1. Preamble

This Policy covers benefits under Wellness and OPD. Expense incurred outside the Policy Period will **NOT** be covered. All applicable benefits, details and limits are mentioned in your Certificate of Insurance.
All treatments in this policy will be considered if they are conducted in India.

2. Definitions

2.1. Standard Definitions:

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

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.

3. **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.

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

5. **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.

6. **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:
   i. has Qualified Nursing staff under its employment;
   ii. has qualified Medical Practitioner(s) in charge;
   iii. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
   iv. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

7. **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.

8. **Disclosure to information norm:** 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.

9. **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.

10. **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.

11. **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.

12. **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 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.

13. **Hospitalization** or **Hospitalized** means the admission in a Hospital for a minimum period of 24 consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

15. **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:
       i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
       ii. it needs ongoing or long-term control or relief of symptoms
       iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
       iv. it continues indefinitely
       v. it recurs or is likely to recur

16. **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.

17. **Inpatient** means admission for treatment in a Hospital for more than 24 hours for an Insured Event.

18. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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

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

21. **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.

22. **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.

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

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

24. **Migration** means the right accorded to individual 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.

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

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

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

28. **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.

29. **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.

30. **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.

31. **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.

32. **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

33. **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.

34. **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.

35. **Unproven/Experimental treatment:** 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. <u>Specific Definitions:</u>

1. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

2. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner* (s) on day care basis without in-patient services and must comply with all the following criterion:
i. Having qualified registered AYUSH *Medical Practitioner(s)* in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

5. **Base Sum Insured** means the amount stated in the Policy Schedule.

6. **Bone Marrow Transplant** is the actual undergoing of a transplant of human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following will be excluded:
i) Other stem-cell transplants

ii) Where only islets of langerhans are transplanted

7. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

8. **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.

9. **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's amount. A Co-payment does not reduce the Sum Insured.

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

11. **Diagnostic Services** means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.

12. **Emergency** means a medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

13. **Evidence Based Clinical Practice** means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.

14. **e-Consultation** means opinion from a Medical Practitioner 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 license.

15. **Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Primary Insured Person; and/or
b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or
c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).

16. **First Policy** means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.

17. **Information Summary Sheet** means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.

18. **Individual Policy** means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.

19. **Insured Event** means any event specifically mentioned as covered under this Policy.

20. **Insured Person** means person(s) named as insured persons in the Policy Schedule.

21. **IRDAI** means the Insurance Regulatory and Development Authority of India.

22. **Maternity expenses:** Maternity expenses means;
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period

23. **Medical Record** means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by Medical Practitioners who have knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

24. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

25. **New Born Baby:** Newborn baby means baby born during the Policy Period and is aged up to 90 days

26. **Policy** means these terms and conditions, the Policy Schedule (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.

27. **Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

28. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.

29. **Policy Schedule** means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.

30. **Primary Insured Person** means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

31. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

32. **Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.

33. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

34. **Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.

35. **Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.

36. **Standby Services** are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

37. **Sum Insured** means the total of the Base Sum Insured which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person(s) which is specified in the Policy Schedule.

38. **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 Center by a Medical Practitioner.

39. **Survival Period** means the period, if any, specified under the Policy after the occurrence of an Insured Event that the Insured Person has to survive before a claim becomes admissible under the Policy.

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

41. **We/Our/Us** means Niva bupa Health Insurance Company Limited.

42. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

3. Scope of Cover: Benefits

a. The terms, conditions and exclusions governing the Benefits under this Policy are described below and the Benefits listed in thi section will be payable accordingly.
b. The Certificate of Insurance will specify the Benefits, Sum Insured, pay outs, limits, sub limits, Deductible and/or Franchis applicable to the respective benefits available for the Insured Person.
c. Policy will be active only during the date and/or time as specified in Certificate of Insurance.
d. All claims for any Benefits under the Policy must be made in accordance with the claim process defined under the respective section in which the Benefit is being claimed.

