Rise - Prospectus cum Sales Literature

1. **Policy Design**
   - **Rise** can be issued to individual customer(s) or to a family with up to 5 children (refer to as family floater).
   - This policy covers persons in the age group 91 days and 99 years. The minimum entry age for adult is 18 years and for dependent child is 91 days. The maximum entry age limit for adult is 99 years, and dependent child is 30 years.
   - There is no maximum cover ceasing age on renewals.
   - In an Individual policy, maximum up to 6 members (maximum of 4 adults and a maximum of 5 children can be included in a single policy.
   - **Relationships allowed in the policy:** Self, Spouse, Son, Daughter, Daughter-in-law, Father, Mother, Father-in-law, Mother-in-law, Grandfather, Grandmother, Grandson, Grand-daughter, Son-in-law, Brother, Sister, Sister-in-law, Brother-in-law, Nephew, Niece, Uncle, Aunt, Employer-Employee.
   - Your premium depends upon your age, base sum insured opted, no. of years of pre-existing waiting period left in the policy and the Zone.
   - **Multi Individual Discount:** 10% discount on premium if 2 or more members are covered under an individual policy.
   - **Term discount:** The default policy term for all plans is one year. Two year and three-year policy term options are also available under the product. The level of discount is as below:
     - 2-year term: 7.5% on the premium for second policy year
     - 3-year term: 10% on the premium for third policy year + 7.5% on the premium for second policy year

     Term Discount is not applicable if premium is paid via Flexi, Monthly, Half Yearly or Quarterly basis.
   - **Staff Discount:** A discount of 10% on the policy premium (inception & renewals) to Niva Bupa employees
   - **Standing Instruction discount:** 2.5% discount on premium if standing instruction for renewal is provided and the policy is renewed using the same.
   - **Doctor discount:** 5% discount on premium if an Insured Person is a certified Medical Practitioner.
   - **Digital Discount**: 5% digital discount at the time of buying the policy and subsequent renewals, if the policy is bought through an online public portal
   - **Early Renewal Discount**: 2.5% discount on premium if you renew with us early. Either of Standing Instruction or Early Renewal discount will be given.
   - **Discount in Lieu of Commission**: we will offer a discount of up to 25% at new business and renewal in lieu of commission
   - **Favourable Claim Experience Discount:** You will get a discount on your policy of up to 39% on the renewal premium basis the value of the claims paid in a policy year.
     A Trend and Level Score will be allotted to you each year.
     - Trend Score: A score for the policy basis the claim amount paid in the policy year.
     - Level Score: A calculated score at policy level which will determine the discount on the renewal premium.

     Level Grid:

Level	-3	-2	-1	0	1	2	3	4	5	6	7	8	9	10
Discount	39%	36%	33%	30%	27%	24%	21%	18%	15%	12%	9%	6%	3%	0%

- **Level 0:** When customer takes a new policy with Niva Bupa, they start at level 0 with 30% Discount
- **Level -3** is the highest level a customer can be at with 39% discount. And **Level 10** can be the lowest level a customer can reach, with 0% discount.

The movement between levels will depend on following Trend Grid:

Customer Claim Scenario	Movement During Renewal
0 or No Claim	Moves up the grid by 1 level
Claim up to INR 40,000	Stays in the same level
More than INR 40,000- and up to INR 75,000	Moves down the grid by 1 level
More than INR 75,000- and up to INR 1,50,000	Moves down the grid by 2 levels
More than INR 1,50,000	Moves down the gird by 3 levels

For new policy, the customers would be considered at Level 0 by default and applicable discount as per the grid would be applied on the policy.

2. Sum Insured(s)

The coverage options start from INR 50,000 up to INR 1 Crore.
The product offers you so much more! More benefits, More options and More Sum Insured. Sum Insured will be utilized as per following sequence in event of any claim:

1. Base Sum Insured
2. Loyalty Sum Insured
3. Safeguard/Safeguard+ Sum Insured
4. Re-fill

3. Benefits available under the policy.

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

3.1.1. Expenses in reaching a Hospital

a. **Road Ambulance:** We will pay you up to INR 2000 per hospitalization.

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

3.1.2. Expenses during Hospitalization

a. We will pay the expenses incurred by you on treatment (Naturally this excludes expenses not linked to treatment like food, beverage, toiletries and cosmetics).

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

- We will pay for expenses incurred in a Twin Sharing Room (which means any room with minimum 2 beds), without any Co-Payment. Admission in any ICU ward will always be paid up to Sum Insured.

