

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
1	Name of Insurance Product/ Policy	Heart Beat
2	Policy Number	NBHHLIP27058V102627
3	Type of Insurance Product/ Policy	Both Indemnity and Benefit
4	Sum Insured	Sum Insured Options are: INR 2 Lacs, 3 Lacs, 5 Lacs, 7.5 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 30 Lacs, 50 Lacs, 100 Lacs The Sum Insured opted by you is mentioned in the Policy Schedule.
5	Policy Coverage	Base Coverage: • Hospital admission longer than 24 hrs • Related medical expenses up to Sum Insured incurred up to 60 days prior to hospitalization • Related medical expenses incurred up to Sum Insured within 90 days from date of discharge • All procedures requiring less than 24 hours hospitalization, list of day care procedures per Annexure III of Policy Document • Domiciliary hospitalization covered up to Sum Insured • Alternative treatment covered up to Sum Insured • Living organ donor transplant covered up to Sum Insured • Emergency Ambulance covered up to Rs. 2,000 per hospitalization (for hospitalization in non-network hospitals) and up to Sum Insured (for hospitalization in network hospitals) • Maternity benefit covers Reasonable Medical Expenses for delivery of a child & medically necessary termination of pregnancy, where female Insured Person of age 18 years or above is covered under Family First Policy; Or both Insured Person and his / her legally married spouse are covered under Family Floater Policy, after a period of 24 months of continuous coverage since the inception of the first Policy, with maternity as a benefit, with Us. Medical Expenses for Pre and Post Hospitalization under Maternity Benefit will not be available. • New born baby will be covered as an insured person from birth till the end of policy year in which the baby is born, subject to Maternity Benefits should be payable. Vaccination expenses of the new born baby for the first Year, subject to addition of the new born baby in the policy at renewal of the policy are also covered under this benefit. • Health Check-up is covered post completion of 1st policy year as per plan and Sum Insured chosen by You

	• Re-fill benefit is covered up to 100% of Base Sum Insured in case the Sum Insured gets exhausted during Policy Year • Pharmacy and diagnostic services • Loyalty additions through increase in Sum Insured by 10% of expiring Base Sum Insured in a Policy Year, maximum up to 100% (50% in case of silver plan) of Base Sum Insured, irrespective of claims status • Expenses incurred by the Insured Person for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS are covered up to a maximum of Rs. 50,000 • Emergency Assistance service are covered within India up to Sum Insured • Mental disorders treatment covered up to Sum Insured (sub-limit applicable on few conditions / disorders) • Modern Treatments covered up to Sum Insured <u>Additional coverage applicable only for Platinum Plan:</u> • Coverage for Second Medical Opinion can be availed for planned surgery and specified illnesses • Child Care benefits for specified vaccination expenses for Insured children until they have completed 12 years are covered. Expenses for nutrition and growth consulting provided for the child during a visit for such vaccination is also covered. • Specified Illness Cover is covered if an Insured Person suffers a Specified Illness during the Policy Period and while the Policy is in force, We will cover Reasonable and Customary expenses for In-patient treatment and Hospital Accommodation as long as: ○ The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of 90 day from the inception of 1st Policy with us. ○ The Specified Illness is diagnosed by a Medical practitioner within India during the Policy Period and after completion of 90 day from the inception of 1st Policy with us. ○ Medical treatment for the Specified Illness is taken outside India, but only within those regions specified in the Schedule of Insurance Certificate. ○ The Specified Illnesses covered are as follows, ○ Cancer, Myocardial Infarction (Heart Attack), Coronary Artery Bypass Graft (CABG), Major Organ Transplant, Stroke, Surgery of Aorta, Coronary Angioplasty, Primary Pulmonary Arterial Hypertension & Brain Surgery. • OPD Treatment and Diagnostic Services expenses are covered for medically necessary consultation as an outpatient with a Medical Practitioner to assess the Insured Person's condition.
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		- Emergency Medical Evacuation: We will cover Emergency Medical Evacuation, outside India, but within only those regions specified in the Policy Schedule. - Emergency Hospitalization: We will cover Emergency Hospitalization if required immediately after the emergency medical evacuation outside India, but within only those regions specified in the Policy Schedule. Optional Coverage: - Personal Accident coverage against accidental death, permanent total and permanent partial disability - Critical Illness coverage for 20 major illnesses which includes cancer, first heart attack, open chest CABG, etc. - e-Consultation for unlimited tele / online medical consultations - One time premium waiver benefit if the Policyholder (who should also be an Insured Person) dies or is diagnosed with any of the specified illness as mentioned in Policy Document - Hospital Cash benefit is paid as per the plan chosen for a maximum for 30 days per insured person per policy year, provided that the Insured Person should have been Hospitalized for a minimum period of 48 hours and In-patient Care Hospitalization should have been paid by Us. - Enhanced Geographical Scope for Specified Illness, Emergency Medical Evacuation (outside India) and Emergency Hospitalization (outside India) for extending cover to USA & Canada (applicable under Platinum plan only)
6	Exclusions	Standard Exclusions 1. Pre-existing Diseases (Code-Excl01) 2. 30-day Waiting Period (Code-Excl03) 3. Specified disease/procedure waiting period (Code- Excl02) 4. Investigation & Evaluation (Code-Excl04) 5. Rest Cure, rehabilitation and respite care (Code-Excl05) 6. Obesity/ Weight Control (Code-Excl06) 7. Change-of-Gender treatments (Code-Excl07) 8. Cosmetic or plastic Surgery (Code-Excl08) 9. Hazardous or Adventure sports (Code-Excl09) 10. Breach of law (Code-Excl10) 11. Excluded Providers (Code-Excl11) 12. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code-Excl12) 13. Treatments received in health spas, 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) 14. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins,

		minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure (Code-Excl14) 15. Refractive Error (Code-Excl15) 16. Unproven Treatments (Code-Excl16) 17. Sterility and Infertility (Code-Excl17) 18. Maternity (Code-Excl18) Specific Exclusions 1. Ancillary Hospital Charges - Charges related to a Hospital stay not expressly mentioned as being covered. This will include charges for admission, discharge, administration, RMO charges, night charges, registration, documentation and filing, surcharges and service charges levied by the Hospital. 2. Circumcision - Circumcision unless necessary for the treatment of a disease or necessitated by an Accident 3. 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. 4. External Congenital Anomaly - Screening, counseling or treatment related to external Congenital Anomaly 5. Dental/oral treatment - Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident 6. Hormone Replacement Therapy - Treatment for any condition / illness which requires hormone replacement therapy 7. Sexually transmitted Infections & diseases (other than HIV / AIDS) - Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS) 8. Sleep disorders - Treatment for any conditions related to disturbance of normal sleep patterns or behaviors 9. Any treatment or medical services received outside the geographical limits of India 10. 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
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		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. 11. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by: - Deep coma and unresponsiveness to all forms of stimulation - Absent pupillary light reaction - Absent oculovestibular and corneal reflexes - Complete apnea 12. AYUSH Treatment - Any form of AYUSH Treatments, except as mentioned under Section 3.6 of the policy wording Permanent Exclusions for Personal Accident Cover: We shall not be liable to make any payment under any benefits under Section 4.1 (Personal Accident Cover) if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following - Suicide or self-inflicted Injury, whether the Insured Person is medically sane or insane. - 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. - Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time. - Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule. - Committing an assault, a criminal offence or any breach of law with criminal intent. - Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person. - Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports. - Engaging in or taking part in professional/ adventure sports or any hazardous pursuits, speed contest or racing of any
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		kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, polo, snow and ice sports, hunting Permanent Exclusions for Critical Illness Cover: We shall not be liable to make any payment under Section 4.2 (Critical Illness Cover) directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy. 1. AYUSH Treatment - Any covered Critical Illnesses diagnosed and/or treated by a Medical Practitioner who practices AYUSH Treatment 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 3. External Congenital Anomaly - Screening, counseling or treatment related to External Congenital Anomaly 4. 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. 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. 6. Hazardous or Adventure sports (Code-Excl09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, parajumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving 7. 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
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		8. Maternity (Code-Excl18) – - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy - Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period 9. Sexually transmitted Infections & diseases (other than HIV / AIDS) - Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS) 10. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code-Excl12) 11. 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 12. Treatments received in health spas, 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) 13. 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 Personal Waiting Periods: Conditions specified for an Insured Person under Personal Waiting Period in the Policy Schedule will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us
7	Waiting period - Time period during which specified diseases/treatments are not covered. - It is counted from the beginning of the policy coverage.	Initial waiting Period: 30 days for all illness (not applicable on renewal or for accidents) Specific Waiting periods: For all Insured Persons who are above 45 years of Age as on the date of inception of the First Policy with Us, 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.

