Health Companion
variant 1,2,3, Family First

Health Companion - Start a healthy relationship

Heath Companion from Niva Bupa is a comprehensive health insurance cover for you and your family. It gives you the flexibility to choose just the right cover for your needs. Apart from giving you a comprehensive health insurance cover to suit your needs, we are also committed to provide you one of the best quality service when you need it the most.

Which is why Niva Bupa is the Healthier Health Insurance for you and your family:

- You talk to us directly, not through any third parties. We will be there for you when you need us. Because you should concentrate on getting better, not chasing your claims.
- You can access our cashless facility at quality hospitals of your city, with the best medical facilities included in our partner network.
- We cover families across life stages – from newborns to senior citizens of any age, covering up to 19 relationships in one policy.
- Our health check-up cover helps you to nurture and improve your and your family's health.
- Managing our relationship - As a customer, you can access your own page on the Niva Bupa website to keep track of your policy details and benefits.
- To build a relationship that lasts a lifetime, we make all efforts to understand your health profile during enrollment, so that when you need us, we can provide speedy and efficient support.
- We assure you renewability of your policy for lifetime, if you pay renewal premium within the grace period of 30 days of expiry of your previous policy. You should renew on or before the renewal date of the policy to ensure you have continued medical insurance cover even during the grace period.
- As with all health insurance policies, you may save tax under Section 80D of the Income Tax Act when you buy a Niva Bupa health insurance policy. (Tax benefits are subject to changes in the tax laws, please consult your tax advisor for more details)

Policy Design

- Niva Bupa'sHealth Companion can be issued to an individual customer, a family (family floater) and/or extended family (family first).
- The family floater policy is available in any of the following combinations:
  - 1 Adult + 1 Child
  - 1 Adult + 2 Children
  - 1 Adult + 3 Children
  - 1 Adult + 4 Children
  - 2 Adults
  - 2 Adults + 1 Child
  - 2 Adults + 2 Children
  - 2 Adults + 3 Children
  - 2 Adults + 4 Children
- The family includes spouse and dependent children and can comprise up to a unit of 6 insured person of which up to 4 can be children.
- The premium for family floater policies depends on the age of the eldest insured customer.
- The Family First may be available in any of the below relationships with the Proposer
  a. Legally married spouse as long as he or she continues to be married to You;
  b. Son;
  c. Daughter-in-law as long as Your son continues to be married to Your Daughter-in-law;
  d. Daughter;
  e. Son-in-Law as long as Your daughter continues to be married to Your Son-in-law;
  f. Father;
  g. Mother;
  h. Father-in-law as long as Your spouse continues to be married to You;
  i. Mother-in-law as long as Your spouse continues to be married to You.;
  j. Grandfather;
  k. Grandmother;

l. Grandson;m.

m. Granddaughter;

n. Brother;

o. Sister;

p. Sister-in-law;

q. Brother-in-law;

r. Nephew;

s. Niece.

- The premium for Family First policies depends on the individual age of each insured customer in the Extended Family.
- The minimum entry age for dependent children is 91 days at policy inception. The maximum entry age for dependent children is 21 years.
- The minimum entry age for adults is 18 years.
- This policy covers persons of any age. There is no maximum entry age for the insured.

  Please note if any Insured Person who is a child and has completed 22 years at the time of Renewal, then such Insured Person will have to take a separate policy based on our underwriting guidelines, as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

  There is no maximum cover ceasing age in this policy.

- The default policy term for all plans is one year. A two or three year policy term option is also available under the product for a discount of 12.5% on second year premium and 15% on third year premium.
- Individual Family Floater Variant1 sum insured Rs.2lacs is available for renewal policyholder's only. Optional annual aggregate deductible can be opted under any plan and thereby avail a discount offered.
- The premium rates for the plans offered are annexed hereto with the prospectus.
- For the purpose of calculating premium, the country has been divided into the following 3 zones:
  - **Zone 1:** Delhi, Gurgaon, Faridabad, Gautam Buddha Nagar, Ghaziabad, Noida, Surat, Kolkata, Mumbai, Thane
  - **Zone 2:** Pune, Nasik, Ludhiana, Jaipur, Baghpat, Bulandshahr, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak and Sonipat
  - **Zone 3:** Rest of India