Note:

- **We will NOT pay, even if you were Hospitalized, if there was no treatment and only investigations were done. Examples: MRI, CT Scan, Endoscopy, Colonoscopy etc.**
- **We will NOT pay for Automation machine for peritoneal dialysis**

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

1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	2. Immunotherapy-Monoclonal Antibody to be given as injection	3. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	4. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5. Balloon Sinuplasty	6. Oral Chemotherapy	7. Robotic surgeries	8. Stereotactic radio Surgeries
9. Deep Brain stimulation	10. Intra vitreal injections	11. Bronchical Thermoplasty	12. IONM - (Intra Operative Neuro Monitoring)

Note: A limit of maximum INR 50,000 per claim will apply to all modern treatments

3.1.3. Expenses before and after hospitalization **(Pre & Post hospitalization)**

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

3.1.4. Home Care / Domiciliary Treatment

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

a. The medical practitioner advices the insured person to undergo treatment at home
b. There is continuous active line of treatment with monitoring of health status by a medical practitioner for each day through the duration of the home care treatment
c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

Note:

- We will pay for Pre & Post hospitalization benefit as per section 3.1.3 for Home Care / Domiciliary Treatment.
- **We pay for peritoneal dialysis, Chemotherapy taken at home.**
- **We do NOT pay for any Medical & ambulatory devices used at home** (like Pulse Oxymeter, BP monitors, Sugar monitors, automation device for peritoneal dialysis, CPAP, BiPAP, Crutches, wheel chair etc.)

3.1.5. Organ donor

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

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

3.1.6. Rise-Tiered Network

There is a specific list of hospitals that are applicable for you in this policy. If any treatment is taken outside this network, then a flat 20% co-payment will be applicable to the admissible claim amount. This co-payment you would have to bear for every claim. Rest we will pay.

Note: This will NOT apply to any of these benefits:
Health Check-up, Second Medical Opinion, Digital Consultation, Personal Accident, Hospital Daily Cash, Return, Smart Cash, Return+, Smart Cash+.

Refer Annexure 2 for the Rise-Tiered Network List**.**

3.1.7. Re-fill

Once in a policy year, we will add an amount equal to the base sum insured. This amount will be added at complete or partial utilization of Base Sum Insured.

NOTE: Benefit applies for any illness (same or different).

3.1.8. Loyalty Bonus

We will add an amount equal to 10% of your expiring Base Sum Insured, every policy year. This will accumulate up to 100% of Base Sum Insured. You can use this amount as your Sum Insured in the policy.

3.1.9. Return

Get maximum RETURN with Rise!

Get back 50% of the premium paid as separate sum insured. Accumulate this amount and get 10% as bonus on the accumulated Sum Insured. You can use the accumulated Sum Insured, for any claim that is not paid because of listed exclusions, Waiting Periods (Section 5) and complete rejection of claim of any kind.

NOTE:

- **You can only use it only for completely rejected claims under sections "Expenses during hospitalization", Home Care / Domiciliary Treatment” and “Organ donor”**
- **You can use this amount for all Waiting Periods & All Exclusions listed in this policy only. Except for any exclusion and claim rejection under Maternity, IVF, OPD, Alcoholism, Cosmetics, Fraud, Misrepresentation & Non-disclosures.**
- **Unused accumulated Return Sum Insured will lapse if policy is not renewed.**
- **For Inpatient, hospitalization will be considered for 24 hours.**

3.1.10. Smart Cash

We take pride in the Government lead health infrastructure of our country and the state of art treatments that we have.

IF you choose to get any treatment at a Government hospital, we will pay you INR 5000 for the same. Maximum up to Sum Insured.

NOTE:

- We will **pay this if the claim was admissible under following benefits** "Expenses in reaching the hospital", "Expenses during hospitalization", "Organ Donor", "Home Care/Domiciliary".
- Hospitalization will be considered for 24 Hours.
- We will only pay this benefit, **if we have not paid** claim under "Expenses during hospitalization", "Expenses in reaching the hospital", "Organ Donor", "Home Care/Domiciliary" for the same hospitalization.

3.1.11. Digital Consultations

You can take **unlimited Digital Consultations with a General Practitioner** our Partner Network.

Optional Benefit:

3.1.12. Hospital Cash

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

3.1.13. Personal Accident

a. Accidental Death (AD)

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

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

b. Permanent Total Disability

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

Condition for Permanent Total Disability	**% of 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%

- 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.

c. Permanent Partial Disability

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

Condition for Permanent Partial Disability	**% of 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%

- 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.
- 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 Sum Insured opted. Once Total Sum Insured is paid, the policy will lapse.

3.1.14. Safeguard

a. **Claim Safeguard:** Items in mentioned in Annexure 1 in 'List I – Expenses not covered' of non-payable items will be covered. However, the charges for the same must be Reasonable and Customary Charges (Clause 2.1.34) will still apply.

