Date: 11/07/2024

Policy Number: 33311851202401
Customer ID: 2002797256

MR. KUSHAL SATISH SANCHETI
RIDDHI SIDDHI APARTMENT FLAT NO 6 PARIJAT NAGAR N4 CIDCO,
AURANGABAD,
AURANGABAD,
MAHARASHTRA - 431001
Mobile: XXXXXX8727

Subject : Niva Bupa Health Insurance Policy No. 33311851202401

Dear MR. KUSHAL SATISH SANCHETI,

Thank you for renewing your Niva Bupa health insurance policy. At Niva Bupa, we put your health first and are committed to provide you access to the very best of healthcare, backed by the highest standards of service.

Please find enclosed your Niva Bupa Policy Kit which will help you understand your policy in detail and give you more information on how to access our services easily. Your policy kit includes the following:

- Insurance Certificate: Confirming your specific policy details like date of commencement, persons covered and specific conditions related to your plan.
- Premium Receipt: Receipt issued for the premium paid by you.

Do visit us online at www.nivabupa.com to view and download our updated list of network hospitals in your city, download claim forms and for other useful information. You can register with us online using your policy number, date of birth & email id and access your policy details. In case of any further assistance, call us at 1860-500-8888 (customer helpline number) or raise a request using our self-service platform, Insta Assist by clicking: https://rules.nivabupa.com/customer-service/.

We request you to read your policy terms and conditions carefully so that you are fully aware of your policy benefits. For benefits related to section 80D, please consult your tax advisor.

Assuring you of our best services and wishing you and your loved ones good health always.

Yours Sincerely,

Director - Operations & Customer Service
For and on behalf of Niva Bupa Health Insurance Co. Ltd.
(Formerly known as Max Bupa Health Insurance Co. Ltd.)

Important - Please read this document and keep in a safe place.

Policyholder Servicing Turnaround Times as prescribed by Insurance Regulatory and Development Authority of India (IRDAI)

POLICY SERVICING

	Turnaround time* (Calendar Days)
Post Policy issue service requests – from the date of receipt of service request	**10 Days**
Proposal refund in case of cancellation – from the date of decision of the proposal	**15 Days**

CLAIM SERVICING

	Turnaround time* (Calendar Days)
From the date of receipt of last necessary document (no investigation)	**30 Days**
From the date of receipt of last necessary document (with investigation)	**45 Days**

GRIEVANCE HANDLING

	Turnaround time* (Calendar Days)
Acknowledge a grievance – from the date of receipt of grievance	**3 Days**
Resolve a grievance– from the date of receipt of grievance	**14 Days**

*Turnaround time will start from the date of receipt of complete documents at Niva Bupa Health Insurance Company Ltd.

ReAssure 2.0 Insurance Certificate

Policyholder Name: MR. KUSHAL SATISH SANCHETI
Policyholder Address: RIDDHI SIDDHI APARTMENT FLAT NO 6 PARIJAT NAGAR N4 CIDCO, AURANGABAD, AURANGABAD, MAHARASHTRA - 431001

Policy Number	33311851202401
Policy Commencement Date and Time	From 17/07/2024 00:00
Policy Expiry Date and Time	To 16/07/2025 23:59
Base Sum Insured	INR 7,50,000
Variant Opted	Bronze+
Plan Opted	Family Floater
Policy Period	1 Year
Renewal / Payment Due Date	16/07/2025
Reported claims in the policy since inception	0

Details of Electronic Insurance Account (eIA)

eIA Number	None
Insurance Repository Name	None

Cover Details

Name of the Insured Person(s)	Base Sum Insured (INR)	Sum Insured Safeguard (INR)	Booster+ Sum Insured (INR)	Sum Insured (Base Sum Insured + Sum Insured Safeguard + Booster+ Sum Insured) (INR)	Live Healthy Discount %	Personal Accident opted
Mr. Satish Navalchand Sancheti	7,50,000	42,450	7,50,000	15,42,450	0.00	0
Mrs. Anita Sancheti						0

Premium Details

Net Premium/Taxable Value (INR)	Integrated Goods and Service Tax (18.00%)	Central Goods and Service Tax (9.00 %)	State/UT Goods and Service Tax (9.00 %)	Loading	Gross Premium (INR)	Gross Premium (INR) (in words)
48,139.00	0.00	4,332.51	4,332.51	0.00	56,804.00	Fifty-Six Thousand Eight Hundred Four Only

Nominee Details

Nominee Name	Relationship with the Policyholder
Anita Sancheti	Mother

Intermediary Details

Intermediary Name	Intermediary Code	Intermediary Contact No.
Jainuine Insurance Brokers Pvt. Ltd	BR03860005	008055565559

Claim Administrator	Servicing Branch Details
Niva Bupa Health Insurance Company Limited	Niva Bupa Health Insurance Company Ltd, Citi mall 4th floor,415 A/B/C, 132/B/1, Plot No. 1,GaneshKhind Road Near University Circle, Pune(Maharashtra)- 411007

Optional Benefit/Feature Details

Particulars	Details
Hospital Cash	Not Opted
Safeguard	Yes
Safeguard+	Not Opted
Personal Accident	Not Opted
Smart Health+ (Disease Management)*	Gold
Smart Health+ (Acute Care)	Best Consult
Pre Existing Disease Waiting Time Modification	Yes; Pre-existing waiting period of 4 years
Co-payment	Not Opted
Room Type Modification	Not Opted
Annual Aggregate Deductible	Not Opted

**In case of Smart Health+ (Disease Management) opted, all loadings and pre-existing disease waiting periods for Diabetes & Hypertension will be waived off. If the add-on benefit at any renewal is removed, then the applicable loadings and pre-existing disease waiting periods will reapply to the plan opted.*

Product Benefit Table[1]

Expenses in Reaching Hospital	• Road Ambulance: Up to Sum Insured • Air Ambulance: up to INR 2,50,000 per hospitalization
Expenses During Hospitalization (Covers AYUSH)	• Up to Sum Insured • Modern Treatments: Covered up to Sum Insured with sub-limit of Rs. 1L per claim on few robotic surgeries
Expenses Before and After a Hospitalization	60 Days and 180 Days Respectively. Covered Up to Sum Insured
Home Care/Domiciliary	Covered up to Sum Insured
Organ Donor	Covered up to Sum Insured
Annual Health Check-up (Only Cashless)	For defined list of tests; up to INR 3,750 Per Policy
ReAssureX	First claim paid triggers ReAssure "Forever". It is unlimited. Each Claim under ReAssure "Forever" will be up to Base Sum Insured.
Booster+	Carry forward unutilized sum Insured Maximum up to 3 times of Base Sum Insured
Live Healthy	Up to 30% Discount on Renewal premium basic steps taken.
Shared Accommodation Benefit	INR 800 per day; Maximum INR 4,800
Second Medical Opinion	Once for any condition in a Policy year.
e-consultation	Unlimited e-consultation within our network

[1] The details of the benefits will change depending upon the plan opted. All the benefits are on per Policy Year basis, if otherwise not mentioned.