3.1. Video Consultations with General Practitioner

We will cover Video Consultations with certified General Practitioners for the Insured. A video consultation is an out-patient consultation, which is conducted over a video call between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance.
These consultations can be booked digitally via our/empaneled service provider's website, Mobile application, and/or through our call centers.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.2. Tele Consultations with General Practitioner

We will cover Tele Consultations with certified General Practitioners for the Insured. A Tele consultation is an out-patient consultation, which is conducted over an audio call between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance.
These consultations can be booked digitally via our/empaneled service provider's website, Mobile application, and/or through our call centers.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.3. Physical Consultations with General Practitioner

We will cover Physical Consultations with certified General Practitioners for the Insured. A Physical Consultation is an out-patient consultation, which is conducted over a face-to face meeting between the Insured and the General Practitioner. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, as specified in the Policy Schedule/Certificate of Insurance. These consultations can be booked via our/empaneled service provider's website, Mobile application, and/or through our call centers or/and at the doctor's clinic/hospital.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.4. Video Consultations with specialists

We will cover Video Consultations with Specialists for the Insured. A video consultation is an out-patient consultation, which is conducted over a video call between the Insured and the Specialist. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.
These consultations can be booked digitally via our/empaneled service provider's website, Mobile application, and/or through our call centers.

The type of specialists covered will be as per Annexure 3.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.5. Tele Consultations with specialists

We will cover Tele Consultations with Specialists for the Insured. A Tele consultation is an out-patient consultation, which is conducted over an audio call between the Insured and the Specialist. The insured can take the number of consultations or as per a pre-defined limit within network or outside of the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.
These consultations can be booked digitally via our/empaneled service provider's website, Mobile application, and/or through our call centers.

The type of specialists covered will be as per Annexure 3.

Any unutilized amount or no. of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.6. Physical Consultations with specialists

We will cover Physical Consultations with Specialists for the Insured. A Physical Consultation is an out-patient consultation, which is conducted over a face-to face meeting between the Insured and the Doctor. The insured can

take the number of consultations or as per a pre-defined limit within network or outside of the network, with the specified specialists as mentioned in the Policy Schedule/Certificate of Insurance.
These consultations can be booked via our/empaneled service provider's website, Mobile application, and/or through our call centers or/and at the doctor's clinic/hospital.

The type of specialists covered will be as per Annexure 3.

Any unutilized amount or number of consultations in one Policy Year cannot be carry forwarded to the next Policy Year.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.7. Diagnostic Services

The Insured Person may avail specified diagnostic tests as per Annexure 4 or Up to a pre-set limit or/and set of specified diagnostic tests, as specified in the Policy Schedule/Certificate of Insurance, from us / Our empanelled Service Provider through our/its mobile application or website. However, We shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further the diagnostic tests taken from us/ Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

Conditions:

a. Diagnostic Tests are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia – with or without Hospitalization for less than 24 hours.

3.8. Pharmacy Services

The Insured Person may purchase prescription or/and over the counter pharmacies(medicines) or Up to a pre-set limit can be utilized for prescription or/and over the counter pharmacies(medicines) as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of medicines from us/our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.9. Home Health Care Services

The Insured person may avail home health care services, which are services that can be availed at your home for treatment of al illness or injury, as per Annexure 5 or up to the limit as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Home Health Care Services from us/Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Conditions:

a. The medical condition of the Insured Person must be such that the treating Medical Practitioner expects the condition to improve in a reasonable and generally predictable period of time.
b. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the treatment plan for the condition of the Insured Person.
c. The amount, frequency and time period of the services under this Benefit shall be reasonable, and in agreement between treating Medical Practitioner and the Insured Person availing the service.

d. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.10. Vaccination Cover

The Insured person may avail specified Vaccinations as per Annexure 6 or up to a pre-set limit as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Vaccination Services from us/Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Conditions:

a. The expenses incurred are Reasonable and Customary (as per clause 2.1.33)
b. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.11. Annual Health Check-up

The Insured Person may avail a health check-up during the Policy Period as per the list specified in Annexure 7 or for a pre-defined list of tests or up to the limit specified in the Policy Schedule/Certificate of Insurance. These tests can be booked via our/empaneled service provider's website, Mobile application, through our call centers, or/and at the doctor's clinic/hospital.

a. The eligibility of the Insured Person under this Benefit and the frequency of heath check-ups will be as specified in the Policy Schedule/Certificate of Insurance.
b. Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.
c. Any unutilized test or amount in one Policy Year cannot be carry forwarded to the next Policy Year.

