stereotactic radio surgeries
- ix. Bronchial Thermoplasty
- x. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- xi. IONM - (Intra Operative Neuro Monitoring)
- xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.
 - a. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections

3.2 and 3.3 within the overall benefit sub-limit.

Special condition applicable for robotic surgeries:

A limit of maximum INR 1 Lac will apply to all robotic surgeries, except the following:

- a. Robotic total radical prostatectomy
- b. Robotic cardiac surgeries
- c. Robotic partial nephrectomy
- d. Robotic surgeries for malignancies

4. Optional Benefits

The following optional benefit shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if the optional benefit is selected by **You**. This optional benefit can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**, on payment of the corresponding additional premium. If a loading applies to the premium for the main **Policy**, such loading will also apply to the premium for this optional benefit selected.

The Optional Benefit covers **Reasonable and Customary Charges** incurred towards the medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness, Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**.

All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 7.2 (XIII) (Claim process & Requirements).

I. Hospital Cash

If We have accepted an Inpatient Care Hospitalization claim under Section 3.1 (Inpatient Care), We will pay the Hospital Cash amount specified in the Product Benefits Table up to a maximum 30 days of Hospitalization during the Policy Year for the Insured Person for each continuous period of 24 hours of Hospitalization from the first day of Hospitalization provided that:

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

5. Claim Cost Sharing Options

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

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

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

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

II. Annual Aggregate Deductible

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

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

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

6. Exclusions

6.1. Standard Exclusions

I. Pre-existing Diseases (Code-Excl01):

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months (under Variant 2, Variant 3 Plans and Family First Policy)/ 48 months (under Variant 1 Plan) 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 (under Variant 2, Variant 3 Plans and Family First Policy)/ 48 months (under Variant 1 Plan) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

I. 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,
 - viii. Chronic kidney disease and failure,
 - ix. Varicose veins of lower extremities,
 - x. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,
 - xi. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
 - xii. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,

- xiii. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,
- xiv. Internal Congenital Anomaly.

II. 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.

III. 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.

IV. 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.

V. 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

VI. 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.

VII. 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.

VIII. 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.

IX. 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.

- X. 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.
- XI. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code-Excl12)**
- XII. Treatments received in health 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)**
- XIII. 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)**
- XIV. Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XV. 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.
- XVI. 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
- XVII. Maternity (Code-Excl18)**
- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
 - b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

6.2. Specific Exclusions

- I. Personal Waiting Periods:**
Conditions specified for an Insured Person under Personal Waiting Period in the Schedule of Insurance Certificate will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us and will be covered from the commencement of the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.
- II. Ancillary Hospital Charges**
Charges related to a Hospital stay not expressly mentioned as being covered. This will include RMO charges, surcharges and service charges levied by the Hospital.
- III. Circumcision:**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.
- IV. Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

- V. External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.
- VI. Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.
- VII. Hormone Replacement Therapy:**
Treatment for any condition / illness which requires hormone replacement therapy.
- VIII. Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).
- IX. Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.
- X. Any treatment or medical services received outside the geographical limits of India.**
- XI. Unrecognized Physician or Hospital:**
 - d. 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.
 - e. 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.
 - f. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.
- XII. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:**
 - e. Deep coma and unresponsiveness to all forms of stimulation; or
 - f. Absent pupillary light reaction; or
 - g. Absent oculovestibular and corneal reflexes; or
 - h. Complete apnea.
- XIII. AYUSH Treatment**
Any form of AYUSH Treatments, except as mentioned under Section 3.4.
- XIV. OPD Treatment:**
OPD Treatment is not covered except for animal bite vaccinations to the extent stated in Section 3.9.

7. General Terms and Clauses

7.1. Standard General Terms and Clauses

I. Free Look Period

The Free Look Period shall be applicable on 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

II. Cancellation

- a. The Policyholder may cancel this Policy by giving 30 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.