Insured Person Details

Name of the Insured Person (s)	Age	Insured DOB	Gender	Relationship	Insured with Niva Bupa (Since)	Additional Sum Insured	Pre Existing Condition[#]	Personal Waiting Period[*]
Mr. Satish Navalchand Sancheti	64	30/12/1959	Male	Father	17/07/2023	0	1. Diabetes mellitus 2. Hypertensive diseases /and its complications 3. Hypertensive diseases	None
Mrs. Anita Sancheti	52	02/02/1972	Female	Mother	17/07/2023	0	None	None

([#] -Pre existing Disease as disclosed by You / Insured Person or discovered by us during medical underwriting)
(* - Please refer to Policy terms & Conditions for details)

Permanent Exclusion (if any):

None

Pursuant to Notification no 13/2020- Central Tax and Notification no 14/2020- Central Tax both dated 21st March 2020 read with rule 54 (2) of CGST Rules 2017, the provisions of E Invoicing & QR code are not applicable to an Insurance company, hence E Invoice number and QR code has not been printed on this document. GST under RCM: NIL

GSTI No.: 27AAFCM7916H1Z8	SAC Code / Type of Service : 997133 / General Insurance Services
Niva Bupa State Code: 27	Customer State Code / Customer GSTI No.: 27 /NA

Policy issuing office: Delhi, Consolidated Stamp Duty deposited as per the order of Government of National Capital Territory of Delhi.

Location: New Delhi
Date: 11/07/2024

Director - Operations & Customer Service
For and on behalf of Niva Bupa Health Insurance Company Limited
(formerly known as Max Bupa Health Insurance Co. Ltd.)

Premium Receipt - ReAssure 2.0

Dear MR. KUSHAL SATISH SANCHETI
RIDDHI SIDDHI APARTMENT FLAT NO 6 PARIJAT NAGAR N4 CIDCO
AURANGABAD
AURANGABAD
MAHARASHTRA - 431001

We acknowledge the receipt of payment towards the premium of the following health insurance policy:

Policyholder Name	Mr. Kushal Satish Sancheti			Policy Number	33311851202401
Product Name	ReAssure 2.0	Plan Opted	Family Floater	Base Sum Insured	7,50,000
Policy Commencement Date#	17/07/2024			Policy Expiry Date	16/07/2025
Premium Calculation:					
Premium (Rs.) - Base Product				37,270.00	
Premium (Rs.) - Safeguard				2,795.00	
Premium (Rs.) - Smart Health+: Disease Management Add-on				6,522.00	
Premium (Rs.) - Smart Health+: Acute Care Add-on				2,140.00	
Underwriting Loading (Rs.)				0.00	
Member Discount				214.00	
Complete Care Discount				374.00	
Net Premium / Taxable value (Rs.)				48,139.00	
Integrated Goods and Service Tax (18.00 %)				0.00	
Central Goods and Service Tax (9.00 %)				4,332.51	
State/UT Goods and Service Tax (9.00 %)				4,332.51	
Gross Premium (Rs.)				56,804.00	

#Issuance of policy is subject to clearance of premium paid

Details of persons Insured:

Name of Person Insured	Age	Gender	Relationship**
Mr. Satish Navalchand Sancheti	64	Male	Father
Mrs. Anita Sancheti	52	Female	Mother

For the purpose of deduction under section 80D, the benefit shall be as per the provisions of the Income Tax Act,1961 and any amendments made thereafter. For your eligibility and deductions, please refer to provisions of Income Tax Act 1961 as modified and consult your tax consultant. In the event of non-realization of premium, tax benefits cannot be obtained against this premium receipt.

Upon issuance of this receipt, all previously issued temporary receipts, if any, related to this policy are considered null and void.

GSTI No.: 27AAFCM7916H1Z8	SAC Code / Type of Service : 997133 / General Insurance Services
Niva Bupa State Code: 27	Customer State Code / Customer GSTI No.: 27 /NA

Policy issuing office: Delhi, Consolidated Stamp Duty deposited as per the order of Government of National Capital Territory of Delhi.

Location: New Delhi
Date: 11/07/2024

Director - Operations & Customer Service
For and on behalf of Niva Bupa Health Insurance Company Limited
(formerly known as Max Bupa Health Insurance Co. Ltd.)

List of Un-recognized Hospitals

Sr. No.	State	City	Hospital	Address
1	Gujarat	Surat	Aakanksha Hospital	126, Aaradhnanagar Soc., B/H. Bhulkabhavan School, Aanand-Mahal Rd., Adajan, Surat
2	Gujarat	Surat	Abhinav Hospital	Harsh Apartment, Nr Jamna Nagar Bus Stop, God Dod Road Surat
3	Gujarat	Surat	Adhar Ortho Hospital	Dawer Chambers, Nr. Sub Jail, Ring Rd., Surat
4	Gujarat	Surat	Aris Care Hospital	A 223-224, Mansarovar Soc, 60 Feet , Godadara Road, Surat
5	Gujarat	Surat	Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd., Surat
6	Gujarat	Surat	Auc Hospital	B-44 Gujarat Housing Board, Nandeshara
7	Gujarat	Surat	Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara
8	Gujarat	Surat	Dr. Santosh Basotia Hospital	Bhatar Road, Surat
9	Gujarat	Surat	Ghevariya Dental Clinic	202, M K Complex, Variya Compound, Hirabag Circal
10	Gujarat	Surat	God Father Hospital	344, Nandvan Soc., B/H. Matrushakti Soc., Puna Gam, Surat.
11	Gujarat	Surat	Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya, Kaji Medan, Gopipura, Surat
12	Gujarat	Surat	Hari Milan Hospital	L H Road
13	Gujarat	Surat	Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi, Surat
14	Gujarat	Surat	Jeevan Path Gen. Hospital	2nd. Fl., Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan, Surat.
15	Gujarat	Surat	Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna
16	Gujarat	Surat	Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara Surat
17	Gujarat	Surat	Krishnavati General Hospital	Bamroli Road
18	Gujarat	Kutch	Mantra Orthopaedic Hospital Gandhidham(Kutch)	Dr. Bhavin N. Patel
19	Gujarat	Surat	Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park
20	Gujarat	Surat	Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat
21	Gujarat	Surat	Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road, Surat
22	Gujarat	Surat	Prayosha Hospital	A-102/103, Shagun Residency, Puna Bombay Market Road, Puna, Surat, Gujarat
23	Gujarat	Surat	R.D Janseva Hospital	120 Feet Bamroli Road, Pandesara, Surat
24	Gujarat	Surat	Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road
25	Gujarat	Surat	Santosh Hospital	L H Road
26	Gujarat	Surat	Shaurya Hospital	Udhna, Surat
27	Gujarat	Surat	Shikha General Hospital - Changed Name To Sai Hospital	14 – Umiya Nagar – 1, Navagam Dindoli Road, Udhna
28	Gujarat	Surat	Shishumangal Children Hospital	Surat