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

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

3.1.15. Safeguard+

a. **Claim Safeguard+:** Items in mentioned in Annexure 1 in 'List I,II,III,IV – Expenses not covered' of non-payable items will be covered. However, the charges for the same must be Reasonable and Customary Charges (Clause 2.1.34) will still apply.
b. **Sum Insured Safeguard+**: Preserves the value of Sum Insured. Safeguards it against inflation. We will increase the Base Sum Insured on cumulative basis at each renewal by the rate of inflation in the previous year. Inflation rate would be the average consumer price index (CPI) of the entire calendar year published by the Central Statistical Organization (CSO).

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

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

3.1.16. Health Checkup (Only Cashless)

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

NOTE:
If you undergo multiple tests, make sure that all these are done within 7 days.

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

3.1.17. Health Checkup (Cashless & Reimbursement)

Available once every Policy Year, from day 1 of the policy. You can choose any test(s) from the list specified below up to your eligibility limit. This benefit is only available for the Adults in the policy. The tests MUST be booked through digital assets (e.g. Mobile App). This benefit is available on cashless & reimbursement basis. A flat 20% co-payment will apply on reimbursement basis.

NOTE:

If you undergo multiple tests, make sure that all these are done within 7 days. Test taken once, cannot be repeated in a policy year irrespective of the limit left in the policy.

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

Note: No other co-payments will be applicable under this benefit for Reimbursement claims.

3.1.18. Second Medical Opinion

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

3.1.19. Co-Payment:

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

NOTE: Co-payment will NOT apply to Health Check-up (Cashless), Health Check-up (Cashless & Reimbursement), Second Medical Opinion, Digital Consultations, Return, Smart Cash, Return+, Smart Cash+, Personal Accident, Hospital Daily Cash

Co-Payment & Annual Aggregate Deductible cannot be opted together.

3.1.20. Pre-Existing Disease Waiting Time Modification

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

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

3.1.21. Room Type Modification

You can as per your lifestyle, choose to change the room category we are offering, and opt for what suits you best!
You can choose between a General Ward (any room with 4 beds and more), Single Private Room or All Room Category.
ICU admission will always be paid up to Sum Insured.

NOTE: You will have to bear additional co-payment IF treatment is taken in a higher room category than the eligible room category.

Category Available (as Opted for)	Category Claimed for	Co-Payment Percentage
Twin Sharing Room	Single Private Room	20%
Twin Sharing Room	All Room Category	20%
General Ward	Twin Sharing Room	20%
General Ward	Single Private Room	20%
General Ward	All Room Category	30%
Single Private Room	All Room Category	20%

3.1.22. Specific Disease Waiting Time Modification

You can choose to reduce or increase the Specific Disease waiting time.

NOTE: This can only available at the time of buying the policy and cannot be opted/modified/removed at renewal

3.1.23. Annual Aggregate Deductible

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

NOTE:

- Deductible amount borne by you should also be payable as per policy terms and conditions.
- Deductible will NOT apply to Health Check-up (Cashless), Health Check-up (Cashless & Reimbursement), Second Medical Opinion, Digital Consultations, Return, Smart Cash, Return +, Smart Cash+, Personal Accident, Hospital Daily Cash

Co-Payment & Annual Aggregate Deductible cannot be opted together.

3.1.24. No Co-Pay Network

If opted, we will remove the applicable Co-payment under the benefit “Rise-Tiered Network”. All other conditions for the policy will remain same.

3.1.25. Modern Treatment+

If opted, we will remove the applicable sub-limit from “Modern Treatments” under the benefit “Expenses during Hospitalization” enhancing the limit for the benefit up to Sum Insured. All other conditions for the policy will remain same.

3.1.26. Smart Cash+

We take pride in the Government lead health infrastructure of our country and the state of art treatments that we have.

IF you choose to get any treatment at a Government hospital, we will pay from INR 5000 to up to INR 25,000 in multiples of 5000 for the same. Maximum up to Sum Insured.

NOTE:

- We will **pay this if the claim was admissible under following benefits** "Expenses in reaching the hospital", "Expenses during hospitalization", "Organ Donor", "Home Care/Domiciliary”.

- Hospitalization will be considered for 24 Hours.
- We will only pay this benefit, **if we have not paid** claim under "Expenses during hospitalization", "Expenses in reaching the hospital", "Organ Donor", "Home Care/Domiciliary" for the same hospitalization.

<u>You can either have Smart Cash or Smart Cash+ at a given point in time.</u>

3.1.27. Return+

Get maximum RETURN with Rise!

Get back 100% of the premium paid as separate sum insured. Accumulate this amount and get 10% as bonus on the accumulated Sum Insured. You can use the accumulated Sum Insured, for any claim that is not paid because of listed exclusions, Waiting Periods (Section 5) and complete rejection of claim of any kind.

