Senior First

Prospectus cum Sales Literature

Retirement means different things to different people, while some want to relax and take a trip around the world, some want to start up a venture of their own, and pursue a dream harnessed for years. However, its also a time to start being more careful about one's health. Niva Bupa 'Senior First' health insurance policy is designed specifically for senior citizens keeping in mind their needs and requirements. Apart from offering you this health insurance cover, we are also committed to provide you with quality services when you need it the most.

Why Niva Bupa is the healthier Health Insurance for you and your spouse:

- 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 healthier, not chasing your claims.
- You can access our cashless facility at the hospitals of your city which are part of our partner network.
- 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, so please consult your tax advisor for more details)

Policy Design

- Niva Bupa's 'Senior First' product can be issued to individual or to a couple (husband and wife).
- The entry age under this policy is from 61 years to 75 years (as on last birthday). Policy can be renewed for lifetime subject to timely payment of due premium
- In an Individual policy, maximum up to 2 adults (self & spouse) can be included in a single policy. 10% discount on premium if 2 members are covered under an individual policy.
- The policy is also available on family floater basis (self & spouse). The premium for family floater policies depends on the age of the eldest insured person.
- **Term discount**: The default policy term 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: 15% on the premium for third policy year + 7.5% on the premium for second policy year
- **Staff discount**: A staff discount of 15% on the policy premium will be given for the first policy year and on every renewal of such policy.
- **Standing Instruction discount**: 2.5% discount on premium if standing instruction for renewal is provided and the policy is renewed using the same.
- There is a co-payment applicable under this product. Default co-payment is 50%, however you can modify the same to 40% or 30% or 20% while buying the policy i.e. at inception of the first policy.
- **No-Claim Discount**: In case a consumer is receiving No Claim Bonus at the time of renewal, as specified in the policy wordings, we will offer a flat discount of INR 49 to the policy. This discount is applicable only at Renewals on the renewal premium and will not be offered if No Claim Bonus is not offered in a particular policy period. The discount will be offered for each policy period where there is No Claim Bonus including the policy that has reached its maximum limit of No Claim Bonus.
- The premium rates for the plans offered are annexed hereto with the prospectus (Annexure III). The premium rates are basis the following age bands: 61-65, 66-70, 71-75, 76-80, 81-85 and 86+.

Coverage Options

There are two variants under the policy – Gold and Platinum. Gold variant has sum insured options of Rs.5 Lac and Rs.10 Lac. Platinum variant has sum insured options from Rs.5Lac to Rs.25 Lac (in multiples of Rs.5 Lac). The details of the variants, benefits, room category, limits/amounts are specified in the product benefit table (Annexure I).

1. **Benefits**

This Policy covers Allopathic and AYUSH treatments taken in India **ONLY**. Expense incurred outside the policy period will **NOT** be covered. Unutilized Sum Insured will expire at the end of policy year. Following benefits are available under this product:

DESCRIPTION (What we pay and what we DON'T)	IMPORTANT TERMS (what it means)
1.1. Expenses to reach hospital **(Ambulance)** By road, maximum Rs. 2,000 & by air maximum Rs. 2,50,000 per hospitalization. Applies **ONLY** when Hospital admission claim is paid. **IMPORTANT**: You **MUST** use a registered ambulance / air ambulance provider. Air ambulance is available only for **Emergency care**. 1.2. Expenses during hospitalization **(Hospital admission)** 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) if you were: • Admitted for 2 hours or more **NOTE**: minimum 24 hours admission in AYUSH Hospital MUST for **AYUSH treatment** coverage • You had Angiography, Dialysis (Hemo / Peritoneal), Radiotherapy or Chemotherapy for cancer **NOTE: Admission in a hospital happens in what is called wards or rooms of various categories, ICUs, CCUs, NICU etc or in Day care**. **IMPORTANT**: **i. We will NOT pay, even if you were admitted, if there was no treatment and only investigations were done. Example: Admission only for investigations like MRI, CT Scan, Endoscopy, Colonoscopy etc.** **ii. We will NOT pay for Automation machine for peritoneal dialysis** b. We pay for Modern treatments as specified below:	**Def 1: Emergency care** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health. **Def 2: AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems. **Def 3: Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is: a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and b. which would have otherwise required a Hospitalization of more than 24 hours.