Sr. No.	State	City	Hospital	Address
29	Gujarat	Surat	Shree Ramdev General & Surgical Hospital	248,Shiv Nagar G.I.D.C. Road,Nr:Udhna Citizen Co-Operative Bank,Pandasara
30	Gujarat	Surat	Shree Sai Hospital & Prasuti Gruh	14, Umiya Nagar-1, Navagam Dindoli Road, Udhna
31	Gujarat	Surat	Shreyans Anorectal & Daycare Hospital	5Th Floor, Opp. Ayurvedic Collage, Station Road, Surat
32	Gujarat	Surat	Shri Panchratna Hospital & Prasutugruah	Geetanagar, Near Dindoli Jakat Naka, Navagam, Udhna, Surat
33	Gujarat	Surat	Shubham General Hospital	2nd Floor, Nirmal Complex, Near Maruti Gaushala, Opp. Bhagwati Rus
34	Gujarat	Surat	Siddhi Clinic & Nursing Home	33- Nandanvan Apt., Naginawadi, Surat
35	Gujarat	Surat	Sparsh Multy Specality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank
36	Gujarat	Surat	Sree Uday Narayan General Hospital	193,Sukhi Nagar, Bamroli Road, Near New Bridge, Pandesara, Surat
37	Gujarat	Surat	Tripathi Chartiable Hospital	Geetanagar, Near Dindoli Jakat Naka, Navagam, Udhna, Surat
38	Gujarat	Ahmedabad	Umiya Medical & Surgical Hospital	2Nd Floor, Centre Plaza, Sattadhar Char Rasta, Sola Road
39	Gujarat	Surat	Varachha General Hospital	17-26, Samarth Park Near Archana School
40	Uttar Pradesh	Kushi Nagar	Aastha Multispecialty Hospital	Padrauna Road, Kushinagar, Up, Ph : 9598440966/9793196178
41	Maharashtra	Thane	Ashwini Nursing Home	Prashanti, Ground Floor, Agarkar Road, Dombivli East, Thane
42	Maharashtra	Thane	Asmita Nursing Home	Prashanti, Ground Floor, Agarkar Road, Dombivli East, Thane
43	Maharashtra	Thane	Balaji Nursing Home	Prashanti, Ground Floor, Agarkar Road, Dombivli East, Thane
44	Haryana	Rohtak	Channan Devi Memorial Hopital	Plot No.952, Ward No.23, Lal Chand Colony Chowk, Near Durga Mandir, Rohtak
45	Telangana	Hyderabad	Goodlife Hospitals	#1-7-309, Hanuman Nagar, Opp. Jaginis Foodland, Chaitanyapri X Roads, Dilskhnagar
46	Orissa	Dhenkanal	Jagannath Clinic & Nursing Home	Durgabazar, Nuahata, Kantabania, Banarpal
47	Uttar Pradesh	Allahabad	Jeevan Jyoti Hospital	162, Bai Ka Bagh, Lowther Road, Allahabad, Up
48	Tamilnadu	Mayiladuthurai	Krishna Hospital	No 8 Pattamangala Street Mayiladuthurai
49	Maharashtra	Mumbai	Mumtaz Nursing Home	3/299/3774, Opp. Choti Masjid, Tagore Nagar, Near Hariyali Police Chowki, Vikhroli (E), Mumbai-400083
50	Telangana	Kesava Nagar Colony	Padmaja Hospital	# 17-1- 386/1/18 Kesava Nagar Colony Champapet Hyderabad
51	Bihar	Harnaut	Pragya Nurshing Home	Harnaut
52	Telangana	Jeedimetla	Ram Hospitals	Shapur Nagar, Ida, Jeedimetla
53	Haryana	Gurgaon	Ramanarayan Hospital	Vill Bass Hariya P.O Bass Lambi Ggn-122503
54	Maharashtra	Mumbai	Royal Nursing Home	Plot No 7, Sector-1, Airoli,, Navi Mumbai-400708
55	Orrissa	Cuttak	Sabarmati General Hospital	Mahanadi Vihar
56	Uttar Pradesh	Meerut	Sahara Hospital	Ajanta Colony, Garh Road

Sr. No.	State	City	Hospital	Address
57	Maharashtra	Mumbai	Sb Nursing Home	Powai
58	Uttar Pradesh	Meerut	Shagun Hospital	24 Tyagi Market Tej Garhi
59	Haryana	Gurgaon	Shri Balaji Hospital & Trauma Center	Gadoli, Pataudi Road, Gurgaon
60	Telangana	Hyderabad	Sri Sai Thirumala Hospitals	Kishan Kumar Complex, Durga Nagar, Karmanghat Main Road
61	Madhya Pradesh	Bhopal	Venus Hospital And Medical Research Centre	H. No-2,Pipal Square,Karond, Bhopal
62	Telangana	Vanasthali Puram	Vijaya Nursing Home	Near Double Road, Vanasthali Puram
63	Uttar Pradesh	Allahabad	Virendra Hospital	7 Stanley Road (Next To Mishra Bhavan)Civil Lines, Allahabad
64	Uttar Pradesh	Meerut	Yog Nursing Home	Near Tej Garhi, University Road

Note:

1. Claims whether Cashless or reimbursement pertaining to treatments taken at the above mentioned Hospitals shall not be entertained, processed or paid by Niva Bupa.

2. The above list is only for the purpose of admissibility of claims with respect to any health insurance policies of Niva Bupa Health Insurance Company Limited.

3. The above list is subject to be updated from time to time. For updated list please visit this site at www.nivabupa.com or call our customer care at 1860 500 8888

Customer Information Sheet/ Know Your Policy

This document provides key information about your policy. You are advised to go through your policy document

Sl. No	Title	Description	Policy Clause Number
1	**Name of Insurance Product/ Policy**	ReAssure 2.0	
2	**Policy Number**	33311851202401	
3	**Type of Insurance Product/ Policy**	Both Indemnity and Benefit	
4	**Sum Insured**	Sum Insured Options are: 5 Lacs, 7.5Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs, 75 Lacs, 100 Lacs The Sum Insured opted by you is mentioned in the Policy Schedule.	
5	**Policy Coverage**	**Expenses in respect of:** **Base Coverage**: • Expenses in reaching the hospital: Road ambulance covered up to Sum Insured and Air ambulance up to INR 2,50,000 per hospitalization • Expenses during Hospitalization: 2 hours and more covered (AYUSH covered for 24 hours and more). • Modern treatments like Robotic surgeries, oral chemotherapy etc. are covered • Expenses before and after hospitalization: 60 and 180 days respectively. Up to Sum Insured. • Home Care/Domiciliary treatment covered up to Sum Insured. • Organ donor expenses covered up to Sum Insured • Annual Health Check-up can be availed from day 1 of the policy as per plan chosen by You • ReAssure+ – · ReAssure “Forever”: The first paid claim triggers ReAssure “Forever”. Maximum amount this benefit pays for any single claim is up to Base Sum Insured.	4.1 4.2.1 4.2.2 4.3 4.4 4.5 4.6 4.7