		List of specific diseases/procedures: ▪ Pancreatitis and Stones in Biliary and Urinary System ▪ Cataract, Glaucoma and other disorders of lens, disorders of Retina ▪ Hyperplasia of Prostate, Hydrocele and spermatocele ▪ Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/ Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy, ▪ Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region ▪ Hernia of all sites ▪ Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders ▪ Chronic kidney disease and failure ▪ Varicose veins of lower extremities ▪ Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, ▪ All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump ▪ Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract ▪ Tonsils and Adenoids, Nasal Septum and Nasal Sinuses ▪ Internal Congenital Anomaly Pre-existing diseases: Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months (under gold & platinum Plans)/ 36 months (under Silver Plans) of continuous coverage after the date of inception of the first Policy with Us. • For critical illness cover, 90 days initial waiting period along with Pre-existing Disease waiting period of 36 months and Survival Period exclusion of 30 days will apply for all conditions • Mental disorder treatment will have a waiting period of 36 months since inception of the policy and subject to continuous renewal. • Cases related to HIV/AIDS will be subject to a waiting period of 36 months from the inception of the policy with us. • Personal Waiting Periods - Conditions specified for an Insured Person under Personal Waiting Period in the Policy Schedule will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us.
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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) ii. Co-Payment (It is a specified amount/ percentage of the admissible claim amount to be paid by policyholder/ insured) 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))	i. Sub-limits - Room rent sub limit applicable as per plan chosen by you - Ambulance cover for Rs.2,000 per hospitalization (for non-network hospital) and up to Sum Insured (for network hospitals) - Maternity sub limit applicable as per plan and Sum Insured chosen by you - Health Checkup limits per insured person as per plan and sum insured chosen by you - Treatment for any condition caused or associated with HIV/AIDS will have a sublimit of Rs. 50,000 per policy year - Mental disorders treatment - sub-limit as per the plan chosen by you is applicable on specific mental conditions / disorders on a cumulative basis as specified in section 3.17 of policy terms and conditions Treatment - OPD treatment is covered up to a sub limit as per plan chosen by You - Personal Accident: up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore - Critical illness cover: Critical illness cover will be equal to base Sum Insured; subject to maximum of 10 lacs ii. Co-Payment - If You select Zone 2 (cities other than Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State), then a zone-wise co-payment of 20% will apply for treatment in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata & Gujarat State. (Not applicable to platinum plan) - Additional optional co-payment of 10% or 20% can be chosen by You. iii. Annual Aggregate Deductible (not available for new business) - Options of INR 10,000/ INR 20,000/ INR 30,000/ INR 50,000/ INR 1 lac/ INR 2 lacs / INR 3 lacs/ INR 4 lacs/ INR 5Lacs/ 10 Lacs can be availed along with premium Discount for Gold and Platinum Variants for Family Floater and Individual plans. - Options of INR 10,000/ INR 20,000/ INR 30,000/ INR 50,000/ INR 1 lac/ INR 2 lacs / INR 3 lacs can be availed along with premium Discount for Silver Variant for Family Floater and Individual plans.
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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- 1 Hours TAT for cashless final bill authorization- grant final authorization within three hours of the receipt of discharge authorization request from the hospital. In case of delay, any additional amount charged by hospital, will be borne by us. Network Hospital Details- https://rules.nivabupa.com/hospital-network/ Helpline No- 1860-500-8888 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
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Documents for issuance and claim settlement

- Pan Copy/ Form 60 (Proposer)
- Address Proof (Proposer) - Aadhaar Copy (Both sides) / Driving License / Voter ID card / Passport copy (First & last page)
- NRI/ FN/ NRI- Questionnaire (as applicable)
- Portability- Previous year Policy Documents
- Indian address proof & Foreign address proof (as applicable)
- Indian / Foreign passport (as applicable)
- Visa copy (as applicable)
- OCI Card (as applicable)
- PEP form
- Cancel Cheque (in case of Neft Payment) ** additional medical document may be requested based on Health Declaration.

Basic documents and verifications required for claim settlement

- Duly completed claim form signed by the insured/ policyholder and Medical Practitioner, along with policy number, health card and valid photo identity proof.
- Original hospital bills, receipts, discharge summary/ certificate/ card and itemised final bill.
- Original pharmacy bills supported by prescriptions; investigation reports and payment receipts; indoor case papers.