NOTE:

- **You can only use it only for completely rejected claims under sections "Expenses during hospitalization", Home Care / Domiciliary Treatment" and "Organ donor"**
- **You can use this amount for all Waiting Periods & All Exclusions listed in this policy only. Except for any exclusion and claim rejection under Maternity, IVF, OPD, Alcoholism, Cosmetics, Fraud & Misrepresentation.**
- **You will lose all accumulated Return Sum Insured if you opt out of this benefit at any point in time.**
- **For Inpatient, hospitalization will be considered for 24 hours.**

<u>You can either have Return or Return+ at a given point in time.</u>

3.1.28. ReAssure Forever

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

Note:

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

Illustration:

Year 1: Once the Policy is bought.

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

					Sum Insured and 9 Lakh from **ReAssure Forever)**			

Year 2: Once the policy is renewed:

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

If this benefit is opted, the base Re-fill benefit will be removed

4. Payment Methods

The consumer can choose any of the following ways to pay the premiums:

1. **One time:** the complete premium for the policy tenure is paid up front.
2. **Monthly:** the policy premium for the complete tenure is paid on a monthly basis.
3. **Quarterly:** the policy premium for the complete tenure is paid on a quarterly basis.
4. **Half Yearly:** the policy premium for the complete tenure is paid in a half-yearly basis.
5. **Flexi-Pay:** where
    a. The consumer can choose to pay the premium anytime in the policy tenure, post the minimum enrollment and monthly payments.
    b. Now have the flexibility to choose your own payment method!
    Following is the month wise discount and schedule of payments. There is a higher discount if you pay earlier. Whichever component of premium you pay in that month; you will receive the discount as mentioned in your policy schedule. (Annexure 5 refers to the discount schedule).
    c. **Components:**

- **Enrollment Premium**: You will have to pay a minimum percentage of the total premium (like token money) in order for us to issue the policy.
- **Minimum Monthly Premium:** You will have to pay a small percentage of the left-over premium (Total Premium-Enrollment premium) as a minimum monthly

premium in order to keep your policy active. If you fail to pay this, we will not be able to let you use any benefit in the policy till all due pending minimum monthly payments are made. We will consider claims that arises in the Inactive period, once the policy is made active.

- **Lump sum Amount:** You have the freedom to choose and pay any amount as many times (up to the left-over premium) during the entire policy tenure.

NOTE:

- If the complete amount is not paid till the last day of the policy tenure, then the policy will not be eligible for renewal and no continuity benefits will be offered.
- In case of any claim we will deduct the complete leftover premium from the claim.
- To ensure your policy continues the premiums should be paid within 10 months for 1-year tenure. 20 months for 2 years and 30 months for 3 years.

5. Exclusions

5.1. Standard Exclusions

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy.
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 (Insurance Products) Regulations, 2024 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 for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:
   i. Pancreatitis and stones in biliary and urinary system
   ii. Cataract, glaucoma and retinal detachment
   iii. Hyperplasia of prostate, hydrocele and spermatocele

iv. Prolapse uterus or cervix, endometriosis, Fibroids, Polycystic ovarian disease (PCOD), hysterectomy (unless necessitated by Malignancy)
v. Hemorrhoids, fissure, fistula or abscess of anal and rectal region
vi. Hernia of any site or type,
vii. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
viii. Varicose veins of lower extremities
ix. All internal or external benign neoplasms/ tumours, cyst, sinus, polyps, nodules, mass or lump
x. Ulcer, erosion or varices of gastro intestinal tract
xi. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

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

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

5.1.4. Investigation & Evaluation (Code-Excl04)

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

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

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

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

5.1.6. Obesity/ Weight Control (Code-Excl06)

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

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
   i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
    1. Obesity-related cardiomyopathy
    2. Coronary heart disease
    3. Severe Sleep Apnea
    4. Uncontrolled Type2 Diabetes

5.1.7. Cosmetic or plastic Surgery (Code-Excl08)

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

5.1.8. Hazardous or Adventure sports (Code-Excl09)

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

5.1.9. Breach of law (Code-Excl10)

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

5.1.10. Excluded Providers (Code-Excl11)

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

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

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

5.1.13. Refractive Error (Code-Excl15)

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

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

5.1.14. Unproven Treatments (Code-Excl16)

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

5.1.15. Sterility and Infertility (Code-Excl17)

Expenses related to sterility and infertility. This includes:

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

5.1.16. Maternity Expenses (Code-Excl18)

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

5.2. Specific Exclusions

5.2.1. Personal Waiting Period

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

5.2.2. Conflict & Disaster:

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

5.2.3. External Congenital Anomaly:

Screening, counseling or treatment related to external Congenital Anomaly.

5.2.4. Dental treatment:

All dental treatments other than due to accidents and cancers.