3.12. Second Medical Opinion

If the Insured Person 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 choice, obtain a Second Medical Opinion during the Policy Period and within the region(s) as mentioned in the Policy Schedule/Certificate of Insurance, from us / our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever.

Further availing the second medical opinion from us/Our empanelled Service Provider Is at the Insured Person's absolute discretion and choice. The second medical opinion under this benefit shall not be valid for any medico legal purposes

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

3.13. Monitoring / Medical Devices

The Insured person may avail monitoring / medical devices which are medically necessary and recommended by a registered medical practitioner as per Annexure 8 or up to the limit or percentage of sum insured as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Monitoring/Medical Devices from us/Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Expenses can be claimed under this Section on a Reimbursement basis or on Cashless basis as mentioned in the policy schedule/ certificate of Insurance.

Conditions:

a. The monitoring / medical device(s) being recommended by treating Medical Practitioner, would help in improving the condition in a reasonable and generally predictable period of time.

b. The Medical Device / Monitoring device can only be purchased if recommended by a registered medical practitioner only

3.14. Condition Management Packages

The Insured person may choose to opt for one or more condition management package/(s) for a medical condition as defined in Annexure 9, on the recommendation of a registered medical practitioner up to the limits as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website. However, we shall not be responsible for any dispute between the Insured Person and the Service Provider for any reason whatsoever. Further purchase of Condition Management Package(s) from us/Our empanelled Service Provider is the Insured Person's absolute discretion and choice.

Expenses can be claimed under this Section on Cashless basis only.

3.15. Wellness benefits

The policy offers benefits to encourage Good Health and a healthier lifestyle. The Insured person may choose to avail any of the benefits outlined below up to the limits as mentioned in the Policy Schedule/Certificate of Insurance, from us/our empanelled Service Provider through our/its mobile application or website.

3.15.1. Access to Fitness Centre / Digital Fitness Coaching / AI Fitness Coaching

Access to Physical Fitness Centres or Gyms / Digital Fitness Coaching sessions / AI led fitness coaching sessions to stay healthy. These benefits will be provided by our empanelled service providers on cashless basis only. Utilisation of the benefits will be at the sole discretion and choice of the insured.

3.15.2. Access to Nutritionist/Wellness Coaching

Access to Dietician / nutritionist / health coach / emotional wellness coach / psychologist / Assessments for maintaining a healthier and balanced lifestyle. The consultations can be availed through our /empanelled service provider's application /website via audio, video or chat channels on cashless basis only. Utilisation of the benefits will be at the sole discretion and choice of the insured.

3.16. Wallet

The insured can utilise the wallet limits for benefits as defined in the the Policy Schedule/Certificate of Insurance. The wallet can consist of benefits as defined in section 3.1 to 3.15. The conditions for the respective benefits given under the wallet will be applicable.

The wallet will be available in below options, as mentioned in your Policy Schedule/Certificate of Insurance:

3.16.1. Master Wallet

Master Wallet, as specified in your Certificate of Insurance/Policy schedule, can either be a list of benefits with a single limit/sub-limit. or a single benefit with a defined limit. The limit in the wallet can be utilized for one benefit alone or for combination of benefits (if applicable).

3.16.2. Individual Benefit Wallet

Individual Wallet, as specified in your Certificate of Insurance/Policy schedule, will be a wallet with specific benefits with individual limit/sub-limit for each benefit. The limit in the wallet can be utilized for each benefit or for combination of benefits (if applicable).