		· Lock the Clock: Entry age is locked at the time of buying the policy, till a claim is paid • ReAssureX - The first paid claim triggers ReAssure "Forever". Maximum amount this benefit pays for any for any single claim is up to Base Sum Insured. • Booster+ - carry forward unutilized sum insured for maximum 10 times of Base Sum Insured. • Live Healthy - discount on premium at renewal • Shared accommodation Cash Benefit- additional amount paid each day if shared room is opted. • Second Medical opinion – choose to take a second medical opinion once in a policy year. • E-consultation- Unlimited e-consultation with our partners. **Optional Coverage:** • Hospital Daily Cash - Up to INR 5 Lakh Base Sum Insured: INR 1,000/day - Between INR 10 Lakh to INR 15 Lakh Base Sum Insured: INR 2,000/day - Above 15 Lakh Base Sum Insured: INR 4,000/day - Maximum coverage offered under this benefit is for 30 days / policy year / insured person. • Personal Accident • Safeguard • Safeguard+ • Annual aggregate deductible • Co-payment • Pre-Existing Disease Waiting Time Modification • Room Type Modification	4.8 4.9 4.10 4.11 4.12 4.13 4.14 4.15 4.16 4.17 4.18 4.19 4.20 4.21
6	**Exclusions**	**Standard Exclusions** • Pre-existing Diseases (Code–Excl01) • Specified disease/procedure waiting period (Code- Excl02) • 30-day waiting period (Code- Excl03) • Investigation & Evaluation (Code-Excl04) • Rest Cure, rehabilitation and respite care (Code-Excl05) • Obesity/ Weight Control (Code-Excl06) • Cosmetic or plastic Surgery (Code-Excl08) • Hazardous or Adventure sports (Code-Excl09)	5

		• Breach of law (Code-Excl10) • Excluded Providers (Code-Excl11) • Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code-Excl12) • Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13) • Refractive Error (Code-Excl15) • Unproven Treatments (Code-Excl16) • Sterility and Infertility (Code-Excl17) • Maternity Expenses (Code-Excl18) **Specific Exclusions** • Personal Waiting Period- Conditions specified for an Insured Person under Personal Waiting Period will be subject to a Waiting Period of up to 48 months from the inception of the First Policy with Us • 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. • External Congenital Anomaly- Screening, counseling or treatment related to external Congenital Anomaly. • Dental treatment- All dental treatments other than due to accidents and cancers. • Unrecognized Physician or Hospital- - 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. - 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.	

		- Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India. • Costs which are not Reasonable and Customary and treatments which are not Medically Necessary. Refer Definition 2.1.36 for Reasonable and Customary Charges. • Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state	
	Waiting period	• **Initial Waiting Period (Excl03)-** 30 days for all illnesses (not applicable in case of continuous renewal or accidents) • **Specific Waiting Period (Not applicable for claims arising due to an accident) (Excl02)**: 24 months for all of the following conditions o Pancreatitis and stones in biliary and urinary system o Cataract, glaucoma and retinal detachment o Hyperplasia of prostate, hydrocele and spermatocele o Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy) o Hemorrhoids, fissure, fistula or abscess of anal and rectal region o Hernia of any site or type, o Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair o Varicose veins of lower extremities o All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump o Ulcer, erosion or varices of gastro intestinal tract o Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses	5.1.3 5.1.2

		• **Pre-existing diseases (Excl01)**: Covered after 36 months of continuous coverage (48 months for Bronze, Silver & Gold Variants) • **Personal Waiting Period-** Conditions specified for an Insured Person under Personal Waiting Period will be subject to a Waiting Period of up to 48 months from the inception of the First Policy with US	5.1.1 5.2.1
8	**Financial Limits of Coverage** **i. Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit)**	**i. Sublimit** A. **Modern Treatments:** Up to INR 1Lac on few robotic surgeries B. **Air Ambulance** up to INR 2.5L per hospitalization **C. Annual Health Check-up:** a. Up to INR 500 for every INR 1 Lac Base Sum Insured b. Individual policy: maximum INR 5,000 per Insured per Policy Year c. Family Floater policy: maximum INR 10,000 per policy per Policy Year **D. Shared Accommodation:** a. For sum insured up to INR 15 Lacs: INR 800 per day; maximum INR 4,800 b. For sum insured above INR 15 Lacs: INR 1,000 per day; maximum up to INR 6,000 **E. Hospital Cash:** a. Up to INR 5 Lakh Base Sum Insured: INR 1,000/day b. Between INR 10 Lakh to INR 15 Lakh Base Sum Insured: INR 2,000/day c. Above 15 Lakh Base Sum Insured: INR 4,000/day d. Maximum coverage offered under this benefit is for 30 days / policy year / insured person. F. **Personal Accident**: up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore. G. **Room Type Modification**: optional benefit with following options- Single Private Room and a Sharing Room	4.2.2 4.1.2 4.6 4.11 4.14 4.15 4.21

	ii. Co-Payment (It is a specified amount/ percentage of the admissible claim amount to be paid by policyholder/ insured)	ii. **Co-payment-** Optional benefit with following options- 20%, 30%, 40% and 50%.	4.19
	iii. Deductible (It is a specified amount up to which an insurance company will not pay any claim, and which will be deducted from total claim amount (if claim amount is more than specified amount)	iii. **Annual Aggregate Deductible-** Optional benefit with following options- INR 10,000/ 20,0000/ 30,000/ 50,000/ 1,00,000.	4.18
	iv. Any other limit (as applicable)		
9	**Claims/ Claims Procedure**	Details of procedure to be followed for cashless service as well as for reimbursement of claim including pre and post hospitalization. **Turn Around Time (TAT)** for claims settlement - TAT for pre-authorization of cashless facility- 2 Hours - TAT for cashless final bill authorization- 4 Hours **Network Hospital Details-** https://rules.nivabupa.com/hospital-network/ **Helpline No-** 1860-500-8888	6.2.4

		Downloading/ getting claim form- https://transactions.nivabupa.com/pages/downloads.aspx **Hospitals which are blacklisted or from where no claim will be accepted by insurer-** https://rules.nivabupa.com/doc/Exclude_List.pdf	5.2.5
10	**Policy Servicing**	• Call center no of Insurer- Contact No: 1860-500-8888 • Details of Company Officials-- Website: www.nivabupa.com 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 Self-service platform, Insta Assist https://rules.nivabupa.com/customer-service/	6.1.8
11	**Grievances/Complaints**	Details of • Grievance Redressal Officer of the insurer Grievance Redressal Officer Niva Bupa Health Insurance Company Limited D-5, 2nd Floor, Logix Infotech Park opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301 For details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx • Insurance company grievance portal/ Department Website: www.nivabupa.com 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 Contact No: 1860-500-8888 Fax No.: 011-41743397	6.1.8

		Self-service platform, Insta Assist https://rules.nivabupa.com/customer-service/ Senior citizens may write to us at at: seniorcitizensupport@nivabupa.com Insured person may also approach the grievance cell at any of the company's branches with the details of grievance • IRDAI/(IGMS/Call Centre): Email ID: www.igms.irdai.gov.in Ombudsman (Refer Annexure II of policy document for List of Insurance Ombudsmen)	
12	**Things to Remember**	• **Free Look cancellation:** You may cancel the insurance policy if you do not want it, within 15 days (30 days for policies with a term of 3 years, if sold through distance marketing) days from the beginning of the policy. You have 15 days from receipt of the policy document to re visit your policy terms & conditions and if you have any disagreement to it, you may apply for Free look cancellation through submission of Free look Cancellation form. Please note that free look cancellation is applicable only when no claims have been paid under any benefits. Also, there could be few deductions that may be applicable as per policy document. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to: i. refund of the premium paid, less any expenses incurred by the Company on medical examination of the insured person. • **Policy renewal:** Except on grounds of fraud, moral hazard or misrepresentation or non-cooperation, renewal of your policy shall not be denied, provided the policy is not withdrawn. • **Migration and Portability:** When your policy is due for renewal, you may migrate to another policy with us or port your policy to another insurer. You can contact Customer Service Department	6.1.1 6.1.3 6.1.12 & 6.1.13