Coverage Options

- **In case of Individual or Family Floater –** Base Sum Insured range from Rs. 2 lacs (for renewal policy) / Rs. 3 lacs (for new policy) to Rs.100lacs depending on the plan you choose. The details of the plans are available in the product benefits table. SumInsured of Rs. 2 Lacs will be available for life to renewal customers who opted this Sum Insured in the expiring Policy.
- **In case of Family First:**

  Flexible Base Sum Insured per person (one amount chosen for all family members) as well as a floater Sum Insured that can be utilized once the Base Sum Insured per person is consumed. This provides flexibility for families to decide their optimal cover:

  Choose individual cover from options given below:

- Base Sum Insured Options are - Rs 1L, Rs 2L, Rs 3L, Rs 4L, Rs 5L & Rs.10L
- Family Floater Sum Insured Options are – Rs. 3L, Rs. 4L, Rs. 5L, Rs. 10L, Rs. 15L & Rs.20L

  Sum Insured for a Family First Policy means the total of the Base Sum Insured for each Insured Person No Claim Bonus for each Insured Person and the Floater Sum Insured which is Our maximum, total and cumulative liability for all claims during a Policy Year in respect of allInsured Persons. For these purposes:

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

Illustration for Family First Policy:

Family Members	Age	Base Sum Insured (in lacs)
Father	66	2
Mother	65	2
Son	40	2
Daughter-in law	39	2
Base Sum Insured for all Insured Persons taken together		**8 lacs**
Floater Sum Insured		5 lacs
Sum Insured		13 lacs

The details of the plans are available in the product benefits table for Family First Policy.

i. Product Features and Benefits – Key Highlights

The policy covers reasonable charges incurred towards medical treatment taken during the Policy Period for an Illness or an Injury. The expenses that are not covered or subsumed into room charges/ procedure charges/ costs of treatment are mentioned in Annexure I. We cover the following expenses

1. Inpatient Care:

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

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

   i. Room Rent;
   ii. Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges;
   iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
   iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
   v. Medicines, drugs as prescribed by the treating Medical Practitioner;
   vi. Intravenous fluids, blood transfusion, injection administration charges,consumablesand/or enteral feedings;
   vii. Operation theatre charges;
   viii. The cost of prosthetics and other devices or equipment if implanted internally during Surgery;
   ix. Intensive Care Unit charges.

c. If the Insured Person is admitted in the Hospital in a room category higher than the eligibility as specified in the Product Benefits Table, then We shall be liable to pay only a pro-rated proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the entitled room category to the Room Rent actually incurred.
d. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless such:

   i. Medical Practitioner's treatment or advice has been sought by the Hospital; and
   ii. Visiting fees or consultation charges are included in the Hospital's bill; and
   iii. Visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

2. Pre-hospitalization Medical Expenses

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

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

3. Post-hospitalization Medical Expenses

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

a. We have accepted a claim for Inpatient Care.

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

4. Alternative Treatments

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

Pre-Hospitalization Medical Expenses incurred for upto30 days prior to the Alternative Treatments being commenced and Post-Hospitalization Medical Expenses incurred for up to 60 days following the Alternate Treatment being concluded will also be indemnified under this Benefit provided that these Medical Expenses relate only to Alternative Treatments only and not Allopathy. Permanent Exclusion xxvii shall not apply to the extent this Benefit is applicable.

5. Day Care Treatment

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

a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment
c. The following procedures will be covered as Day Care Treatment under this benefit as they each require a period of specialized observation or care after completion of the procedure:
    i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
    ii. Renal dialysis(Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)
d. We will not cover any OPD Treatment and Diagnostic Services under this Benefit.
e. If We have accepted a claim under this benefit, We will also indemnify the **Insured Person's Pre-hospitalisation Medical Expenses** and **Post-hospitalisation Medical Expenses** in accordance with Sections I.2 and I.3 within the overall benefit sub-limit.

6. Domiciliary Hospitalization

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

a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.
c. If We have accepted a claim under this benefit, We will also indemnify the **Insured Person's Pre-hospitalisation Medical Expenses** and **Post-hospitalisation Medical Expenses** in accordance with Sections I.2 and I.3 within the overall benefit sub-limit.