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 Rs. 1,00,000 per claim will apply to all robotic surgeries, except for total radical prostatectomy, cardiac surgeries, partial nephrectomy and surgeries for malignancies

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

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

1.4. Treatment at home **(Domiciliary Hospitalization)**

We will pay the expenses incurred by you on treatment at home only if:

a. the treating doctor has given in writing that there was no room available for treatment at the hospital, or that the insured was not in a position to reach the hospital, and

b. minimum 3 consecutive days of treatment was received by the Insured

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 **Hospital admission** claim is paid.

1.6. No Claim Bonus (NCB)

For every claim free year, we will add 10% of expiring policy base sum insured as NCB, maximum up to 100%.

NOTE:

IMPORTANT: Below points apply for changes made within the same product. Change in product is called **Migration** in which you **CAN NOT** carry NCB.

a. NCB applies the same way as the policy sum insured type. If policy is floater, NCB is floater & if policy is individual sum insured, NCB too is individual basis.

b. Individual NCB can be carried to any policy with individual sum insured as long as sum insured is NOT reduced.

c. If two or more policies merge into a floater policy, the lowest of the NCB among all policies will be carried to the new merged floater policy.

d. In case You change individual sum insured policy to Floater, the lowest of the NCB of members in previous policy will be carried to floater policy.

e. If Floater policy is converted to individual sum insured policy, NCB of previous policy will be given to each of previously insured member on individual basis as long as sum insured is NOT reduced.

f. If any one reduces base sum insured, same percentage of NCB will be given as was the previous NCB of the previous base sum insured.

Example:

Base Sum Insured	Accumulated NCB	Base Sum Insured is reduced to 5 Lac	Revised Base Sum Insured	Revised Accumulated NCB
10 Lac	5 Lac(after 5 claim free years)		Stereotactic radio Surgeries	2.5 Lac

Def 4: Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing conditions and specific waiting periods from one health insurance policy to another with the same insurer.

1.7. ReAssure

The first paid claim triggers ReAssure, a benefit with unlimited sum insured.

NOTE: Maximum amount ReAssure benefit pays for any single claim is up to base sum insured.

Illustration:

Base Sum Insured	1st paid Claim		Balance Base Sum Insured	2nd payable claim	Claim amount paid	Balance Base Sum Insured	3rd Payable claim	Claim amount paid
10 Lac	7 Lac	ReAssure benefit is triggered	3 Lac	12 Lac	12 Lac (3 Lac from base SI and 9 Lac from ReAs-sure	Nil	11 Lac	10 Lac from ReAssure

1.8. Health Checkup

Available once every Policy Year, from day 1 of the policy. You can choose any test(s) from the list specified below. Please note that the tests must be taken within the duration of 7 days.

List of tests covered:		
Complete blood count	Complete Physical Examination by Physician	Serum Electrolytes
Urine Routine	Post prandial/lunch blood sugar (PPBS / PLBS)	HbA1C
Erythrocyte Sedimentation Rate (ESR)	Uric Acid	Thyroid profile (TSH)
Fasting Blood Glucose	Lipid Profile	LiverFunctionTest (LFT)
Electrocardiogram	Kidney function test	Treadmill test (TMT)
S Cholesterol	Serum Vitamin D	Ultrasound test

Plan type	Limit's basis	Eligibility
Individual sum insured plan	Per insured	Rs. 500 for every 1 Lac rupees base sum insured, maximum up to Rs. 5,000
Floater sum insured plan	For all insureds together	Rs. 500 for every 1 Lac rupees base sum insured, maximum up to Rs. 10,000

2. **Claim Cost Sharing**

DESCRIPTION (What we pay and what we DON'T)	IMPORTANT TERMS (what it means)
2.1. **Co-payment** **Co-payment** once chosen **CAN NOT** be changed. It's the percentage of admissible claim amount You would have to bear, Rest we will pay. The default co-payment in the product is 50% which You can modify to 40% or 30% or 20% at inception of the first policy. **Note:** a. Co-payment will **NOT** apply to Ambulance and Health Check-up benefits. b. You will have to bear additional 10% co-payment **IF treatment is taken in a higher room category** than the eligible room category.	**Def 5: Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum Insured.
2.2. **Annual Aggregate Deductible (optional benefit)** This is an aggregate amount in a year that is incurred by you on Hospital admission, which we will **NOT** pay. Once the total expense exceeds this amount, balance we will pay. This too, once chosen **CAN NOT** be changed. Deductible will be 1/5th of Base Sum Insured (e.g. 1 Lac deductible is applicable for 5 Lac Base Sum Insured; and 5 Lac Deductible is applicable for 25 Lac Base Sum Insured). **Note:** a. Deductible amount borne by you should also be payable as per policy terms and conditions. b. Deductible will **NOT** apply to Health Check-up benefit. c. If Deductible is opted, then co-payment will **NOT** apply, except as specified in section 2.1 (b) for admission to higher than eligible category of room	**Def 6: Deductible** means a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

3. **Waiting Periods**

The Waiting Periods will be applicable to every Insured person individually.