		(details provided above) for migration and portability. • **Change in Sum Insured:** Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh **only for the enhanced portion of the sum insured.** ii. **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 eight 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 policy shall be contestable except for proven Fraud and permanent exclusions specified in the policy contract.	6.2.3.c 6.1.10
13	**Your Obligations**	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. Disclosure of Information- The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)	6.1.14

Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
			Illustration 1							
18	7,787	5,00,000	7,787	779	7,008	5,00,000	7,787	14,716	22,005	5,00,000
21	7,787	5,00,000	7,787	779	7,008	5,00,000	7,787			
39	9,761	5,00,000	9,761	976	8,785	5,00,000	9,761			
45	11,386	5,00,000	11,386	1,139	10,247	5,00,000	11,386			

<table>
<tr><td colspan="3">Total premium for all members of the family is <u>Rs.36,721,</u> when each member is covered separately.

Sum Insured available for each individual is <u>Rs.500,000</u>.</td><td colspan="4">Total premium for all members of the family is <u>Rs.33,049</u>, when they are covered under a single policy.

Sum Insured available for each family member is <u>Rs.500,000</u>.</td><td colspan="4">Total premium when the policy is opted on floater basis is <u>Rs.22,005</u>.

Sum Insured of <u>Rs.500,000</u> is available for the entire family.</td></tr>
<tr><td colspan="11">Illustration 2</td></tr>
<tr><td>55</td><td>20,244</td><td>5,00,000</td><td>20,244</td><td>2,024</td><td>18,220</td><td>5,00,000</td><td>20,244</td><td rowspan="2">9,642</td><td rowspan="2">46,275</td><td rowspan="2">5,00,000</td></tr>
<tr><td>63</td><td>35,673</td><td>5,00,000</td><td>35,673</td><td>3,567</td><td>32,106</td><td>5,00,000</td><td>35,673</td></tr>
<tr><td colspan="3">Total premium for all members of the family is <u>Rs.55,917</u>, when each member is covered separately.

Sum Insured available for each individual is <u>Rs.500,000</u>.</td><td colspan="4">Total premium for all members of the family is <u>Rs.50,325</u>, when they are covered under a single policy.

Sum Insured available for each family member is <u>Rs.500,000.</u></td><td colspan="4">Total premium when the policy is opted on floater basis is <u>Rs.46,275</u>.

Sum Insured of <u>Rs.500,000</u> is available for the entire family.</td></tr>
<tr><td colspan="11">Illustration 3</td></tr>
<tr><td>65</td><td>35,673</td><td>5,00,000</td><td>35,673</td><td>3,567</td><td>32,106</td><td>5,00,000</td><td>35,673</td><td rowspan="2">20,678</td><td rowspan="2">60,605</td><td rowspan="2">5,00,000</td></tr>
<tr><td>70</td><td>45,609</td><td>5,00,000</td><td>45,609</td><td>4,561</td><td>41,048</td><td>5,00,000</td><td>45,609</td></tr>
<tr><td colspan="3">Total premium for all members of the family is <u>Rs.81,282</u>, when each member is covered separately.

Sum Insured available for each</td><td colspan="4">Total premium for all members of the family is <u>Rs. 73,154</u>, when they are covered under a single policy.

Sum Insured available for each family member is <u>Rs.500,000</u>.</td><td colspan="4">Total premium when the policy is opted on floater basis is <u>Rs.60,605</u>.

Sum Insured of <u>Rs.500,000</u> is available for the entire family.</td></tr>
</table>

individual is **Rs.500,000.**		

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

Premium is considered for Platinum+ Variant and Zone 1

ReAssure 2.0 – Policy Wordings

1. Preamble

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

2. Definitions

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

2.1. Standard Definitions:

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

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

a. Central or state government AYUSH Hospital; or

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

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

i. Having at least five in-patient beds;

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

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

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

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

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

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

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

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

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

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

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

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

a. has Qualified Nursing staff under its employment;

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

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

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

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

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

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

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

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

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

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

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

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

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

2.1.14. **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.

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

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

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

a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    b. it needs ongoing or long-term control or relief of symptoms
    c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    d. it continues indefinitely
    e. it recurs or is likely to recur

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

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

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

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

2.1.22. **Maternity Expenses** shall include:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization)
b. Expenses towards lawful medical termination of pregnancy during Policy Period.

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

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

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

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

a. is required for the medical management of the Illness or Injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a Medical Practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.27. **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.

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

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

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

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

2.1.32. **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.

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

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

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

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

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

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

2.1.35. **Portability** means the right accorded to an 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.

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

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

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

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

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

2.2. Specific Definitions

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

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

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

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

3. Sum Insured(s)

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

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

4. Benefits available under the policy.

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

4.1. Expenses in reaching a Hospital

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

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

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

4.2. Expenses during Hospitalization

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

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

Note:

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

II. **We will NOT pay for Automation machine for peritoneal dialysis**

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

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

NOTE: A limit of maximum INR 1,00,000 per claim will apply to all robotic surgeries, except for total radical prostatectomy, cardiac surgeries, partial nephrectomy and surgeries for malignancies.

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

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

4.4. Home Care / Domiciliary Treatment

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

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

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

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

Note:

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

4.5. Organ donor

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

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

4.6. Annual Health Checkup

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

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

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

4.7. ReAssure+

4.7.1 ReAssure "Forever":

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

Note:

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

Year 1: Once the Policy is bought

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

Year 2: Once the policy is renewed

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

4.7.2 Lock the Clock:

Your age is locked at entry when you buy the policy, till a claim is paid.

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

Note:

- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age. No additional premium will be charged In the middle of the tenure in case of claims.
  At the time of renewal (in case of a claim), the premium will be charged as per the current age of the consumer at renewal.
- If you add a member to the floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.

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

4.8. ReAssureX

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

Note:

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

Year 1: Once the Policy is bought

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

Year 2: Once the policy is renewed

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

4.9. Booster+

Don't lose what you don't use.

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

Example: If you have chosen Base Sum Insured of INR 10 lakh and Titanium+ Variant, then at the end of 10 years (if you have made no claims in these years) you will have
1.10 Crore Sum Insured (that is 10 Lakh base + 1 Crore Booster+). Don't forget that you would have the Safeguard / Safeguard+ (this is a great benefit. You must choose it) and ReAssure "Forever" (in case of claim) over and above the 1.10 Crore.