Policy in-force up to	Policy Period 1 year	Policy Period 2 years
	Refund Premium (%)	Refund Premium (%)
Up to 30 days	75%	87.5%
31 to 90 days	50%	75%
91 to 180 days	25%	62.5%
181 to 365 days	0%	50%
366 to 455 days	Not applicable	25%
456 to 545 days	Not applicable	12%
Exceeding 545 days	Not applicable	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.

V. 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.

VIII. 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.

XI. 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.

XVI. 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.

XVII. Withdrawal of Policy

- a. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
- b. Insured Person will have the option to 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.

XVIII. 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: customercare@nivabupa.com (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)

Fax: 011-3090-2010

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

Head - Customer Services

Niva Bupa Health Insurance Company Limited

D-5, 2nd Floor, Logix Infotech Park

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

Customer Helpline No: 1860-500-8888

Fax No.: 011-3090-2010

Email ID: customercare@nivabupa.com

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

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

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

XIX. Claim settlement (Provision for Penal interest)

- a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- b. 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 last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it 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, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(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)

XX. 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.

XXI. 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.

XXII. 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)

XXIII. 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.

XXIV. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge

towards payment of claim by the Company to the extent of that amount for the particular claim.

XV. Portability

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 Policy renewal date as per IRDAI 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 IRDAI 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

XVI. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for Migration of the policy at least 30 days before the Policy renewal date as per IRDAI 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 Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI 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

7.2. Specific Terms and Clauses

I. Loading on Premium

- d. Based on Our discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading applicable shall not exceed more than 350% of the premium.
- e. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.
- f. We may apply a specific personal Waiting Period on a medical condition/ailment depending on the past history or additional Waiting Periods on Pre-existing Diseases as part of the special conditions on the Policy.

II. Automatic Cancellation:

iv. Individual Policy:

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

v. For Family Floater Policies and Family First Policies:

The Policy shall automatically terminate in the event of the death of all the Insured Persons. .

vi. Refund:

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

III. Other Renewal Conditions:

a. Continuity of Benefits on Timely Renewal:

- iv. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period.
- v. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:
 - D. You proposed to add an Insured Person to the Policy

- E. You change any coverage provision
- F. You change Your residence to different zip code
- vi. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person, and for Family First Policies it shall be the individual Age of each Insured Person of the family.

b. Reinstatement:

- iv. 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.
- v. We will not pay for any Medical Expenses which are incurred happen between the date the Policy expires and the date immediately before the reinstatement date of Your Policy.
- vi. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

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

d. Renewal for Insured Persons who have achieved Age 21:

If any Insured Person who is a child and has completed Age 21 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

e. Addition of Insured Persons on Renewal:

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

f. Changes to Sum Insured on Renewal:

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

IV. Change of Policyholder

- d. 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.
- e. Any alteration in the plan due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately. Coverage of Benefits in such scenario will be limited to current Policy Year.
- f. Renewal of such Policies will be according to terms and conditions of existing Policy.

V. Obligations in case of a minor

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

of Your and all other adult Insured Person's demise) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

VI. Authorization to obtain all pertinent records or information:

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

VII. Policy Disputes

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

VIII. Territorial Jurisdiction

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

IX. Notices

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

- e. You/the Insured Person at the address specified in the Schedule of Insurance Certificate or at the changed address of which We must receive written notice.
- f. Us at the following address:
Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: 011-3090-2010
- g. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
- h. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to YourPolicy from time to time.

X. Alteration to the Policy

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

XI. Zonal pricing

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

- Zone 1: Delhi (NCR), Surat, Kolkata, Mumbai, Thane
- Zone 2: Pune, Ludhiana, Jaipur
- Zone 3: Rest of India

XII. Assignment

The Policy can be assigned subject to applicable laws.

XIII. Claims Process & Requirements

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

A. Claims Administration:

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

- a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of wilful failure to comply with such directions, advice or guidance.
- b. We/Our representatives must be permitted to inspect the medical and Hospitalization records

pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

- c. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.
- d. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

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

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

- i. **Process for Obtaining Pre-Authorization**

- 7.2.1.1. **For Planned Treatment:**

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

- 7.2.1.2. **In Emergencies**

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

- 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.