3.1 **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 24 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 24 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

3.2 **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.

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 and cervix, endometriosis, Fibroids, PCOD, hysterectomy (unless necessaiated by Malignancy)

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

vi. Hernia of all sites,

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 or neoplasms/ tumours, cyst, sinus, polyp, nodules, mass or lump

x. Ulcer, erosion and 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

3.3 **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.

3.4 **Personal Waiting Periods:**

Conditions specified for an Insured Person under Personal Waiting Period (if any) will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us.

4. **Permanent Exclusions**

We will not cover the following conditions in the policy and no claims will be made for them.

4.1 **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.

4.2 **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.

4.3 **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

4.4 **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.

4.5 **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.

4.6 **Hazardous or Adventure sports (Code-Excl09)**

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

4.7 **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.

4.8 **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.

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

4.10 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)**

4.11 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)

4.12 **Refractive Error (Code-Excl15)**

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

4.13 **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.

4.14 **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

4.15 **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.

4.16 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.

4.17 **Circumcision**:

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

4.18 **Conflict & Disaster**:

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

4.19 **External Congenital Anomaly**:

Screening, counseling or treatment related to external Congenital Anomaly.

4.20 **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.

4.21 **Hormone Replacement Therapy**:

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

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

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

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

4.24 **Sleep disorders**:

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

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

4.26 Any expenses incurred on OPD treatment.

4.27 **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.

4.28 Treatment related to intentional self inflicted Injury or attempted suicide by any means.

4.29 Costs which are not Reasonable and Customary and treatments which are not Medically Necessary.

4.30 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.

5. **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 II.

d. 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.

e. 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 hopspital will be borne by us. This amount will be paid over and above the policy limits.

Note: 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. **General Terms and Conditions**

Clause	**What it means?**
6.1. **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 retun 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.

6.2 **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 upto 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.	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. 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.
6.3. **Automatic Cancellation**: The Policy shall automatically terminate in the event of death of the all Insured Person(s). A refund in accordance with Section 6.2 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.	
6.4. **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	
6.5. **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.	Pay you renewal premium before end of policy period to maintain continuity of benefits. A grace period of 30 days is also available to pay the premium after policy expiry.

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 6.6. **Other Renewal Conditions**: a. **Renewal Premium**: Renewal premium will alter based on Age. For Family Floater policies, the age of eldest insured person will be considered for calculating the premium. b. **Addition of Insured Persons on Renewal**: If a new member is added in the Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable afresh for that member. c. **Changes to Sum Insured on Renewal**: You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement. 6.7. **Possibility of Revision of Terms of the Policy Including the Premium Rates** The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected. 6.8. **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.	The terms and conditions of the policy can be changed with prior approval from IRDAI.

6.9. **Fraud**

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

6.10. **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.

6.11. **Territorial Jurisdiction**

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

6.12. **Notices**

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

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

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

- You withheld any information from us, whole or part that would have invited any decision other than a 'standard acceptance' of your application for insurance.

  Note: Non standard decisions are:

  - Loading – We ask for additional premium
  - Exclusions – We apply a additional waiting period for health conditions or treatments
  - Rejection – We hate to do this. But sometimes are compelled to say no to a customer

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

b. Us at the following address:

Niva Bupa Health Insurance Company Limited

2nd Floor, Plot No D-5, Sector 59,

Noida, Gautam Budhnagar – 201301

Fax No.: +91 11 41743397

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

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

6.13. **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.

6.14. **Zonal pricing**

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

i. Zone 1: Delhi NCR, Mumbai (including Navi Mumbai and Thane), Kolkata and Gujarat State

ii. Zone 2: Rest of India

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

6.15. **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 product or to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

6.16. **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 : +91 11 41743397

If we withdraw any product, we will inform you at least 90 days before. You will also have the option to either renew (up to 90 days from renewal date) same product or to shift your policy with all accrued benefits to another similar health insurance product available with us.

You can contact us anytime for any service related to your policy, claim or complaint.