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- Medical Practitioner referral/ admission advice for non-accident hospitalization and relevant consultation/ treatment records.
- For cashless claims, hospital pre-authorization form and supporting clinical documents. Notify at least 48 hours before planned hospitalization or within 24 hours of emergency hospitalization.
- NEFT/ bank details, KYC verification and any other document required to assess admissibility or investigate the claim. Reimbursement claims are processed within 15 days after receipt of the complete claim form and documents, as stated in the policy.

Frequently Asked Questions- Heartbeat**Q1. What is the room rent limit in Heartbeat?**

Answer:

Plan	Individual/ Family Floater			Family First		
	Silver	Gold	Platinum	Silver	Gold	Platinum
Room Rent	Shared room or 1% of SI per day	Covered up to SI (except suite & other room category)	Covered up to SI	Rs. 3000 per day or shared room	Covered up to SI (except suite & other room category)	Covered up to SI

Q2. What is Premium Waiver in Heartbeat?

Answer: - If the Policyholder (who should also be an Insured Person) dies or is diagnosed or undergoes treatment for the first time, with any of the Specified Illness (mentioned in the policy document), During the Policy Period, the cover under the Policy shall be automatically extended for a tenure of 1 Policy Year starting from the end of that Policy Period.

Conditions in Premium Waiver:

- I. This optional benefit is provided once in the lifetime in the Policy regardless of the number of years the Policy has served with Us.
- II. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- III. The Specified Illness is diagnosed by a Medical Practitioner during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.
- IV. If We have admitted a claim under this optional benefit during the Policy Period, this optional benefit shall not be renewed for any subsequent Policy Period

Note: This benefit is not available under Individual Policy.

Q.3 What are the cost sharing options available in Heartbeat?

Answer: - The customers can opt for 10% or 20% co-payment in their policy. (this is applicable for all variants of the product.

Customers opting for Silver and Gold Variant, will also have the option of choosing zone based loading where co-payment will be applicable if treatment is taken in Mumbai (including Navi Mumbai & Thane), Delhi NCR, Kolkata and Gujarat state.

Q4. Who can avail health checkup benefit and what is the frequency?

Answer: - Any Insured Person on the commencement of that Policy can avail health checkup post completion of 1st policy year.

Plan	Individual / Family floater			Family First		
	Silver	Gold	Platinum	Silver	Gold	Platinum
Coverage amount	Once in 2 years as per defined list	Annual, Test covered up to worth Rs. 1250 (For 5 lac S.I) Rs. 1875 (For 7.5 lac S.I) Rs. 2500 (For 10 L - 50 Lac S.I)	Annual, Test covered up to worth Rs. 3750 (For 15 lac S.I) Rs. 5000 (For 20 lac - 1 Cr. S.I)	Once in 2 years as per defined list	Annual, Test covered up to worth Rs. 2500	Annual, Test covered up to worth Rs. 5000

Q5. Will refill trigger on subsequent claim even if sum insured in partially exhausted due to claim?

Answer: Yes, even if Base Sum Insured has been partially exhausted due to claims made and paid or claims made and accepted as payable for any Illness or Injury during the Policy Year, then We will provide a Re-fill amount of maximum up to 100% of the Base Sum Insured which may be utilized for claims arising in that Policy Year.

Q6. What is Second Medical Opinion in Heartbeat?

Answer: If the Insured Person is diagnosed with a Specified Illness as defined in the policy document or is planning to undergo a planned Surgery or a Surgical Procedure for any Illness or Injury, the Insured Person can, at the Insured Person's sole direction, obtain a Second Medical Opinion.

Q7. What are we covering in the optional cover Personal Accident Cover in Heartbeat?

Answer:

- Accidental Death within 365 days of accident
- If the Injury due to Accident solely and directly results in the Permanent Total Disability of the Insured Person which means that the Injury results in one or more of the following conditions within 365 days from the occurrence of an Accident, We will make payment of 125% of the Personal Accident Cover Sum Insured as specified in the Policy Schedule
- Accidental Permanent Partial Disability{PPD} - If the Injury due to Accident solely and directly results in the Permanent Partial Disability of the Insured Person within 365 days from the occurrence of such Accident, we will make a payment in accordance to the grid mentioned in the policy document.