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

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

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

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

ii. Reauthorization

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

b. For Reimbursement Claims:

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

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

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

- a. Claim form duly completed and signed by the claimant.
Please provide mandatorily following information if applicable
 - i. Current diagnosis and date of diagnosis;
 - ii. Past history and first consultation details;
 - iii. Previous admission/Surgery if any.
- b. Age/Identity proof document: Of Insured Person in case of cashless claim (not required if submitted at the time of pre-authorization request) and Proposer in case of Reimbursement claim.
 - i. Self attested copy of passport / driving license / PAN card / class X certificate / birth certificate;
 - ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);
- c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).
- d. Original discharge summary.
- e. Additional documents required in case of Surgery/Surgical Procedure.
 - i. Bar code sticker and invoice for implants and prosthesis (if used);
- f. Original final bill from Hospital with detailed break-up and paid receipt.

- g. Room tariff of the entitled room category (in case of a Non-Network provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken. (In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of Our Network Provider within the same geographical area for identical or similar services.)
- h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
- i. Copy of death certificate(in case of demise of the Insured Person).
- j. For Medico-legal cases(MLC) or in case of Accident
 - i. MLC/First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);
 - ii. Original self-narration of incident in absence of MLC / FIR.
- k. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
- l. Original X-Ray/ MRI / ultrasound films and other radiological investigations.
In the event of the Insured Person's death during Hospitalization, written notice accompanied by a copy of the post mortem report (if any) shall be given to Us regardless of whether any other notice has been given to Us.

D. Claims Assessment & Repudiation:

- a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized by Us in writing.
- b. Payment for Reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Schedule of Insurance Certificate or Your legal heirs or legal representatives holding a valid succession certificate.
- c. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods including the Deductible for each Policy Period. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.
- d. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-
 - i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Schedule of Insurance Certificate, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Section 3.1c.
 - ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per policy terms and conditions exceeds the Deductible limit within the same Policy Year.
 - iii. Co-payment (if applicable) as specified in the Schedule of Insurance Certificate shall be applicable on the amount payable by Us.
- e. The claim amount assessed above would be deducted from the amount mentioned against each benefit and Sum Insured as specified in the Schedule of Insurance Certificate. The re-fill amount will be applied only once the Base Sum Insured and No Claim Bonus is exhausted in the Policy Year.

E. Delay in Claim Intimation or Claim Documentation:

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

control.

F. Claims process for Section 3.10 (Health Checkup)

- a. The Insured Person shall seek appointment by contacting Our Service Provider.
- b. Our Service Provider will facilitate Your appointment.
- c. Reports of the medical tests can be collected directly from the Service Provider.

ANNEXURE - I
List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, UT of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.

<p>JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in</p>	<p>Rajasthan.</p>
<p>ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in</p>	<p>Kerala, UT of Lakshadweep, Mahe-a part of UT of Pondicherry.</p>
<p>KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in</p>	<p>West Bengal, Sikkim, UT of Andaman & Nicobar Islands.</p>
<p>LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in</p>	<p>Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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.</p>
<p>MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.</p>
<p>NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in</p>	<p>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>

EXECUTIVE COUNCIL OF INSURERS, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
Tel.: 022 - 69038801/03/04/05/06/07/08/09 | Email: inscoun@cioins.co.in
Shri B. C. Patnaik, Secretary General | Smt. Poornima Gaitonde, Secretary

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

Sl. No.	Item	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.	TROLLEY 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, HARMONICSCALPEL,SHAVER	20.	SURGICAL TAPE
5.	CAMERA COVER	13.	SURGICAL DRILL	21.	APRON
6.	DVD, CD CHARGES	14.	EYE KIT	22.	TORNIQUET
7.	GAUSE SOFT	15.	EYE DRAPE	23.	ORTHOBUNDLE, GYNAEC BUNDLE
8.	GAUZE	16.	X-RAY FILM		

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

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