Courier: Customer Services Department Niva Bupa Health Insurance Company Limited 2nd Floor, Plot No D-5, Sector 59, Noida, Gautam Budhnagar – 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 2nd Floor, Plot No D-5, Sector 59, Noida, Gautam Budhnagar – 201301 Contact No: 1860-500-8888 Fax No.: +91 11 41743397 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 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 Policy Terms and Conditions). Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in	
6.17. **Assignment** The Policy can be assigned subject to applicable laws.	
6.18. **Claim settlement (Provision for Penal interest)** I. The Company shall settle or reject a claim, as the case may be, within 15 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. III. (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)	We will provide our decision on claim within 15 days from the claim submission date. For any delay in payment of claim, we will pay interest on the claim amount at a rate of 2% above bank rate.

6.19. **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 morararium 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	After 5 years, no health insurance claim shall be contestable except for proven fraud and permanent exclusions.
6.20. **Multiple Policies** A. **Indemnity Based 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 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. b. 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**: a. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies.	
6.21. **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	You can shift your policy to any other health insurance product / plan offered by us as per migration guidelines.

6.22. **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.	You can also shift your policy to any other insurer as per portability guidelines.
6.23. **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)	The policy shall be considered void in case of misrepresentation, mis-description or non-disclosure of any material fact.
6.24. **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.	
6.25. **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.	

7. **Pre-Policy Medical Check-up (PPMC)**

The product envisages that there is no set pre-medical limit. However, appropriate tests may be required based on declarations, disclosure and past medical history of the proposed to be insured.

The underwriter may seek additional medical tests or past medical records if required for making an informed underwriting assessment and decision. The following grid of cost of tests sharing will be applicable on costs incurred towards PPMC:

Accepted Proposal	Decline Proposal
100 % to be borne by Niva Bupa	100 % to be borne by customer

During the underwriting process, each individual's medical history will be evaluated for risk and upon full assessment of facts, based on the severity and prognosis of the condition(s), it will be ascertained whether the proposed insured's declared condition presents a future medical risk.

Three potential options will be determined as per the underwriting guidelines.

1. Standard risk- accept application with no loading or condition /exclusion(s)
2. Sub-standard risk- such proposals are accepted by applying pertinent waiting periods/ exclusions with/without charging extra loading premium to the proposed insured(s), as applicable.
3. Risk outside of Niva Bupa's risk appetite - decline the proposal. We may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. We will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

ANNEXURE I – Product Benefit Table (all limits in INR unless defined as percentage)

Variant	Gold	Platinum
Base Sum Insured	5L / 10L	5L / 10L / 15L / 20L / 25L
Benefits		
In-patient Care	Covered up to Sum Insured	
Room Category[1]	Shared Room	Single Private Room
Pre-Hospitalization (60 days)	Covered up to Sum Insured	
Post-Hospitalization (180 days)	Covered up to Sum Insured	
Day Care Treatment	Covered up to Sum Insured	
Modern treatments	Covered up to Sum Insured with sub-limit of Rs.1L per claim on few robotic surgeries	
Ambulance	Road ambulance: up to Rs.2,000 per hospitalization Air ambulance: up to Rs.2,50,000 per hospitalization	
AYUSH Treatments	Covered up to Sum Insured	
Treatment at home (Domiciliary Hospitalization)	Covered up to Sum Insured	
Organ Donor	Covered up to Sum Insured	
No Claim Bonus	Not applicable	In case of claim free year, increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured (In case of claim, no reduction in No Claim Bonus)
ReAssure	Not applicable	Unlimited reinstatement up to base Sum Insured (Applicable for both same & different illness)
Health Check-up	Not applicable	Annual (From Day 1); For defined list of tests; up to Rs. 500 for every Rs. 1L Base Sum Insured (Individual policy: maximum Rs. 5,000 per Insured; Family Floater policy: maximum Rs. 10,000 per policy)
Co-payment[1]	50%	
Optional Benefits		
Annual Aggregate Deductible[2]	1L / 2L / 3L / 4L / 5L	
Modification in co-payment	40% / 30% / 20%	

Notes:

(1) 10% additional co-payment applicable, if treatment is taken in higher room category than eligible room category

(2) Deductible will be 1/5th of the base sum insured chosen. If deductible is opted, then co-payment will NOT apply except as specified in point(1) for treatment taken in higher than eligible category of room

Annexure II

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, HARMONICS-CALPEL,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 III

Premium rates for Base product are based on age of the eldest member in the family for floater Sum Insured basis and on age of each individual member for individual sum insured basis and differ by Family Combination, Sum insured, Zone and Variant All Premium rates and Sum insured are in INR. Premiums are exclusive of tax. Ages are in years (age last birthday)