Q8. What is Pharmacy and Diagnostic Services in Heartbeat?

Answer: Policy holder may purchase medicines and diagnostic services from Our empanelled Service Provider through Our mobile application or website. The cost for the purchase of the medicines or diagnostic services shall be borne by policyholder.

Q9. What is the limit for ambulance in Heartbeat?

Answer:- Same in all variants

- Network Hospital: Covered up to Sum Insured
- Non-network Hospital: Covered up to Rs. 2,000 per event

Q10. What is a Pre-Hospitalization limit in Heartbeat?

Answer: We will cover Pre-Hospitalization Medical Expenses for 60 days immediately preceding the Insured Person's admission to Hospital for Inpatient Care and it is covered up to sum insured.

Q11. What is a Post-Hospitalization limit in Heartbeat?

Answer: We will Cover Post-Hospitalization Medical Expenses for 90 days immediately following the Insured Person's discharge from Hospital and it is covered up to sum insured.

Q12. What is initial Waiting period in Heartbeat?

Answer: All the benefits under the Policy and any treatment taken unless the treatment needed is the result of an Accident that occurs during the Policy Period will be subject to a waiting period of 30 days since the inception of the First Policy with Us. Please note that Waiting Periods shall not apply to Health Checkup, Pharmacy and diagnostic services, Personal Accident Cover, Critical Illness Cover, e-Consultation and Premium waiver.

Q13. What is the specific waiting period and list of illness?

Answer: For all Insured Persons who are above 45 years of Age as on the date of inception of the First Policy with us, the medical conditions and/or surgical treatment listed below will be subject to a Waiting Period of 24 months unless the condition is directly caused by Cancer (covered after Initial Waiting Period of 30 days) or an Accident (covered from day 1) and will be covered in the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break. Following is the list of specific diseases:

- Pancreatitis and Stones in Biliary and Urinary System,
- Cataract, Glaucoma and other disorders of lens, disorders of Retina,
- Hyperplasia of Prostate, Hydrocele and spermatocele,
- Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy,
- Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,
- Hernia of all sites,
- Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders,
- Chronic kidney disease and failure
- Varicose veins of lower extremities
- Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane
- All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump
- Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract
- Tonsils and Adenoids, Nasal Septum and Nasal Sinuses
- Internal Congenital Anomaly.

Note: *If the Insured Person is suffering from the above Illness/condition as a Pre-existing Diseases (if disclosed by the Insured Person and accepted by Us), any claim in respect of that Illness/condition shall not be covered*

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until 24 months (under Gold and Platinum plans), 36 months (under Silver plan) of continuous coverage have elapsed since the inception of the First Policy with us.

Q14. Do Heartbeat covers Maternity Benefits?

Answer: Yes, covered in all the variants (silver, gold and platinum) as per the defined limit ranging from Rs. 20000 to 2 Lac)

Q15. If child is included in family floater plan, when child has to take separate policy?

Answer: If any Insured Person who is a child and has completed Age 22 years at the time of Renewal, then such Insured Person will have to take a separate policy.

Q16. What is the OPD Treatment & Diagnostic Services limit in Heartbeat?

Answer: OPD and diagnostics services are covered only in platinum variant.

(For Individual and Family floater)

For 15 lacs S.1- covered up to Rs. 15000

For 20 lacs S.1- covered up to Rs. 20000

For 50 lacs S.1- covered up to Rs. 35000

For 1 Cr. S.1- covered up to Rs. 50000

(For Family First)- Covered upto Rs. 35000

Q17. What are the optional benefits available in Heartbeat ?

Answer:

- Personal Accident cover (for insured aged 18 years & above on individual basis)
- Critical illness cover (for insured 18 years & above on individual basis)
- E-consultation
- Premium Waiver (Applicable in Family Floater/Family First)
- Enhanced Geographical Scope for International cover-age (Applicable in Platinum Plan)
- Annual aggregate Deductible
- Safeguard
- Safeguard+

Q18. What is the coverage of mental disorder treatment in Heartbeat?

Answer: After 3 years of waiting period Expenses incurred for inpatient treatment for mental illness are Covered under the policy subject to sub-limit of Rs. 50,000 for specific conditions.

Q19. What is the coverage of HIV AIDS in Heartbeat?

Answer: After 3 years of waiting period, covered under the policy subject to sub-limit of Rs. 50,000.