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

Note:

- If you convert an Individual Sum Insured policy in any manner, into a floater plan, then the least of the Booster+ Sum Insured of individual insured members will be carried forward to the floater plan.
- If a floater plan, splits into multiple policies, then the Booster+ Sum Insured of floater plan will be carried forward to the split policies, provided the Base Sum Insured is not reduced.
- If you reduce the Base Sum Insured, Booster+ Sum Insured will be proportionately reduced. Let's say if you reduce the current INR 10 lakh Sum Insured to INR 5 lakh, your Booster+ Sum Insured will be halved.
- You can and should regularly increase Sum Insured of your Health insurance policy. Medical inflation is a reality and current Sum Insured will fall short in future for advanced treatments. When you enhance your Sum Insured, the accumulated Booster+ Sum Insured will continue and grow even more (remember Booster+ is up to maximum 3/5/10 times (based on the plan you have chosen) of the Base Sum Insured. Higher the Base Sum insured higher the Booster+ Sum Insured).

4.10. Live Healthy

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

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

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

Policy Period: 1 year

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

Policy Period: 2 years

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

Policy Period: 3 years

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

4.11. Shared accommodation Cash Benefit

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

4.12. Second Medical Opinion

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

4.13. e-Consultation

You can take Unlimited e-consultations from our Partners.

Optional Benefit:

4.14. Hospital Cash

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

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

4.15 Personal Accident

4.15.1. Accidental Death (AD)

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

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

4.15.2. Permanent Total Disability

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

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

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

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

4.15.3. Permanent Partial Disability

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

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

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

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

4.16. Safeguard

4.16.1. **Claim Safeguard:** We will cover non-payable items mentioned in **'List I – Expenses not covered' of Annexure I'**. Clause 2.1.36 for Reasonable and Customary Charges will still apply.

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

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

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

4.17. Safeguard+

4.17.1. **Claim Safeguard+:** We will cover non-payable items mentioned in **'List I,II,III,IV of Annexure I'.** Clause 2.1.36 for Reasonable and Customary Charges will still apply.

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

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

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

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

4.18. Annual Aggregate Deductible

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

Note:

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

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

4.19. Co-payment

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

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

4.20. Pre-Existing Disease Waiting Time Modification

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

4.21. Room Type Modification

You can as per your lifestyle, choose to change the room category we are offering, and opt for what suits you best!
You can choose between a Single Private Room and a Sharing Room. Irrespective of the Room type you choose, ICU admission will always be paid up to Sum Insured.

5. Exclusions

5.1. Standard Exclusions

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months (48 months for Bronze, Silver & Gold Variants) 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 (48 months for Bronze, Silver & Gold Variants) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy 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 retinal detachment
   iii. Hyperplasia of prostate, hydrocele and spermatocele
   iv. Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy)
   v. Hemorrhoids, fissure, fistula or abscess of anal and rectal region
   vi. Hernia of any site or type,
   vii. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
   viii. Varicose veins of lower extremities
   ix. All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump
   x. Ulcer, erosion or varices of gastro intestinal tract
   xi. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

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

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

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

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
    i. greater than or equal to 40 or
    ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        1. Obesity-related cardiomyopathy
        2. Coronary heart disease
        3. Severe Sleep Apnea
        4. Uncontrolled Type2 Diabetes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

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

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

5.2. Specific Exclusions

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

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

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

5.2.4. **Dental treatment:**
All dental treatments other than due to accidents and cancers.

5.2.5. **Unrecognized Physician or Hospital:**

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

5.2.6. Costs which are not Reasonable and Customary and treatments which are not Medically Necessary. Refer Definition 2.1.36 for Reasonable and Customary Charges.

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

6. General Terms and Clauses

6.1. Standard General Terms and Clauses

6.1.1. Free Look Period

The Free Look Period shall be applicable on 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:

i. refund of the premium paid, less any expenses incurred by the Company on medical examination of the insured person.

Simplified for you

Free look is a 15 / 30 days period during which you can return back your policy, if you don't like what you have purchased.

6.1.2. Cancellation

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

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

The below grid shall be applicable for 'Yearly / Annual/One Time' premium payment frequency.

Simplified for you

You can cancel your policy whenever you wish.

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

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

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

No refund is applicable for Half Yearly, Quarterly & Monthly premium frequencies.

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

ii. 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.

6.1.3. **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 (15 days in case of other than single premium policies) 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.

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

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

6.1.5. **Nomination**

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

6.1.6. **Fraud**

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

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

For the purpose of this clause, the expression "fraud" means any of the 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

Simplified for you

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

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

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

Note: You are NOT insured during the grace period.

Simplified for you

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

- You withheld any information from us, whole or part that would have invited any decision other than a 'standard acceptance' of your application for insurance. Note: Non standard decisions are:
  - ° Loading – We ask for additional premium
  - ° Exclusions – We apply a additional waiting period for health conditions or treatments
  - ° Rejection – We hate to do this. But sometimes are compelled to say no to a customer

which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact; c) any other act fitted to deceive; and d) any such act or omission as the law specially declares to be fraudulent

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

6.1.7. **Withdrawal of Policy**

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

6.1.8. **Redressal of Grievance:**

In case of any grievance the Insured Person may contact the company through: Website: www.nivabupa.com
Toll free: 1860-500-8888
E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)
Fax: 011-4174-3397
Courier: Customer Services Department
D-5, 2nd Floor, Logix Infotech Park, opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:
Head – Customer Services
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Contact No: 1860-500-8888
Fax No: 011-4174-3397
Email ID: Email our Grievance officer through our Grievance Redressal platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx
For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx
If the Insured Person is not satisfied with the above, they can escalate to our Grievance Redressal officer through our platform https://transactions.nivabupa.com/pages/grievance-redressal.aspx.

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (Refer below Annexure).
Grievance may also be lodged at IRDAI Integrated Grievance Management System – bimabharosa.irdai.gov.in

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

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the

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

- Cause fraud of any kind

Simplified for you

We will provide our decision on claim within 30 days (45 days for investigated cases) from submission of all necessary claim documents.

date of payment of claim at a rate 2% above the bank rate. iii. 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. iv. 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)	For any delay in payment of claim, we will pay interest on the claim amount at a rate 2% above bank rate.
6.1.10. **Moratorium Period** After completion of 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.	**Simplified for you** After 8 years, no health insurance claim shall be contestable except for proven fraud and permanent exclusions.
6.1.11. **Multiple Policies** i. 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. ii. 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. iii. 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. iv. 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.	**Simplified for you** In case you have multiple policies, you can choose the policy from which you want to claim first. If claim amount exceeds the Sum Insured of first policy you claim from; then you can claim the balance amount from the second policy.
6.1.12. **Migration** The Insured Person will have the option to migrate the Policy to other health insurance products / plans offered by the Company policy by applying for migration of the policy 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	**Simplified for you** You can shift your policy to any other health insurance product / plan offered by us as per migration guidelines.
6.1.13. **Portability** 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	**Simplified for you** You can also shift your policy to any other insurer as per portability guidelines.

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

6.1.14. **Disclosure of Information**

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

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

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

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

6.1.16. **Complete Discharge**

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

6.1.17. **Premium Payment in Instalments**

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

i. Grace Period of 30 days in case of single premium policies, and a period of 15 days in case of other than single premium policies, would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get canceled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

6.2. Specific Terms and Clauses

6.2.1. **Automatic Cancellation:**

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

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

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

after you pay us the additional premium and provide us consent.