7. Living Organ Donor Transplant

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

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

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

a. The living organ donors stay in a hospital that is needed for them to donate their organ.
b. Stem cell donation except for Bone Marrow Transplant.
c. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
d. Screening or any other Medical Expenses of the organ donor.
e. Costs directly or indirectly associated with the acquisition of the donor's organ.

f. Transplant of any organ/tissue where the transplant is experimental or investigational.
g. Expenses related to organ transportation or preservation.
h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

8. Emergency Ambulance

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

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to the nearest Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another nearest Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
b. This benefit is available for one transfer per Hospitalization.
c. The ambulance service is offered by a healthcare or ambulance service provider.
d. We have accepted a claim under Inpatient Care.
e. We will cover expenses up to the amount specified in the product benefits table.
f. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

9. Vaccination for Animal Bite

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

a. The medical expenses incurred are medically necessary and are reasonable and customary charges.
b. Claims under this Benefit can be availed on a reimbursement basis only.

10. Health Checkup

If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 or 3 year Policy Period (if applicable), then the Insured Person may avail a health check-up as per the Plan applicable to the Insured Person as specified in the product benefits table on Cashless Facility basis provided that:

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

11. No Claim Bonus

a. For an Individual Policy or Family Floater Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 or 3 year Policy Period (if applicable) and no claim has been made in the immediately preceding Policy Year, each Policy Year. We will increase the Sum Insured applicable under the Policy by 20% of the Base Sum Insured of the immediately preceding Policy Year; subject up to maximum of 100% of the expiring Base Sum Insured. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.
b. For a Family First Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 or 3 year Policy Period (if applicable) and no claim has been made in the immediately preceding Policy Year, each Policy Year We will increase the Sum Insured applicable under the Policy by 20% of the Base Sum Insured of each individual Insured Person only and the increase shall not apply to the Floater Sum Insured as applicable under the Policy; subject up to maximum of 100% of the expiring Base Sum Insured of each individual Insured Person. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.
c. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated No Claim Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We shall not provide any credit for the accumulated No Claim Bonus to the Family Floater Policy.
d. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated No Claim Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family First Policy, then the accumulated No Claim Bonus to be carried forward for credit in the Renewing Policy would be the accumulated No Claim Bonus for that Insured Person only.
e. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated No Claim Bonus for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy with same or higher Base Sum Insured, then the accumulated No Claim Bonus to be carried forward for credit in the Renewing Policy would be the least of the accumulated No Claim Bonus amongst all the Insured Persons.

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

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

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

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

13. Modern Treatments

The following procedures / treatments will be covered either as **Inpatient Care** or as part of **Day Care Treatment** in a **Hospital**:

i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

a. If We have accepted a claim under this benefit, We will also indemnify the **Insured Person's Pre-hospitalization Medical Expenses** and **Post-hospitalization Medical Expenses** in accordance with Sections 2 and 3 within the overall benefit sub-limit.

ii. Optional Benefits

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

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

All claims for this optional benefit under the Policy must be made in accordance with the process defined under Claim process & Requirements section.

1. Hospital Cash

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

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

2. Personal Accident

i. Accidental Death (AD)

In event of unfortunate demise of the insured within 365 days from the date of the Accident, within the Policy Period, we will pay the Sum Insured. **The Personal accident benefit will terminate after the Accidental Death benefit is paid for.**

ii. Permanent Total Disability

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

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

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

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

iii. Permanent Partial Disability

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

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

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

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

iii. Claim Cost Sharing Options

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

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

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

Co-payment will not apply to any Claim under Health check-up and Hospital cash.

2. Annual Aggregate Deductible

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

It is further agreed that:

a. The provision above on Co-payment (if applicable) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Deductible has been exhausted.
b. Deductible will not apply to any claim under health check-up and Hospital Cash.

Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

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:

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months (under Variant 2, Variant 3 Plans and Family First Policy)/ 48 months (under Variant 1 Plan) of continuous coverage after the date of inception of the first Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 36 months (under Variant 2, Variant 3 Plans and Family First Policy)/ 48 months (under Variant 1 Plan) for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

ii. 30 – day Waiting Period (Code-Excl03):

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

iii. Specified Disease/procedure Waiting Period (Code-Excl02):

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:

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

iv. Personal Waiting Periods:

Conditions specified for an Insured Person under Personal Waiting Period will be subject to a waiting period of 24 months from the inception of the First Policy with Us and will be covered from the commencement of the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.

Permanent Exclusions

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.

i. 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.

ii. 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.

iii. Obesity/ Weight Control (Code-Excl06)

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);

i. greater than or equal to 40 or
ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

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

iv. **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.

v. **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.

vi. **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.

vii. **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.

viii. **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.