3.17. Vouchers

Vouchers are one time use benefits given to the Insured, as mentioned in the
The Insured will get Single time use vouchers of fixed values as specified in the Policy Schedule/Certificate of Insurance.

The value of the voucher will be as per the limit/sub-limit mentioned in your policy schedule/certificate of insurance.

The vouchers can be offered for any or all of the benefits mentioned from Section 3.1 to 3.15. The conditions for the respective benefits given for the vouchers will be applicable. The vouchers will have to be utilized on us/our empanelled Service Provider through our/its mobile application or website

Conditions:

a. These will be one time use vouchers and would lapse when utilized
b. In case of Partial utilization of the voucher, the balance amount would be forfeited and would not be carried forward
c. The voucher would only be allowed to be utilized for the benefits as defined in the policy schedule/certificate of insurance
d. The Vouchers are non-transferable.
e. Expenses can be claimed under this Section on Cashless basis only.

4. Cost Sharing Options

4.1. Co-payment

The Insured Person will pay the pre-determined percentage as specified in the Policy Schedule/ Certificate of Insurance as Co-Payment and We will pay the remaining part of the amount that We assess as the admissible amount in respect of any claim.

4.2. Annual Aggregate Deductible

The Insured Person shall bear on his/her own account an amount equal to the Annual Aggregate Deductible specified in the Policy Schedule/ Certificate of Insurance for any and all admissible claim amounts We assess to be admissible in respect of all claims made by that Insured Person. The deductible can be applied on the basis of limits or number of visits.

4.3. Franchise

The insured would be eligible to avail the benefits post the number of visits / consultations has been done by the insured following which the benefit would be payable from the first completed visit / consultation.

5. Permanent Exclusions

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

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

5.1. Standard Exclusion:

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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 number of months (as mentioned in Policy Schedule /Certificate of Insurance) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

II. **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 number of months (as mentioned in Policy Schedule/Certificate of Insurance) 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).

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

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

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

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

f. List of specific diseases/procedures:

I. Pancreatitis and stones in biliary and urinary system

II. Cataract, glaucoma and other disorders of lens, disorders of retina

III. Hyperplasia of prostate, hydrocele and spermatocele

IV. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy

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

VI. Hernia of all sites,

VII. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair

VIII. Chronic kidney disease and failure

IX. Varicose veins of lower extremities

X. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump

XI. Ulcer, erosion and varices of gastro intestinal tract

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

XIII. Internal Congenital Anomaly

XIV. Surgery of Genito-urinary system unless necessitated by malignancy

XV. Spinal disorders

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

a. Expenses related to the treatment of any Illness upto 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.

IV. **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.

V. **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.

VI. **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:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

VII. **Change-of-Gender treatments (Code-Excl07)**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

VIII. **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.

IX. **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.

X. **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.

XI. **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.

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

XIII. 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)**

XIV. 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)**

XV. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

XVI. **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.

XVII. **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

XVIII. **Maternity (Code-Excl18)**

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

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

5.2. Specific Exclusion:

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

II. **Circumcision**

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

III. **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.

IV. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

V. **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.

VI. **Hormone Replacement Therapy:**

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

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

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

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

IX. **Sleep disorders:**

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

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

6. General Terms and Conditions

6.1. Standard General Terms and Conditions

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 o porting/migrating the policy.

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

If the Insured has not made any claim during the Free Look Period; the Insured shall be entitled to:

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

6.1.2. Cancellation

A. **Cancellation by the policyholder** –

a. The policyholder may cancel this policy by giving 30 days written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below.

b. 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.