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

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

6.2.3. **Other Renewal Conditions:**

a. **Renewal Premium:**
Renewal premium will alter based on Age. For Floater plan, the age of eldest insured person will be considered for calculating the premium.

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

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

6.2.4. **Claims**

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

b. Documents required with claim form:

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

Policyholder documents (Nominee in case of death of Policyholder):
- KYC documents
- Cancelled cheque

IMPORTANT:
- All documents **MUST** be submitted within 30 days from discharge.
- For any delay in submission, You **MUST** provide the reasons in writing. We will condone such delay on merits (i.e. reasons beyond your control).
- You **MUST** submit all claim related documents for expenses within the Deductible amount (if applicable).
- We reserve the right to check and investigate the hospital / medical records from any doctor, Hospital, clinic, individual or institution.

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

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

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

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

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

6.2.5. **Policy Disputes**

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

6.2.6. **Territorial Jurisdiction**

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

6.2.7. **Alteration to the Policy**

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

6.2.8. **Zonal pricing**

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

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

ii. Zone 2: Rest of India

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

6.2.9. **Assignment**

The Policy can be assigned subject to applicable laws.

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

List I – Expenses not covered

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

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

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

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

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

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

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

Annexure II - List of Insurance Ombudsmen

Office Details	Jurisdiction
AHMEDABAD **Shri 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, Dadra & Nagar Haveli, Daman and Diu
BENGALURU **Mr Vipin Anand** 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 R. M. Singh** Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh
BHUBANESWAR **Shri Suresh Chandra Panda** Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH **Mr Atul Jerath** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh
CHENNAI **Shri Segar Sampathkumar** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)

Office Details	Jurisdiction
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, Sonepat & Bahadurgarh
GUWAHATI **Shri Somnath Ghosh** 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 N. Sankaran** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR **Shri Rajiv Dutt Sharma** 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	Rajasthan
ERNAKULAM **Shri G. Radhakrishnan** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
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 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

Office Details	Jurisdiction
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI **Shri Bharatkumar S. Pandya** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)
NOIDA **Shri Chandra Shekhar Prasad** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA **Shri N. K. Singh** Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
PUNE **Shri Vinay Sah** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

Council for Insurance Ombudsmen

3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054

Tel.: 022 -69038800/69038812| Email: inscoun@cioins.co.in

ENDORSEMENT DOCUMENT - Smart Health+

"Smart Health+" covers treatment taken within India only.

You are covered under Smart Health+ only if you have paid additional premium for this and it has been endorsed in to your policy. Means it appears in your policy schedule.
Benefits applicable to you will depend on the chosen variant, mentioned in your policy schedule.
Unutilized Sum Insured will expire at the end of policy year.

1. Variants & Benefits description

A. Best consult

i. What is covered?

This plan covers 'Acute conditions' ONLY.

ii. What you get

You can avail UNLIMITED tele-consultation with **general medical practitioner, specialists and super specialist consultations** through **OUR PARTNER ONLY**, whenever you need, 24 hours a day 7 days a week, 365 days a year. 366 days if it's a leap year.

What is an 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

What it means?

These are the conditions that one suffers from every now and then and are unexpected like fever, cough, cold, injury, diarrhea etc. In these conditions, once treated for a few days you get better completely and the condition is 'cured'. No regular treatment, medicines, follow up, or monitoring is required for such conditions.

Example:

- Mr. X is suffering from diabetes and is on regular medication for diabetes. He falls ill and has urinary tract infection. He can consult doctor through our partner to get treatment for the same.
- Mr. Y is a healthy individual. He has fever for which he can consult doctor through our partner.

iii. What is NOT covered?

a. Chronic conditions.
b. Consultations NOT availed through our partner
c. Cost of medicines, investigations, procedures, in-hospital treatment (whether out-patient, in-patient or day care)

What is a 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

What it means?

Those conditions that are not completely cured by treatment. Regular treatment, medicines, follow ups and monitoring is required to keep these conditions under control. These are conditions like Diabetes, High blood pressure, Asthma, Arthritis etc.

Example:

- Mr X is suffering from diabetes and take regular medication to control his sugar level. Diabetes is a chronic condition and consultation to manage diabetes is not covered
- Mr. Y is suffering from Psoriasis. He consults his doctor every quarter and takes regular medication to keep the condition under control. Psoriasis is a chronic condition and consultation to manage this is not covered
- Mr. Z falls down at home, goes to nearby Doctor for consultation. Doctor prescribes medication for the injury. This is not covered because i) he has not availed consultation through our partner and ii) cost of medication/investigation is not covered under Best Consult

iv. **How it works**

Simple!! Call the number we have provided to you. Doctor will receive your call directly.
We recommend you **store the number on your phone, stick it on your refrigerator or a place easily accessible.**

B. Best care

i. **What is covered?**

This plan covers 'Acute conditions' ONLY.

ii. **What you get**

a. You can avail UNLIMITED tele-consultation with **general practitioner, specialists, and super specialist consultations** through **OUR PARTNER ONLY**, whenever you need, 24 hours a day 7 days a week, 365 days a year. 366 days if it's a leap year :.
b. Investigations up to Sum Insured **as per your policy schedule per year as prescribed by the general practitioner, specialist or super specialist consulted through OUR PARTNER ONLY**. We can help organize it and we will pay. OR you can do it at centers of your choice and we still will pay. Of course, both instances, up to limit only.
c. Medicines up to Sum Insured per your policy schedule year **as prescribed by the general practitioner, specialist or super specialist consulted through OUR PARTNER ONLY.** We can help deliver it at your home and we will pay. OR you can buy it from pharmacy of your choice and we still will pay. Of course, both instances, up to limit only.

What is an 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

What it means?

These are the conditions that one suffers from every now and then and are unexpected like fever, cough, cold, injury, diarrhea etc. In these conditions, once treated for a few days you get better completely and the condition is 'cured'. No regular treatment, medicines, follow up, or monitoring is required for such conditions.
Example:

- Mr X is suffering from diabetes and is on regular medication for diabetes. He falls ill and has urinary tract infection. He can consult doctor through our partner to get treatment for the same including medicine and investigation prescribed by the doctor
- Mr. Y is a healthy individual. He has fever for which he can consult doctor through our partner to get treatment for the same including medicine and investigation prescribed by the doctor

iii. **What is NOT covered?**

a. Chronic conditions.
b. Consultations NOT availed through our partner

What is a 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

What it means?

Those conditions that are not completely cured by treatment. Regular treatment, medicines, follow ups and monitoring is required to keep the condition under control. These are conditions like Diabetes, High blood pressure, Asthma, Arthritis etc.