Zone 1 : 1 Adult (1A)

Gold variant

Age Band/SI	500000	1000000
61-65	13,665	16,986
66-70	18,193	22,622
71-75	26,405	32,845
76-80	37,721	46,932
81-85	45,208	56,250
85+	52,409	65,209

Platinum variant

Age Band/SI	500000	1000000	1500000	2000000	2500000
61-65	16,858	21,590	25,578	29,071	32,632
66-70	22,419	28,513	33,808	38,457	43,213
71-75	32,473	41,028	48,719	55,485	62,420
76-80	46,645	58,670	69,644	79,322	89,276
81-85	55,817	70,144	83,299	94,901	106,833
85+	64,707	81,317	96,566	110,016	123,849

Zone 2 : 1 Adult (1A)

Gold variant

Age Band/SI	500000	1000000
61-65	11,401	14,168
66-70	15,174	18,865
71-75	22,016	27,382
76-80	31,445	39,119
81-85	37,684	46,884
85+	43,686	54,351

Platinum variant

Age Band/SI	500000	1000000	1500000	2000000	2500000
61-65	14,201	18,283	21,606	24,516	27,483
66-70	18,835	24,051	28,462	32,336	36,298
71-75	27,211	34,478	40,886	46,523	52,301
76-80	39,019	49,177	58,319	66,383	74,676
81-85	46,675	58,764	69,724	79,390	89,331
85+	54,109	68,123	80,829	92,034	103,559

Zone 1 : 2 Adult (2A)

Gold variant

Age Band/SI	500000	1000000
61-65	18,971	23,592
66-70	25,036	31,141
71-75	35,203	43,798
76-80	50,723	63,118
81-85	63,269	78,733
85+	73,346	91,274

Platinum variant

Age Band/SI	500000	1000000	1500000	2000000	2500000
61-65	23,006	29,243	35,633	41,328	46,279
66-70	30,391	38,437	46,583	53,831	60,381
71-75	42,846	53,942	65,043	74,901	84,144
76-80	62,083	77,888	93,503	107,358	120,731
81-85	77,763	97,463	116,796	133,955	150,666
85+	90,148	112,986	135,398	155,290	174,663

Zone 2 : 2 Adult (2A)

Gold variant

Age Band/SI	500000	1000000
61-65	15,823	19,673
66-70	20,875	25,962
71-75	29,347	36,508
76-80	42,277	52,604
81-85	52,732	65,616
85+	61,131	76,067

Platinum variant

Age Band/SI	500000	1000000	1500000	2000000	2500000
61-65	19,323	24,659	30,121	35,006	39,131
66-70	25,477	32,319	39,245	45,423	50,880
71-75	35,854	45,237	54,625	62,978	70,678
76-80	51,881	65,188	78,337	90,020	101,161
81-85	64,959	81,524	97,784	112,232	126,155
85+	75,305	94,509	113,358	130,107	146,248

Premium rates for Optional covers offered. Premium rates differ by Family Combination, Sum insured, Zone and Variant.

All Premium rates and Sum insured/Deductible are in INR. Premiums are exclusive of tax. Ages are in years (age last birthday)

1) Modification in Co-payment

Copay option	% loading to base premium
40% Copay	18.5%
30% Copay	37.0%
20% Copay	55.5%

2) Annual aggregate deductible

Deductible	Sum insured	Premium discount factor
1 Lac	5 Lac	15%
2 Lac	10 Lac	30%
3 Lac	15 Lac	55%
4 Lac	20 Lac	70%
5 Lac	25 Lac	75%

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										
65	13,665	500,000	13,665	1,366.50	12,298.50	500,000	13,665	6,822.00	25,036.00	500,000
70	18,193	500,000	18,193	1,819.30	16,373.70	500,000	18,193			
Total premium for all members of the family is **Rs.31,858**, 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.28,672.20**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.500,000.**				Total premium when the policy is opted on floater basis is **Rs.25,036**. Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 2										
70	18,193	500,000	18,193	1,819.30	16,373.70	500,000	18,193	9,395.00	35,203.00	500,000
75	26,405	500,000	26,405	2,640.50	23,764.50	500,000	26,405			
Total premium for all members of the family is **Rs.44,598**, 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.40,138.20**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.500,000.**				Total premium when the policy is opted on floater basis is **Rs.35,203.** 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.
Gold' plan Zone 1 premium is considered.