Short Period Grid – Option 1

	Refund %								
	Policy Term								
Timing of Cancellation	1	1.5	2	2.5	3	3.5	4	4.5	5
Up to 30 days	75.0%	80.0%	85.0%	87.5%	90.0%	92.5%	92.5%	95.0%	95.0%
31 to 90 days	50.0%	65.0%	70.0%	75.0%	80.0%	85.0%	87.5%	87.5%	87.5%
3 to 6 months	25.0%	50.0%	60.0%	65.0%	67.5%	70.0%	75.0%	75.0%	75.0%
6 to 12 months	0.0%	25.0%	40.0%	45.0%	50.0%	55.0%	60.0%	65.0%	65.0%
12 to 18 months		0.0%	15.0%	30.0%	37.5%	45.0%	47.5%	50.0%	55.0%
18 to 24 months			0.0%	15.0%	25.0%	32.5%	37.5%	42.5%	47.5%
24 to 30 months				0.0%	12.5%	20.0%	25.0%	35.0%	40.0%
30 to 36 months					0.0%	10.0%	17.5%	25.0%	32.5%
36 to 42 months						0.0%	10.0%	17.5%	27.5%
42 to 48 months							0.0%	12.5%	20.0%
48 to 54 months								0.0%	10.0%
54 to 60 months									0.0%

Short Period Grid – Option 2

	Refund %								
	Policy Term								
Timing of Cancellation	1	1.5	2	2.5	3	3.5	4	4.5	5
Up to 90 days	100%	100%	100%	100%	100%	100%	100%	100%	100%
3 to 6 months	30.0%	50.0%	60.0%	65.0%	67.5%	70.0%	75.0%	75.0%	75.0%
6 to 12 months	0.0%	25.0%	40.0%	45.0%	50.0%	55.0%	60.0%	65.0%	65.0%

12 to 18 months		0.0%	15.0%	30.0%	37.5%	45.0%	47.5%	50.0%	55.0%
18 to 24 months			0.0%	15.0%	25.0%	32.5%	37.5%	42.5%	47.5%
24 to 30 months				0.0%	12.5%	20.0%	25.0%	35.0%	40.0%
30 to 36 months					0.0%	10.0%	17.5%	25.0%	32.5%
36 to 42 months						0.0%	10.0%	17.5%	27.5%
42 to 48 months							0.0%	12.5%	20.0%
48 to 54 months								0.0%	10.0%
54 to 60 months									0.0%

Short Period Grid – Option 3

	Refund %								
	Policy Term								
Timing of Cancellation	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**
Up to 120 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5 to 6 months	25.0%	40.0%	45.000%	47.500%	50.000%	52.500%	55.0%	60.0%	60.0%
6 to 12 months		15.0%	25.000%	37.500%	40.000%	47.500%	50.0%	55.0%	55.0%
12 to 18 months			10.000%	15.000%	25.000%	35.000%	40.0%	45.0%	45.0%
18 to 24 months			0.0%	5.000%	15.000%	25.000%	30.0%	35.0%	35.0%
24 to 30 months				0.0%	5.000%	15.000%	20.0%	25.0%	25.0%
30 to 36 months					0.0%	2.500%	7.5%	15.0%	15.0%
36 to 42 months						0.0%	2.5%	7.5%	7.5%
42 to 48 months							0.0%	2.5%	5.0%
48 to 54 months								0.0%	0.0%
54 to 60 months									0.0%

No refund is applicable for Half Yearly, Quarterly and 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.

c. 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.

B. **Automatic Cancellation** –
The Certificate of Insurance coverage shall automatically terminate in the event of death of the Insured Person.

C. **Cancellation in case of Credit Linked Cases:**
In cases the Policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure subject to maximum tenure of 5 years, closure of the loan or Policy Period/ Coverage Period Term whichever is earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy.

6.1.3. Renewal of Policy
The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

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

6.1.4. 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/Certificate of Insurance/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.

6.1.5. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy: '

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

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

6.1.6. **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.

6.1.7. Withdrawal of Policy

a. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.
b. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

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)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
d. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

6.1.10. Multiple Policies

a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
b. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
c. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

6.1.11. **Disclosure to 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)

6.1.12. 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.

6.1.13. 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.