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

x. 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)**

xi. 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)**

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

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

xiii. **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.

xiv. **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

xv. **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.

xvi. **Ancillary Hospital Charges**

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

xvii. **Circumcision:**

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

xviii. 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.

xix. External Congenital Anomaly:

Screening, counseling or treatment related to external Congenital Anomaly.

xx. 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.

xxi. Hormone Replacement Therapy:

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

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

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

xxiii. Sleep disorders:

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

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

xxv. Unrecognized Physician or Hospital:

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

xxvi. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

xxvii. AYUSH Treatment

Any form of AYUSH Treatments, except as mentioned under Alternative treatments benefit.

xxviii. OPD Treatment:

OPD Treatment is not covered except for animal bite vaccinations to the extent stated in the respective benefit.

Claims Process & Requirements

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

i. Claims Administration:

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

a. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payment that arises out of wilful failure to comply with such directions, advice or guidance.
b. We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
c. We and Our representatives must be given all reasonable co-operations in investigating the claim in order to assess Our liability and quantum in respect of the claim.

d. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

ii. Claims Procedure:

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a condition precedent to Our liability under the Policy the following procedure shall be complied with:

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

Process for Obtaining Pre-Authorization

A. For Planned Treatment:

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

B. In Emergencies

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

All final authorization requests, if required, shall be sent at least six hours prior to the Insured Person's discharge from the Hospital.

Each request for pre-authorization must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

i. The health card We have issued to the Insured Person at the time of inception of the Policy (if available) supported with KYC document;
ii. The Policy Number;
iii. Name of the Policyholder;
iv. Name and address of Insured Person in respect of whom the request is being made;
v. Nature of the Illness/Injury and the treatment/surgery required;
vi. Name and address of the attending Medical Practitioner;
vii. Hospital where treatment/surgery is proposed to be taken;
viii. Date of admission;
ix. First and any subsequent consultation paper / Medical Record since beginning of diagnosis of that treatment/Surgery.

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

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

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

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

Reauthorization

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

b. For Reimbursement Claims:

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

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

iii. Claims Documentation:

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

a. Claim form duly completed and signed by the claimant.
Please provide mandatorily following information if applicable

i. Current Diagnosis and date of diagnosis;
ii. Past history & First consultation details;
iii. Previous admission/Surgery if any.

b. Age/Identity proof document: Of Insured Person in case of cashless claim (not required if submitted at the time of pre-authorization request) and Proposer in case of Reimbursement claim.

i. Self-attested copy of Passport / Driving License / PAN card / Class X certificate / Birth certificate;
ii. Self-attested copy of identity proof (Passport / Driving License / PAN card / Voter identity card);

c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).
d. Original discharge summary.
e. Additional documents required in case of Surgery/Surgical Procedure.

i. Bar code sticker and Invoice for Implants and Prosthesis (if used);

f. Original final bill from Hospital with detailed break-up and paid receipt.
g. Room tariff of the entitled room category (in case of a non-network provider and if room tariff is not a part of hospital bill): duly signed and stamped by the Hospital in which treatment is taken.

(In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of our Network Provider within the same geographical area for identical or similar services.)

h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside hospital with reports and requisite prescriptions.
i. Copy of death certificate (in case of demise of the Insured Person).
j. For Medico-legal cases (MLC) or in case of Accident

i. MLC/First Information Report (FIR) copy attested by the concerned hospital / police station (if applicable);
ii. Original self-narration of incident in absence of MLC / FIR.

k. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
l. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

In the event of the Insured Person's death during Hospitalization, written notice accompanied by a copy of the post mortem report (if any) shall be given to Us regardless of whether any other notice has been given to Us.

iv. Claims Assessment & Repudiation:

a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized by Us in writing.
b. Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee or Your legal heirs or legal representatives holding a valid succession certificate.
c. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available

Sum Insured in these Policy Periods including the Deductible for each Policy Period. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.

d. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-

   i. If a room has been opted in a Hospital for which room category is higher than the eligible limit as applicable for that Insured Person, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with In-patient Care section.
   ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all eligible claims as per policy terms and conditionsexceeds the Deductible limit within the same Policy Year.
   iii. Co-payment (if applicable) as chosen by the insured shall be applicable on the amount payable by Us.

e. The claim amount assessed in Claims Assessment &Repudiation would be deducted from the amount mentioned against each benefit and Sum Insured. The re-fill amount will be applied only once the Base Sum Insured and No Claim Bonus is exhausted in the Policy Year.

v. Delay in Claim Intimation or Claim Documentation:

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

vi. Claim process for Health Checkup

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

1. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the Policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Portability

For Detailed Guidelines on Portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

2. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for Migration of the policy atleast 30 days before the Policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

General Terms and Conditions

A. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person

B. Cancellation

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

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

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

b. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

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. Pre-Insurance Medical Check-up

We may consider various attributes like age, sum insured, sum insured type, channel, location, insuring self vs insuring self + family etc to deploy different pre-policy medical check-ups and underwriting approaches (tele underwriting, tests etc).