Q20. What is covered under Child Care Benefits?

Answer: In Platinum Plan (Family Floater/Family First) vaccinations for children up to 12 years are covered including one consultation for nutrition and growth during the visit for vaccination

Q21. What is Emergency Hospitalization?

Answer: If the Insured Person is required to be admitted in a Hospital in an Emergency condition, We will

compensate the Medical Expenses specified in the Policy Schedule. Any claim incurred before death of such Insured person shall be admissible subject to terms and conditions under this Policy.

Q22. How many Day Care procedure are covered in Heartbeat?

Answer: In Heartbeat, we cover 536 day care procedures.

Q23. What is an Emergency assistance service in Heartbeat?

Answer: This Policy provides a host of value added Emergency Medical Assistance and Emergency personal Services on cashless Facility basis in India geographical boundaries.

Emergency Assistance Service:

- Medical referral
- Emergency medical evacuation
- Medical repatriation
- Compassionate visit
- Care and/or transportation of minor children
- Return of mortal remains

Q24. Do we have two years policy options, if yes then what will be discount factor for same.

Answer: Yes, 2 year option is available. 12.5% discount will be provided on 2nd year premium.

Q25. Is there any sublimit on modern treatment?

Answer: No, there is no sublimit on modern treatment.

Q26. What is the maximum sum insured in personal accident cover?

Answer: The maximum sum insured in personal accident cover is INR 1 Crore. Insurer has options to choose the factor 1X / 2X / 3X / 4X/ 5X of personal accident sum insured. However, for family first, the personal accident cover is only 5 times of the base sum insured.

Q27. What is SafeGuard (add-on)?

Answer: SafeGuard benefit will cover the following:

- Claim Safeguard: Non-payable items paid up to Sum Insured in case of hospitalization (List 1).
- Sum Insured Safeguard: CPI linked increase in Base Sum Insured

Q28. What is SafeGuard+ (add-on)?

Answer: SafeGuard+ benefit will cover the following:

- Claim Safeguard+: Coverage for non-payable items as per List 1, 2, 3 & 4.
- Sum Insured Safeguard+: Increase in base sum insured on a cumulative basis each policy year based on Inflation Rate

Q29. What is annual aggregate deductible?

Answer: This is an aggregate amount in a year that is incurred by insurer 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.

Deductible is on an Annual Basis and not on every claim. Options available are INR 20,000 / INR 30,000 / INR 50,000 / INR 1 lac / INR 2 lacs / INR 3 lacs / INR 4 Lacs / INR 5 Lacs / INR 10 Lac (Up to INR 3 lacs for Silver plan).

Q30. Is it mandatory to confirm the nomination details at the time of buying the policy and on renewal?

Answer: Yes, it is mandatory to confirm the nomination details at the time of renewal.

Details required for Nominee:

Name: _____ Address: _____

Email ID: _____

Bank Name _____ Branch _____ City _____

Account number _____ IFS Code _____

Account type: ☐ Savings ☐ Current

Q31. Is it mandatory to share Bank Account details of the proposer at the time of logging in the policy?

Answer: Yes, it is mandatory to share Bank Account details of the proposer at the time of logging in the policy.

Q32. How many days are in free look period?

Answer: Free look period consists of 30 days.

Q33. What is the duration of grace period?

Answer: Grace period is of 30 days for all types of policies. For policies with monthly premium payment mode, it is for 15 Days. The coverage too will be given during the 15 Days grace period of a policy taken on monthly mode.

Q34. How is the premium refund calculated upon cancellation after the free look period?

Answer: Post free look period, premium refund on cancellation would be on pro-rata basis.

Q35. When will the customer's consent be obtained for data sharing with third – party service providers?

Answer: Consent of Customer will be taken, at the time of enrolment in to the policy, for data sharing with any third party service provider.

Q36. What is Moratorium period? What is the duration of moratorium period?

Answer: After completion of five continuous years under the policy, no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of five 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. The duration of moratorium period is 5 years (60 months).

Q37. What is Favourable Claim Experience Discount?

Answer: **Discount of up to 42%** on the renewal premium **basis the value of the claims paid** during the policy year.

A Trend and Level Score will be allotted for each policy year.

Trend Score: A score for the policy basis the claim amount paid in the policy year.

Level Score: A calculated score at policy level which will determine the discount on the renewal premium.