5.2.5. Unrecognized Physician or Hospital:

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

5.2.6. Costs which are not Reasonable and Customary and treatments which are not Medically Necessary. **Refer Definition 2.1.33 for Reasonable and Customary Charges.**

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

5.2.8. Treatment taken under any Out Patient Department (like Consultations, Pharmacy, Diagnostics, fracture etc.)

6. General Terms and Clauses

6.1. Standard General Terms and Clauses	**Simplified for you**
6.1.1. Free Look Period The Free Look Period shall be applicable on individual health insurance policies and not on renewals. The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to return the policy to the insurer for cancellation, stating the reasons for the same. Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.	Free look is a 30 days period during which you can return back your policy, if you don't like what you have purchased.
6.1.2. Cancellation The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall: a. Refund proportionate premium for unexpired policy period, if the term of the policy up to one year and there is no claim(s) made during the policy period. b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.	**Simplified for you** You can cancel your policy whenever you wish. **Note:** We will NOT refund any premium if we have paid a claim. We will refund part of the premium depending on how many days your policy has been running for, if there is no claim.
6.1.3. Renewal of Policy A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured. An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy. a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.	

c. Coverage is available during the grace period. d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience. e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured **6.1.4. Possibility of Revision of Terms of the Policy Including the Premium Rat** The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected. **6.1.5. Nomination** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy. The insurer shall obtain nomination at the time of new business and at the time of renewal for existing policies. **6.1.6. Fraud** If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy: a) the suggestion, as a fact of that which is not true and 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	**<u>Simplified for you</u>** If we ever cancel your policy, it will be for Fraud or Non disclosure only. Insurance contract is a legal contract too and it's based on trust. **Fraud** is an action by you or anyone acting on your behalf where you receive benefits, financial or otherwise, for which you are either not eligible at all or not to the extent under the policy. Pay your renewal premium before end of policy period

deceive; and d) any such act or omission as the law specially declares to be fraudulent The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. **6.1.7. Withdrawal of Policy** i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy. **ii.** Insured Person will have the option to either renew (up to 90 days from renewal date) same or to migrate to a similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break. **6.1.8. Redressal of Grievance:** In case of any grievance the insured person may contact the company through: Website: www.nivabupa.com Toll- Free: 1860-500-8888 E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com) Fax : 011-41743397 Courier: Customer Services Department Niva Bupa Health Insurance Company Limited D-5, 2nd Floor, Logix Infotech Park opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301 Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at: Head – Customer Services Niva Bupa Health Insurance Company Limited D-5, 2nd Floor, Logix Infotech Park opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301 Contact No: 1860-500-8888 Fax No.: 011-41743397 Email ID: Email our Grievance officer through our Grievance Redressal platform https:// transactions.nivabupa.com/pages/grievance-redressal.aspx	to maintain continuity of benefits. A grace period is also available to pay the premium after policy expiry. **Note: You are NOT insured during the grace period.** **<u>Simplified for you</u>** We will cancel your policy, will not pay any claim, will not refund any premium paid and have right to take all possible legal action against you including for recovery of benefits paid earlier, if • You withheld any information from us, whole or part that would have invited any decision other than a 'standard acceptance' of your application for insurance. **Note**: Non standard decisions are: ○ Loading – We ask for additional premium ○ Exclusions – We apply a additional waiting

For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.com. If insured person is not satisfied with the Redressal of grievance through above methods, the insured person may also approach the office of insurance Ombudsman of the respective area/region for Redressal of grievance as per insurance Ombudsman Rules 2017 (at the addresses given in Annexure II). Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in **6.1.9. Claim settlement (Provision for Penal interest)** I. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date. II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of claim intimation till the date of payment of claim at a rate of 2% above the bank rate. (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due) **6.1.10. Moratorium Period** After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The moratorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract. Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period **6.1.11. Multiple Policies** A. **Indemnity Based Policies**: i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of	period for health conditions or treatments ○ Rejection – We hate to do this. But sometimes are compelled to say no to a customer **IMPORTANT:** **We understand you may not know how important is the information on your health and it's impact on your policy. Hence it's very important that you disclose all health information and we would decide how important (we call it 'material') it is.** • Cause fraud of any kind **<u>Simplified for you</u>** We will provide our decision on claim

his / her claim in terms of any of his / her policies. In all such cases the insurer chosen by the Policyholder shall be considered as the Primary Insurer and will be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy ii. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement pf the balance amount as per the policy conditions, without causing any hassles to the policy holder B. **Benefit Based Policies**: An occurrence of the insured event, the policy holder can claim from all Insurers under all policies	within 15 days from submission of all necessary claim documents. For any delay in payment of claim, we will pay interest on the claim amount at a rate 2% above bank rate. **<u>Simplified for you</u>**
6.1.12. Migration In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy. The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.	After 5 years, no health insurance claim shall be contestable except for proven fraud and permanent exclusions.
6.1.13. Portability A Policyholder has the choice to port his/ her policies from one Insurer to another irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.	**<u>Simplified for you</u>** In case you have multiple policies, you can choose the policy from which you want to claim first. If claim amount exceeds the Sum Insured of first policy you claim from; then you can claim the balance amount from the second policy.
6.1.14. Disclosure of Information The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)	