If we issue you the policy, the costs of pre-policy medical check-up (if any) will be borne by Us.

D. Automatic Cancellation:

i. Individual Policy:

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

ii. For Family Floater Policies and Family First Policies:

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

iii. Refund:

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

E. Loading on Premium

a. Based on Our discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal Form or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading applicable shall not exceed more than 150% of the premium.
b. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.
c. We may apply a specific personal waiting period on a medical condition/ailment depending on the past history or additional waiting periods on Pre-existing Diseases as part of the special conditions on the Policy.

F. Renewal of Policy

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

i. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iv. At the end of the Policy Period, the Policy shall terminate and can be Renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
v. No loading shall apply on Renewals based on individual claims experience.

G. Other Renewal Conditions:

a. Continuity of Benefits on Timely Renewal:

i. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period.
ii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:

- You proposed to add an Insured Person to the Policy
- You change any coverage provision
- You change Your residence to different zip code

iii. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person, and for Family First policies it shall be the individual age of each Insured Person of the family.

b. Reinstatement:

i. The policy shall lapse after the expiration of the Grace Period. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria as per Our Board approved underwriting policy and no continuing benefits shall be available from the expired Policy.
ii. We will not pay for any Medical Expenses which are incurred happen between the date the Policy expires and the date immediately before the reinstatement date of your Policy.
iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

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

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

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

e. Addition of Insured Persons on Renewal:

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

f. Changes to Sum Insured on Renewal:

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

H. Change of Policyholder

a. The policyholder may be changed only at the time of Renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed upon request in case of Your death, Your emigration from India or in case of Your divorce during the Policy Period.
b. Any alteration in the plan due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately. Coverage of Benefits in such scenario will be limited to current Policy Year.
c. Renewal of such Policies will be according to terms and conditions of existing Policy.

I. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement

(if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

J. Obligations in case of a minor

If an Insured Person is less than 18 years of Age, You or another adult Insured Person or legal guardian (in case of Your and all other adult Insured Person's demise) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

K. Authorization to obtain all pertinent records or information:

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

L. 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.

M. 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.

N. Territorial Jurisdiction

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

O. 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 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.

P. 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.

Q. 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.

R. 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.

S. Redressal of Grievances:

In case of any grievance the Insured Person may contact the company through:
Website: www.nivabupa.com
Toll free: 1860-500-8888
E-mail: 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 –www.bimabharosa.irdai.gov.in

T. Assignment

The Policy can be assigned subject to applicable laws.

U. 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)

V. Moratorium Period

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

W. 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.

X. Disclosure of Information

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

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

Y. 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.

Z. 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.

If you wish to know more about Niva Bupa's Health Companion and/or would like a personal quote, speak to our specially trained sales team or your local advisor. They'll take time to fully understand your requirements and help you to select the right plan for you.

Customer Helpline No: 1860-500-8888

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Product Benefits Table

Benefit Table - Individual / Family Floater - Variant 1 (all limits in Rs unless defined as percentage)			
Base Sum Insured (SI) Rupees	**2 lacs (For renewal only)**	**3 lacs**	**4 lacs**
Benefits			
Inpatient Care	Covered up to Sum Insured		
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges			
Medical Practitioners' fees, excluding any charges or fees for Standby Services			
Medicines, drugs and consumables			
Physiotherapy, investigation and diagnostics procedures directly related to the current admission			
Medicines, drugs as prescribed by the treating Medical Practitioner			
Intravenous fluids, blood transfusion, injection administration charges and /or consumables			
Operation theatre charges			
The cost of prosthetics and other devices or equipment if implanted internally during Surgery			
Intensive Care Unit charges			
Room rent	Covered up to Sum Insured (except for Suite or above room category)		
Pre-hospitalization Medical Expenses (30 days)	Covered up to Sum Insured		
Post-hospitalization Medical Expenses (60 days)	Covered up to Sum Insured		
Day Care Treatment	Covered up to Sum Insured		
Living Organ Donor Transplant	Covered up to Sum Insured		
Emergency Ambulance	Up to Rs.3,000		
No Claim Bonus	In case of no claim, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured		
Refill Benefit [1]	Up to Base Sum Insured		
Vaccination for Animal Bite[2]	Up to Rs.2,500		
Alternative Treatments	Covered up to Sum Insured		
Health Check-up	Once in 2 years		
Domiciliary Hospitalization	Covered up to Sum Insured		
Modern Treatments	Covered up to Sum Insured		
Optional benefits			
Hospital Cash [3]	1,000/day		
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore.		
Claim cost sharing options			
Annual aggregate Deductible	Deductible of Rs.1,2,3,4,5 and 10 lacs		
Treatment only in Tiered Network	Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy		