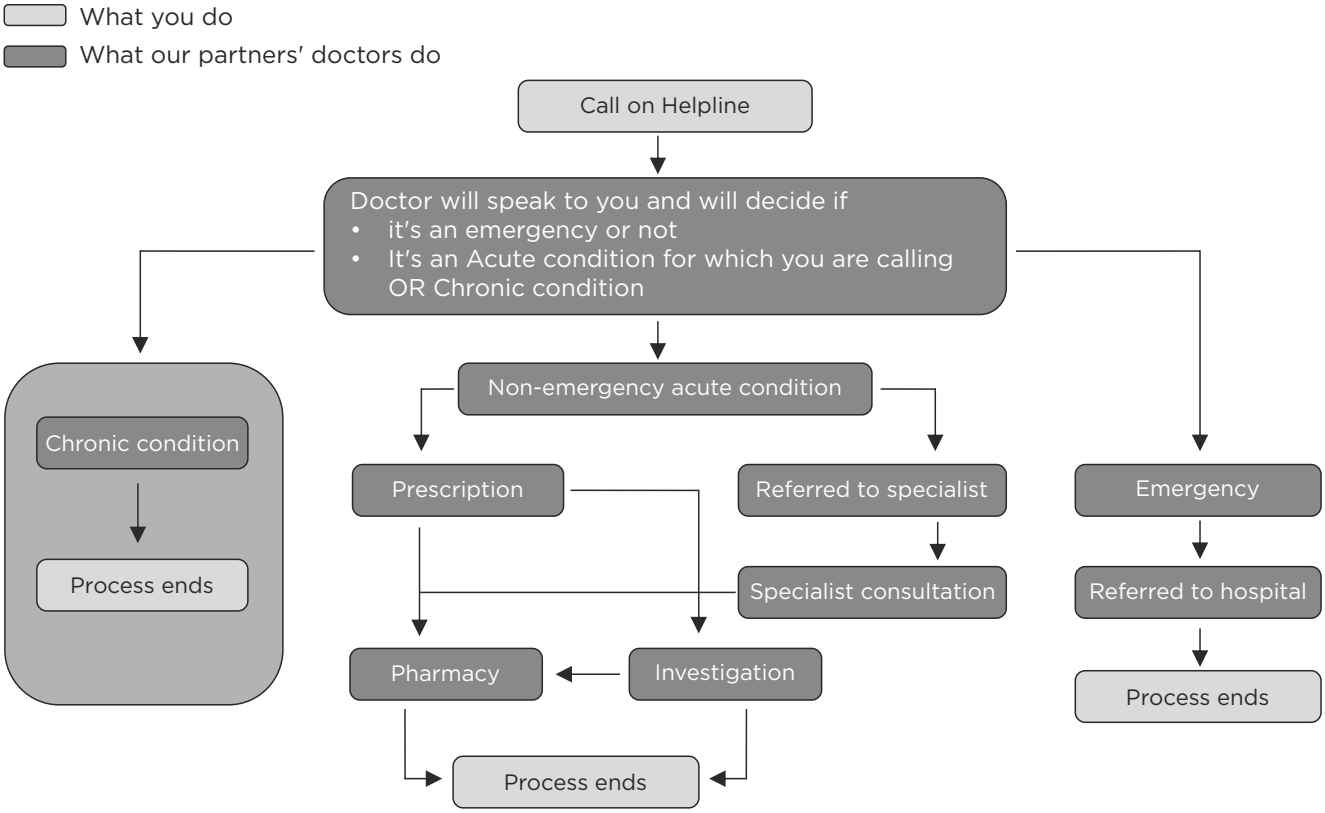
Examples of not covered cases:

- Mr X is suffering from diabetes and take regular medication to keep his sugar level under control. Diabetes is a chronic condition and consultation/medication to manage diabetes is not covered
- Mr. Y is suffering from Psoriasis. He consults his doctor every quarter and takes regular medication to keep the condition under control. Psoriasis is a chronic condition and consultation/medication to manage is not covered.
- Mr. Z falls down at home, goes to nearby Doctor for consultation. Doctor prescribes medication for the injury. This is not covered because he has not availed consultation through our partner

v. **How it works**

Simple!! Call the number we have provided to you. Doctor will receive your call directly.
We recommend you store the number on your phone, stick it on your refrigerator or a place easily accessible.

The following diagram will give a simple step wise view of how it works, what to expect



C. Disease Management "Gold"

What do you get?

- Day 0 Coverage for inpatient hospitalization or day-care treatment for any complications arising out of diabetes or hypertension from the date of this policy inception
- Up to 20% discount on renewal premium of base product and rider. The discount will be calculated as per the grid in Annexure 1

Getting renewal premium discount is easy, here is how:

- You get discount for undergoing health check-up. Just undergo the complete set of tests mentioned under Health Check-up in Annexure 1, and you can get up to 4% discount
- You get discount for results you get in these tests. Submit the test reports to us and get discounts as per test report
- Take the tests up to 4 times a year and get the discount for every time you get the test done
- Just ensure that there is a gap of at least 60 days between 2 set of tests
- And remember, you must submit the report to us at least 75 days prior to the policy renewal date

D. Disease Management "Platinum"

What do you get?

- Day 0 Coverage for inpatient hospitalization or day-care treatment for any complications arising out of diabetes or hypertension from the date of this policy inception
- Up to 20% discount on renewal premium of base product and rider. The discount will be calculated as per the grid in Annexure 1
- We will cover the cost of tests mentioned in Annexure 1. You can get them done through us, in our network, on cashless basis. Or you can get them done at the center of your choice. We will still pay for the tests, on reimbursement basis, up to Rs. 3,000 for all the tests in a policy year.

Getting renewal premium discount is easy, here is how:

- You get discount for undergoing health check-up. Just undergo the complete set of tests mentioned under Health Check-up in Annexure 1, and you can get up to 4% discount
- If you are getting the tests done on cashless basis, no need to do anything further. Just sit back, relax, and we will take care of the rest
- If you are getting them done on reimbursement basis, you will need to submit the report to us and follow the steps below:
  - ¢ You get discount for results you get in these tests. Submit the test reports to us and get discounts as per test report
  - ¢ Take the tests up to 4 times a year and get the discount for every time you get the test done
  - ¢ Just ensure that there is a gap of at least 60 days between 2 set of tests
  - ¢ And remember, you must submit the report to us at least 75 days prior to the policy renewal date

E. Complete Care

Combination of either of Disease Management "Gold" or Disease Management "Platinum" plan with Best Consult or Best Care Plan

Annexure 1

Health Check-up tests:

- **BMI**
- **Lipid Profile**
- **HbA1C**

The applicable discount would be aggregate of discount accrued for undergoing health check-up, and reported value of the individual components of the health check-up (HbA1C Check-up, Lipid Profile, and BMI outcomes) as per the below grid:

Check-up Discount

Health Check-up Done	Discount/Quarter (%)	Total Discount/Annum (%)
Yes	1	4
No	0	0

HbA1C

Reading	Discount/Quarter (%)	Total Discount/Annum (%)
<6.50	2.5	10
6.51 -7.00	2	8
7.01-8.00	1	4
>8.00	0	0

Lipid Profile

Total Cholesterol: HDL Cholesterol ratio

Reading	Discount/Quarter (%)	Total Discount/Annum (%)
<4.00	1	4
4.01-5.00	0.5	2
>5.00	0	0

BMI

Reading	Discount/Quarter (%)	Total Discount/Annum (%)
<18.5	0	0
18.5 - 24.9	0.5	2
>24.9	0	0


niva
Health Insurance
Customer ID: 2002797256
Member No. Name Age Valid From
16679405 Satish Navalchand Sancheti 64 17/07/2023
16679406 Anita Sancheti 52 17/07/2023