6.1.15. Condition Precedent to Admission of Liability The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy. **6.1.16. Complete Discharge** Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim. **6.1.17. Premium Payment in Instalments** If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy) i. Grace Period of 30 days in all types of policies, and a period of 15 days in case of monthly instalments. ii. For policies where premium is paid in instalments only, the coverage will be given during grace period. iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period. iv. No interest will be charged If the instalment premium is not paid on due date v. In case of instalment premium due not received within the grace period, the policy will get canceled. vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable. **6.2. Specific Terms and Clauses** **6.2.1. Automatic Cancellation:** The Policy shall automatically terminate in the event of death of the all Insured Person(s). A refund in accordance with the table in Section 6.1.2 shall be payable provided that no claim has been admitted or lodged or not benefit has been availed by the insured person under the policy. **6.2.2. Additional premium (Risk Loading)** i. We may ask for additional premium after due risk evaluation (it's what referred to as Underwriting) based on all information provided by you. We will issue policy to you only after you pay us the additional premium and provide us consent. ii. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual. iii. Once applied, Risk loading continues even for all renewals. **6.2.3. Other Renewal Conditions:**	**Simplified for you** You can shift your policy to any other health insurance product / plan offered by us as per migration guidelines. **Simplified for you** You can also shift your policy to any other insurer as per portability guidelines.

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

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

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

d. Split of policy for child:
Child under a floater plan will get a separate policy at renewal after attaining age 31 years.

6.2.4. Claims

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

b. Documents required with claim form:

Hospital / Medical records:

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

Policyholder documents (Nominee in case of death of Policyholder):

- KYC documents
- Cancelled cheque

IMPORTANT:

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

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

d. If you opt for a Hospital room which is higher than the eligible room category as specified in your Policy Schedule, then We will pay only a pro-rated

portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:
(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses
Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

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

Please Note:

- Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.
- We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx

6.2.5. Policy Disputes

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

6.2.6. Territorial Jurisdiction

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

6.2.7. Alteration to the Policy

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

6.2.8. Zonal pricing

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

i. Zone 1: Delhi NCR (Delhi NCR Includes Delhi, Baghpat, Bulandshahr, Gautam Buddh Nagar, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Faridabad, Gurugram, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak, Sonipat, Aligarh, Alwar, Hissar, Kaithal, Kurukshetra, Mathura, Saharanpur, Sirsa), Nasik, Surat, Vadodara

ii. Zone 2: Rest of Gujarat, Kolkata, Mumbai, Palghar, Raigarh (MH), Thane

iii. Zone 3: Amritsar, Chennai, Hooghly, Hyderabad, Jaipur, K.V.Rangareddy, Kolkata Ext, Madhya Pradesh, Rest Of Maharashtra, Rest Of Uttar Pradesh, Rest Of Haryana iv. Zone 4: Rest of India (Including Bengaluru and Pune) Your premium depends upon your residential city. Please inform us immediately in case of change in your city. **6.2.9. Assignment** The Policy can be assigned subject to applicable laws.	

Annexure 1

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

List I – Expenses not covered

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

20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		

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

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

11	TISSUE PAPER	24	IM IV INJECTION CHARGES	37	PULSEOXYMETER CHARGES
12	TOOTH PASTE	25	CLEAN SHEET		
13	TOOTH BRUSH	26	BLANKET/WARMER BLANKET		

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

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

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

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

Annexure 2- Rise-Tiered Network List

List of Hospitals where Co-Payment of 20% is not Applicable.

This is just a representation of the network, complete & latest list can be accessed on our website https://rules.nivabupa.com/hospital-network/

Provider Name	CITY
2S WELLNESS AND RESEARCH CENTRE PVT LTD	JODHPUR
3D VISION EYE HOSPITAL-JAIPUR	JAIPUR
7 X HOSPITAL	THANE
7X MULTI SPECIALITY HOSPITAL	BHARUCH
A B LASER EYE CENTRE	GAUTAM BUDDHA NAGAR
A K HOSPITAL (PROP.ANIL KUMAR KHIWANI)	BHOPAL
A M MEDICAL CENTRE PRIVATE LIMITED-KOLKATA	KOLKATA
A S IMAGING CENTRE PRIVATE LIMITED	ARIYALUR
A TO Z MUTLISPECIALITY HOSPITAL LLP	SURAT
A V EYE HOSPITAL & DIAGNOSTICS PVT LTD	BENGALURU
A. B. EYE INSTITUTE	PATNA
A. K. EYE HOSPITAL PVT. LTD.	BAREILLY
A.B.R NEURO AND MULTISPECIALITY HOSPITAL	HYDERABAD
A.C.S. MEDICAL COLLEGE AND HOSPITAL	CHENNAI
A.N NEURO CRITICAL CARE CENTRE AND CMC HOSPITAL	JALANDHAR
A.N.S. HOSPITAL	INDORE
A.P. VARKEY MISSION HOSPITAL - ERNAKULAM	ERNAKULAM
A.R HOSPITAL (P) LTD	MADURAI
A.V. MULTISPECIALITY HOSPITAL	BENGALURU
A.V.HOSPITALS	CHENNAI

Annexure-3

List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, UT of Jammu & Kashmir, Ladakh and Chandigarh.

CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of Lakshadweep, Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030 Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

Annexure-4

Product Benefit Table

Base Benefit	Details
Base Sum Insured	1L, 2L, 3L, 5L, 7.5L, 10L, 15L, 20L, 25L, 50L, 75L, 1Cr
Expenses in Reaching a Hospital	Road Ambulance of up to INR 2000 per hospitalization.
Expenses During Hospitalization	Covered up to Sum Insured for 2+ Hours of Hospitalization. (24+ Hours for AYUSH Treatment)
Room Type	Covered up to Twin Sharing Room without Co-Payment. Flat 20% Co-Payment: If above Twin Sharing Room is opted.
Modern Treatments	Covered up to INR 50,000 per hospitalization.
Expenses Before and After a Hospitalization	Covered up to Sum Insured. 60 days before & 180 days after Hospitalization.
Home Care/Domiciliary	Covered up to Sum Insured
Organ Donor	Covered up to Sum Insured
Re-Fill	Get 100% EXTRA Cover. After 1st Claim. *Same person can use it for same illness.*
Rise-Tiered Network	Get access to an extensive list of hospitals. Flat 20% Co-Payment: if treatment taken outside this list of hospitals.
Loyalty Bonus	Get 10% EXTRA Cover. Every Year. Up to 100% of Base Sum Insured.
Return	Get back 50% of the premium paid & accumulate for life. Get 10% returns on the accumulated amount. No Waiting Periods & Exculsions apply on this amount.
Smart Cash	Get INR 5000, if treatment taken in any Govt. hospital and not claimed under this policy.

Digital Consultations	**Unlimited**
Optional Benefits	
Health Check-Up (Only Cashless)	**Starting from Day 1.**
Health Check-Up (Cashless and Reimbursement with 20% Co-payment)	**Starting from Day 1.**
Pre-Existing Disease Wait Time Modification	**Choose to reduce to 12 month or 24 months.**
Specific Disease Wait Time Modification	**Choose to increase to 36 months or reduce to 12 months**
Room Type Modification	**Choose General Ward, or Upgrade to Single Room or All Room Categories**
Co-Payment	**0%, 10%, 20%, 30%, 40%, 50%**
Personal Accident	**Up to 5X of Base Sum Insured. Maximum up to INR 1 Crore**
Hospital Daily Cash	**Get INR 1000 per day for hospitalization. Maximum 30 days in a year.**
Annual Aggregate Deductible	**INR 10,000; INR 20,000; INR 30,000; INR 50,000; INR 1,00,000; INR 2,00,000; INR 3,00,000; INR 4,00,000; INR 5,00,000**
Safeguard	**Claim Safeguard: Non-payable items will be covered (as per list I of policy annexure 'The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment') Sum Insured Safeguard: CPI linked increase in Base Sum Insured**
Safeguard+	**Claim Safeguard+: Non-payable items will be covered (as per list I, II, III, IV of policy annexure 'The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment') Sum Insured Safeguard+: CPI linked increase in Base Sum Insured**

No Co-pay Network	**Removes co-payment for treatment taken outside the "Rise-Tiered Network".**
Modern Treatment +	**Removes sublimit on modern treatments and covered Up to Sum Insured.**
Smart Cash +	**Enhances the limit for "Smart Cash" up to INR 50,000.**
Return +	**Get back 100% of the premium paid & accumulate for life.** **Get 10% returns on the accumulated amount.** **No Waiting Periods & Exculsions apply on this amount.**
Second Medical Opinion	**For any condition, as many times in a Policy Year.**