Notes

1. Re-Fill benefit - Reinstate up to Base Sum Insured. Applicable for different illness
2. Vaccination for Animal Bite (Post Bite Treatment) - OPD Benefit up to defined limit as part of overall limit
3. Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy
4. year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Product Benefits Table

Benefit Table - Individual / Family Floater - Variant 2 (all limits in Rs unless defined as percentage)				
Base Sum Insured (SI) Rupees	**5 lacs**	**7.5 lacs**	**10 lacs**	**12.5 lacs**
Benefits				
Inpatient Care	Covered up to Sum Insured			
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges				
Medical Practitioners' fees, excluding any charges or fees for Standby Services				
Medicines, drugs and consumables				
Physiotherapy, investigation and diagnostics procedures directly related to the current admission				
Medicines, drugs as prescribed by the treating Medical Practitioner				
Intravenous fluids, blood transfusion, injection administration charges and /or consumables				
Operation theatre charges				
The cost of prosthetics and other devices or equipment if implanted internally during Surgery				
Intensive Care Unit charges				
Room rent	Covered up to Sum Insured (except for Suite or above room category)			
Pre-hospitalization Medical Expenses (30 days)	Covered up to Sum Insured			
Post-hospitalization Medical Expenses (60 days)	Covered up to Sum Insured			
Day Care Treatment	Covered up to Sum Insured			
Living Organ Donor Transplant	Covered up to Sum Insured			
Emergency Ambulance	Up to Rs.3,000			
No Claim Bonus	In case of no claim, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured			
Refill Benefit [1]	Up to Base Sum Insured			
Vaccination for Animal Bite[2]	Up to Rs.5,000			

Alternative Treatments	Covered up to Sum Insured
Health Check-up	Annual
Domiciliary Hospitalization	Covered up to Sum Insured
Modern Treatments	Covered up to Sum Insured
Optional benefits	
Hospital Cash [3]	2,000/day
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore.
Claim cost sharing options	
Annual aggregate Deductible	Deductible of Rs.1,2,3,4,5 and 10lacs
Treatment only in Tiered Network	Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy

Notes

1. Re-Fill benefit - Reinstate up to Base Sum Insured. Applicable for different illness
2. Vaccination for Animal Bite (Post Bite Treatment) - OPD Benefit up to defined limit as part of overall limit
3. Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Benefit Table - Individual / Family Floater - Variant 3 (all limits in Rs unless defined as percentage)					
Base Sum Insured (SI) Rupees	15 lacs	20 lacs	30 lacs	50 lacs	100 lacs
Benefits					
Inpatient Care	Covered up to Base Sum Insured				
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges					
Medical Practitioners' fees, excluding any charges or fees for Standby Services					
Medicines, drugs and consumables					
Physiotherapy, investigation and diagnostics procedures directly related to the current admission					
Medicines, drugs as prescribed by the treating Medical Practitioner					
Intravenous fluids, blood transfusion, injection administration charges and / or consumables					
Operation theatre charges					
The cost of prosthetics and other devices or equipment if implanted internally during Surgery					
Intensive Care Unit charges					
Room rent	Covered up to Sum Insured (except for Suite or above room category)				
Pre-hospitalization Medical Expenses (30 days)	Covered up to Sum Insured				