6.2. Specific Terms and Conditions

6.2.1. Additional premium (Risk Loading)

a. We may ask for additional premium after due risk evaluation (it's what referred to as Underwriting) based on all information provided by you. We will issue policy to you only after you pay us the additional premium and provide us consent.
b. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual.
c. Once applied, Risk loading continues even for all renewals

6.2.2. Other Renewal Conditions:

a. Renewal Premium:
Renewal premium can alter based on Age.

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.

6.2.3. 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.

6.2.4. Notices

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

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

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301
Fax No: 011-4174-3397

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

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

6.2.5. **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.

6.2.6. **Assignment**

The Policy can be assigned subject to applicable laws.

6.2.7. **Premium Payment in Installments**

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)

a. 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.
b. 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.
c. 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.
d. No interest will be charged If the instalment premium is not paid on due date
e. In case of instalment premium due not received within the grace period, the policy will get cancelled.
f. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

6.2.8. **Claims**

a. Cashless claim facility is available at our/empanelled service provider's network hospitals / doctors / Centers ONLY. As list of network hospitals is dynamic, for the latest list, refer to our / empanelled service provider's website

b. Documents required

Documents Required	i. The Policy Number; ii. Name of the Policyholder; iii. Nature of Illness or Injury and the treatment taken; iv. Name and address of the attending Medical Practitioner; v. Prescription from the treating medical practitioner and must mention 1. Date of consultation 2. The medical registration number of the doctor 3. Medicines prescribed for treatment of illness /injury (if applicable) 4. Diagnostic tests prescribed (If applicable) 5. Duly signed and Stamped vi. A valid invoice mentioning 1. Name of the doctor, clinic or hospital name 2. Address vii. Diagnostic test reports, X-rays, OPG, IOPA, CBCT, certificates viii. Itemized bill & payment receipt ix. Any other information that may be relevant to the Illness/ Injury/ Hospitalization x. KYC documents of the member wherever required or asked **Policyholder documents (Nominee in case of death of Policyholder):** • KYC documents • Cancelled cheque

	Note - The list of Documents is indicative more documents may be asked for as per claim servicing requirement

IMPORTANT:

- All documents **MUST** be submitted within 30 days from availing the benefit.
- 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).
- We reserve the right to ask for additional documents/reports from case to case basis.
- We reserve the right to check and investigate the hospital / medical records from any doctor, Hospital, clinic, individual or institution.

Annexure 1
LIST OF INSURANCE OMBUDSMEN

Office Details	**Jurisdiction of Office Union Territory,District)**
AHMEDABAD - **Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Smt. Neerja Shah** Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455	Orissa.

Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Rajasthan.

Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, 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 Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.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.	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj,

Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email:inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

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

Annexure 2

EXPENSES NOT COVERED OR SUBSUMED INTO ROOM CHARGES / PROCEDURE CHARGES / COSTS OF TREATMENT

List I – Expenses not covered

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES

12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK

61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

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

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

Sl. No.	Item

1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

Annexure 3

LIST OF SPECIALISTS

This is an indicative list. Any or all can be opted for from this list. Cover will be available as specified in the Policy Schedule / Certificate of Insurance

Speciality	Doctor Specialization
Specialist	Paediatrician
	Dentist
	Dermatologist
	Orthopaedic
	Ophthalmologist
	Gynaecologist & Obstetrician
	ENT
	Psychiatrist
	General Surgeon
	Anaesthesiologist
	Radiologist
	Pathologist
	Sexologist
	Dermatologist
	ENT Surgeon
	Haematologist
	Preventive medicine specialist
	Paediatric surgeon
	Dental Surgeon
	Cardiologist
	Pulmonologist
	Diabetologist
	Oncologist
	Neurologist
	Gastroenterologist
	Nephrologist
	Urologist
	Orthodontic
	Orthopaedics & Joint Replacement
	Rheumatologist
	Endocrinologist
	Laparoscopic Surgeon
	General Surgeon
	Vascular Surgeon
	Infectious disease specialist