Annexure-5

Flexi-Pay Discount Schedule

Time	Discount - Term 1Y	Discount - Term 2Y	Discount - Term 3Y
Before Policy Inception	7.00%	10.40%	12.30%
Month 1	7.00%	10.40%	12.30%
Month 2	6.20%	9.70%	11.50%
Month 3	5.40%	8.90%	10.80%
Month 4	4.70%	8.20%	10.10%
Month 5	3.90%	7.50%	9.40%
Month 6	3.10%	6.70%	8.60%
Month 7	2.40%	6.00%	8.00%
Month 8	1.60%	5.20%	7.20%
Month 9	0.80%	4.50%	6.50%
Month 10	0.00%	3.70%	5.70%
Month 11	0.00%	3.40%	5.40%
Month 12	0.00%	3.10%	5.10%
Month 13	NA	2.80%	4.70%
Month 14	NA	2.50%	4.40%
Month 15	NA	2.20%	4.10%
Month 16	NA	1.90%	3.80%
Month 17	NA	1.60%	3.40%
Month 18	NA	1.30%	3.10%
Month 19	NA	1.00%	2.80%
Month 20	NA	0.00%	2.40%
Month 21	NA	0.00%	2.10%
Month 22	NA	0.00%	1.80%
Month 23	NA	0.00%	1.60%
Month 24	NA	0.00%	1.40%
Month 25	NA	NA	1.30%
Month 26	NA	NA	1.20%
Month 27	NA	NA	1.00%
Month 28	NA	NA	0.90%
Month 29	NA	NA	0.80%
Month 30	NA	NA	0.00%
Month 31	NA	NA	0.00%
Month 32	NA	NA	0.00%
Month 33	NA	NA	0.00%
Month 34	NA	NA	0.00%
Month 35	NA	NA	0.00%
Month 36	NA	NA	0.00%

Annexure-6
Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
			Illustration 1							
18	7,116.16	5,00,000	7,116.16	711.62	6,404.54	5,00,000	7,116.16	10,731.40	23,466.32	5,00,000
21	7,116.16	5,00,000	7,116.16	711.62	6,404.54	5,00,000	7,116.16			
39	8,891.67	5,00,000	8,891.67	889.17	8,002.50	5,00,000	8,891.67			
45	11,073.73	5,00,000	11,073.73	1,107.37	9,966.36	5,00,000	11,073.73			
Total premium for all members of the family is **Rs. 34,197.72**, when each member is covered separately. Sum Insured			Total premium for all members of the family is **Rs. 30,777.95**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.5,00,000**.				Total premium when the policy is opted on floater basis is **Rs.23,466.32** Sum Insured of **Rs.500,000** is available for the entire family.			

<table>
<tr><td colspan="3">available for each individual is <u>Rs.500,000</u>.</td><td colspan="4"></td><td colspan="4"></td></tr>
<tr><td colspan="3"></td><td colspan="4">Illustration 2</td><td colspan="4"></td></tr>
<tr><td>55</td><td>18,494.98</td><td>5,00,000</td><td>18,494.98</td><td>1,849.50</td><td>16,645.48</td><td>5,00,000</td><td>18,494.98</td><td>1,333.93</td><td>50,918.16</td><td>5,00,000</td></tr>
<tr><td>63</td><td>33,757.11</td><td>5,00,000</td><td>33,757.11</td><td>3,375.71</td><td>30,381.40</td><td>5,00,000</td><td>33,757.11</td><td colspan="3"></td></tr>
<tr><td colspan="3">Total premium for all members of the family is <u>Rs. 52,252.09</u>, when each member is covered separately.

Sum Insured available for each individual is <u>Rs.500,000</u>.</td><td colspan="4">Total premium for all members of the family is <u>Rs.47,026.88</u>, when they are covered under a single policy.

Sum Insured available for each family member is <u>Rs.5,00,000</u>.</td><td colspan="4">Total premium when the policy is opted on floater basis is <u>Rs. 50,918.16</u>

Sum Insured of <u>Rs.500,000</u> is available for the entire family.</td></tr>
<tr><td colspan="3"></td><td colspan="4">Illustration 3</td><td colspan="4"></td></tr>
<tr><td>65</td><td>33,757.11</td><td>5,00,000</td><td>33,757.11</td><td>3,375.71</td><td>30,381.40</td><td>5,00,000</td><td>33,757.11</td><td>8,519.55</td><td>65,629.12</td><td>5,00,000</td></tr>
<tr><td>70</td><td>40,391.56</td><td>5,00,000</td><td>40,391.56</td><td>4,039.16</td><td>36,352.41</td><td>5,00,000</td><td>40,391.56</td><td colspan="3"></td></tr>
<tr><td colspan="3">Total premium for all members of the family is <u>Rs. 74,148.67</u>, when each member is covered separately.

Sum Insured available for each individual is <u>Rs.500,000</u>.</td><td colspan="4">Total premium for all members of the family is <u>Rs.66,733.80</u>, when they are covered under a single policy.

Sum Insured available for each family member is <u>Rs.5,00,000.</u></td><td colspan="4">Total premium when the policy is opted on floater basis is <u>Rs. 65,629.12</u>

Sum Insured of <u>Rs.500,000</u> is available for the entire family.</td></tr>
<tr><td colspan="11">Note: Premium rates specified in the above illustration are standard premium rates without considering any loadings/discounts. Also, the premium rates are exclusive of taxes applicable.</td></tr>
<tr><td colspan="11">Zone 3 premium is considered</td></tr>
</table>