Post-hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Up to Rs.3,000
No Claim Bonus	In case of no claim, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Refill Benefit [1]	Up to Base Sum Insured
Vaccination for Animal Bite [2]	Upto Rs.7,500
Alternative Treatments	Covered up to Sum Insured
Health Check-up	Annual
Domiciliary Hospitalization	Covered up to Sum Insured
Modern Treatments	Covered up to Sum Insured
Optional benefits	
Hospital Cash [3]	4,000/day
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore.
Claim cost sharing options	
Annual aggregate Deductible	Deductible of Rs.1,2,3,4,5 and 10lacs
Treatment only in Tiered Network	Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy

Notes

1. Re-Fill benefit - Reinstate up to Base Sum Insured. Applicable for different illness
2. Vaccination for Animal Bite (Post Bite Treatment) - OPD Benefit up to defined limit as part of overall limit
3. Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Benefit Table - Family First (all limits in Rs unless defined as percentage)	
	Base Sum Insured: 1Lacs, 2Lacs, 3Lacs, 4Lacs, 5Lacs & 10Lacs per Insured Person
	Floater Base Sum Insured – (available on a floating basis over Base Sum Insured): 3Lacs, 4Lacs, 5Lacs, 10Lacs, 15Lacs & 20Lacs.
Benefits	
Inpatient Care	Covered up to Sum Insured
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges	
Medical Practitioners' fees, excluding any charges or fees for Standby Services	
Medicines, drugs and consumables	
Physiotherapy, investigation and diagnostics procedures directly related to the current admission	
Medicines, drugs as prescribed by the treating Medical Practitioner	
Intravenous fluids, blood transfusion, injection administration charges and /or consumables	
Operation theatre charges	
The cost of prosthetics and other devices or equipment if implanted internally during Surgery	
Intensive Care Unit charges	
Room rent	Covered up to Sum Insured (except for Suite or above room category)
Pre-hospitalization Medical Expenses (30 days)	Covered up to Sum Insured
Post-hospitalization Medical Expenses (60 days)	Covered up to Sum Insured
Day Care Treatment	Covered up to Sum Insured
Living Organ Donor Transplant	Covered up to Sum Insured
Emergency Ambulance	Covered up to Rs.3000
No Claim Bonus	In case of no claim, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured
Vaccination for Animal Bite(1)	Up to Rs.5,000
Alternative Treatments	Covered up to Sum Insured
Health Check-up	Annual
Domiciliary Hospitalization	Covered up to Sum Insured
Modern Treatments	Covered up to Sum Insured
Optional benefits	
Hospital Cash (2)	Rs.1,000/day or Rs.2,000/day
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore.
Claim cost sharing options	
Annual aggregate Deductible	Deductible of Rs.1,2,3,4,5 & 10Lacs
Treatment only in Tiered Network	Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy
(1) Vaccination for Animal Bite (Post Bite Treatment) - OPD Benefit upto defined limit as part of overall limit	
(2) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.	

ANNEXURE I

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

List I – Expenses not covered

Sl. No.	Item
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

Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
Illustration 1										
18	8,097.81	5,00,000	NA	NA	NA	NA	8,097.81	15,750.18	25,541.88	5,00,000
21	8,178.78	5,00,000	NA	NA	NA	NA	8,178.78			
39	11,416.22	5,00,000	NA	NA	NA	NA	11,416.22			
45	13,599.25	5,00,000	NA	NA	NA	NA	13,599.25			
Total premium for all members of the family is **Rs.41,292.06,** when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.NA,** when they are covered under a single policy. Sum Insured available for each family member is **Rs.NA.**				Total premium when the policy is opted on floater basis is **Rs.25,541.88** Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 2										
55	23,630.52	5,00,000	NA	NA	NA	NA	23,630.52	7,033.96	53,617.41	5,00,000
63	37,020.85	5,00,000	NA	NA	NA	NA	37,020.85			
Total premium for all members of the family is **Rs.60,651.37**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.NA,** when they are covered under a single policy. Sum Insured available for each family member is **Rs.NA.**				Total premium when the policy is opted on floater basis is **Rs. 53,617.41** Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 3										
65	42,012.77	5,00,000	NA	NA	NA	NA	42,012.77	17,536.99	77,595.88	5,00,000
70	53,120.10	5,00,000	NA	NA	NA	NA	53,120.10			
Total premium for all members of the family is **Rs.95,132.87**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000**.			Total premium for all members of the family is **Rs.NA**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.NA**.				Total premium when the policy is opted on floater basis is **Rs.77,595.88** Sum Insured of **Rs.500,000** is available for the entire family.			
Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.										
Zone 1 premium is considered										