Annexure 4
DIAGNOSTICS TESTS
This is an indicative list. Any or all can be opted for from this list

S.No	Tests
1	CBC- (Haemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW)
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholestrol
6	Lipid Profile
7	Serum Cretinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray, Ultra sound
15	PAP Smear (For Female), PSA-Male
16	ECG
17	Serum Electrolytes
18	Uric Acid
19	Calcium
20	Vitamin B-12
21	Vitamin D3
22	Bone Densitometry Test
23	2D ECHO
24	Treadmill Test (TMT)
25	Mammography & Female hormones (for Female)
26	Erythrocyte Sedimentation Rate (ESR)
27	Dental Consultation
28	Physician Consultation
29	Blood Group
30	Hemogram & ESR
31	Complete Hemogram
32	Complete Urine Analysis
33	Diabetes
34	Cardiac Risk Markers

35	Iron Deficiency
36	Kidney Function Test

Annexure 5

HOME HEALTH CARE SERVICES

This is an indicative list. Any or all can be opted for from this list

S.No	Service
1	Doctor at home
2	Nurse at home
3	Physiotherapist at home
4	Attendant at home
5	Diagnostic Tests at Home

ANNEXURE 6

LIST OF VACCINATIONS

This is an indicative list of services. Any or all can be opted for from this list

S.No	List
1	Influenza
2	Pneumonia
3	Cervical Cancer
4	Hepatitis B
5	Typhoid
6	BCG
7	OPV + IPV 1
8	OPV + IPV 1
9	DPT
10	Haemophilus influenzae type B
11	Tetanus
12	Rota
13	MMR
14	Hepatitis A

ANNEXURE 7

LIST OF TESTS UNDER ANNUAL HEALTH CHECK-UP

This is an indicative list. Any or all can be opted for from this list

S.No	Tests
1	CBC- (Haemoglobin, PCV, TLC, RBC Count, MCV, MCH, MCHC, Platelet Count, Automated DLC, Absolute Differential Counts, RDW
2	Urine- Routine & Microscopic
3	Random Blood Sugar
4	Blood Sugar- Fasting and Post Prandial
5	Serum Cholestrol
6	Lipid Profile
7	Serum Cretinine and Urea
8	Serum LDL
9	Serum LDL & HDL
10	HBA1C
11	Renal Function Test
12	Liver Function Test
13	Thyroid Function Test
14	X-ray, Ultra sound
15	PAP Smear (For Female), PSA-Male
16	ECG
17	Serum Electrolytes
18	Uric Acid
19	Calcium
20	Vitamin B-12
21	Vitamin D3
22	Bone Densitometry Test
23	2D ECHO
24	Treadmill Test (TMT)
25	Mammography & Female hormones (for Female)
26	Erythrocyte Sedimentation Rate (ESR)
27	Dental Consultation
28	Physician Consultation
29	Blood Group

ANNEXURE 8

LIST OF MONITORING /MEDICAL DEVICES

This is an indicative list. Any or all can be opted for from this list

S.No	List
1	Single use devices (i.e. syringes, catheters)
2	Implantable (i.e. hip prothesis, pacemakers)
3	Imaging (i.e. ultrasound and CT scanners)
4	Medical Equipment (i.e. anesthesia machines, patient monitors, hemodialysis machines)
5	Software (i.e. computer aided diagnostics)
6	In-vitro diagnostics (i.e. glucometer, HIV tests)

7	Personal Protective Equipment (i.e. mask, gowns, gloves)
8	Surgical and Laboratory Instruments

ANNEXURE 9

LIST OF CONDITION MANAGEMENT PACKAGES

This is an indicative list. Any or all can be opted for from this list

S.No	List
1	Diabetes
2	Kidney Health
3	Heart
4	Liver
5	Maternity
6	Weight Loss
7	Woman Health

ANNEXURE 10

PRODUCT BENEFIT TABLE

S.No.	Main Benefit	Options within the benefit
1	**Video Consultations with General Practitioner**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 per policy Option 3: Costs up to INR 1 Lac Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network

2	**Tele Consultations with General Practitioner**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1 Lac Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network
3	**Physical Consultations with General Practitioner**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network
4	**Video Consultations with specialists**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network

5	**Tele Consultations with specialists**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network
6	**Physical Consultations with specialists**	Option 1: Unlimited Consultations Option 2: Fixed no. of consultations ranging between 1 to 50 Option 3: Costs up to INR 1L Option 4: Actuals up to INR 5000 per Visit Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above Available on Only Network, Only Non-Network & Combination of both Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network
7	**Diagnostic Services**	Option 1: Services through Company's empanelled Provider Option 2: up to 10 tests per Insured basis indicative list Option 3: Basis select combination of tests Option 4: Costs up to INR 1L Option 5: Unlimited Diagnostic tests and Investigations Option 6: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 7: Any possible reasonable combination of above Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network

8	**Pharmacy Services**	Prescription Based, Over the counter based pharmacies or Both Option 1: Services through Company's empanelled Provider Option 2: Costs up to INR 1L Option 3: Discount on availing the benefit through our/empanelled service providers mobile app/website Co-payment of up to 50% only for non-network Deductible of up to INR 20,000 per policy for non-network Deductible of up to 10 visits per policy for non-network Franchise of up to 10 visits per policy for non-network
9	**Home Health Care Services**	Option 1: Services through Company's empanelled Provider Option 2: Basis select combination of Services Option 3: Costs up to INR 1L Option 4: Services up to INR 10,000 per service. Option 5: Fixed number of services ranging between 1 to 1000 Option 6: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 7: Any Combination of Above
10	**Vaccination Cover**	Option 1: Services through Company's empanelled Provider Option 2: up to 10 vaccinations per Insured basis indicative list Option 3: Basis select combination of Vaccines Option 4: Costs up to INR 1L Option 5: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 6: Any possible reasonable combination of above
11	**Annual Health Check-up**	Option 1: up to 10 tests per Insured basis indicative list Option 2: Basis select combination of tests Option 3: Costs up to INR 1L Option 4: Discount on availing the benefit through our/empanelled service providers mobile app/website Option 5: Any possible reasonable combination of above It can be provided to Option 1: Per Insured Adult Option 2: Per Insured Adult+ One non Insured related Adult

12	**Second Medical Opinion**	Option 1: Covered worldwide, One opinion per Insured Person per Specified Illness / planned Surgery (Network + Non-Network) Option 2: Covered worldwide, One opinion per Insured Person per Specified Illness / planned Surgery (Network only) Option 3: Discount on availing the benefit through our/empanelled service providers mobile app/website
13	**Wallet**	Option 1: Up to INR 1L for any combination of the above benefits (including Co-payment, Deductible, Franchise for non-network). Till INR 10,000 in multiples of INR 500. Post INR 10,000 in multiples of INR 1000
14	**Vouchers**	Option 1: Up to 50 Vouchers Option 2: Up to INR 1L Option 3: Above benefits, can be offered in any capacity within the Voucher Limit Option 4: Any possible reasonable combination of above.
15	**Monitoring / Medical Devices**	Option 1: Up to INR 5L Option 2: Up to 10 Devices in a policy Option 3: Percentage of Base Sum Insured Option 4: Discount on availing the benefit through our/empanelled service providers mobile app/website
16	**Wellness Benefits**	Option 1. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with no limits on the visit/consultation Option 2. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with 10 visit/consultation per week Option 3. For a period of 1 month or multiple of 1 month, maximum up to 12 months in a policy year with up to 10 visit/consultation per month Option 4. Discount on availing the benefit through our/empanelled service providers mobile app/website Option 5. Any of the combination above
17	**Condition Management Packages**	Condition wise packages Diabetes, Kidney Health, Heart, Liver, Pregnancy/Maternity, Weight Loss, Woman Health