

Senior First Policy Wordings

1. Preamble

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. All applicable benefits and details are mentioned in your Policy Schedule.

2. Definitions

2.1. Standard Definitions

- I. **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- II. **AYUSH Hospital** is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a. Central or state government AYUSH Hospital; or
 - b. Teaching Hospital attached to AYUSH college recognized by the Central Government / Central Council of Indian Medicine / Central Council of Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least five in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).
- III. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
- IV. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
 - a. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
 - b. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body.
- V. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
- VI. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:
 - a. has Qualified Nursing staff under its employment;
 - b. has qualified Medical Practitioner(s) in charge;
 - c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
- VII. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

- VIII. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:
- the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
 - the patient takes treatment at home on account of non availability of room in a Hospital.
- IX. **Grace Period** means the specified period of time (30 days) immediately following the premium due date during which a payment can be made to Renew or continue a policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.
- X. **Hospital** means any institution established for Inpatient Care and Day Care Treatment of Illness and /or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
- has Qualified Nursing staff under its employment round the clock;
 - has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
 - has qualified Medical Practitioner(s) in charge round the clock;
 - has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
- XI. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
- XII. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
- XIII. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
- Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
 - Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
 - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - it continues indefinitely
 - it recurs or is likely to recur
- XIV. **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
- XV. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
- XVI. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- XVII. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

- XXVIII. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
- XIX. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.
- XX. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:
- is required for the medical management of the Illness or Injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a Medical Practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- XXI. **Network Provider** means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
- XXII. **Non-Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the network.
- XXIII. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- XXIV. **OPD Treatment** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.
- XXV. **Pre-existing Disease** means any condition, ailment, injury or disease
- That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
 - For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
- XXVI. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- XXVII. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital, provided that:
- Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
 - The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- XXVIII. **Portability** means the right accorded to an individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
- XXIX. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

- XXX. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.
- XXXI. **Reimbursement** means settlement of claims paid directly by Us to the Policyholder/Insured Person.
- XXXII. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all Waiting Periods.
- XXXIII. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- XXXIV. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.2. Specific Definitions

- I. **Age** means age as on last birthday.
- II. **Base Sum Insured** means the amount stated in the Policy Schedule.
- III. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
- IV. **Insured Event** means any event specifically mentioned as covered under this Policy.
- V. **Insured Person** means person(s) named as insured persons in the Policy Schedule.
- VI. **Policy** means these terms and conditions, the Policy Schedule (as amended from time to time), Your statements in the Proposal and any endorsements attached by Us to the Policy from time to time.
- VII. **Policy Period** is the period between the inception date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
- VIII. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
- IX. **Service Provider** means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.
- X. **Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single occupancy room in that Hospital.
- XI. **Sum Insured:**

In case of Individual Policy, Sum Insured means the total of the Base Sum Insured and No claim Bonus (if applicable) for that Insured Person. Our maximum, total and cumulative liability for all claims during the Policy Year in respect of the Insured Person will be Sum Insured and amount provided under ReAssure benefit.

In case of Family Floater Policy, Sum Insured means the total of the Base Sum Insured and No claim Bonus (if applicable). Our maximum, total and cumulative liability for all claims during the Policy Year in respect of all Insured Persons taken together will be Sum Insured and amount provided under ReAssure benefit.

The sequence of utilization of Sum Insured will be as below:

- i. Base Sum Insured followed by;
- ii. Accumulated No Claim Bonus (if applicable) followed by;
- iii. ReAssure benefit (if applicable)

If the Policy Period is 2 years or 3 years, then the Sum Insured shall be applied separately for each Policy Year in the Policy Period. All claims paid (except for Health Check-up) will reduce the Sum Insured for the Policy Year in which the insured event has occurred. Any claim admitted under Pre & Post Hospitalization shall reduce the Sum Insured for the Policy Year in which Hospital admission claim has incurred.

- XII. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.
- XIII. **We/Our/Us** means Niva Bupa Health Insurance Company Limited.
- XIV. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

3. Benefits covered under the policy

DESCRIPTION (What we pay and what we DON'T)	IMPORTANT TERMS (what it means)
<p>3.1. Expenses to reach hospital (Ambulance)</p> <p>By road, maximum Rs. 2,000 & by air maximum Rs.2,50,000 per hospitalization. Applies ONLY when Hospital admission claim is paid.</p> <p>IMPORTANT: You MUST use a registered ambulance / air ambulance provider. Air ambulance is available only for Emergency care.</p> <p>3.2. Expenses during hospitalization (Hospital admission)</p> <p>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:</p> <p>i. Admitted for 2 hours or more NOTE: minimum 24 hours admission in AYUSH Hospital MUST for AYUSH treatment coverage</p> <p>ii. You had Angiography, Dialysis (Hemo / Peritoneal), Radiotherapy or Chemotherapy for cancer</p> <p>NOTE: Admission in a hospital happens in what is called wards or rooms of various categories, ICUs, CCUs, NICU etc or in Day care.</p> <p>IMPORTANT:</p> <p>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.</p> <p>ii. We will NOT pay for Automation machine for peritoneal dialysis</p>	<p>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.</p> <p>Def 2: AYUSH Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.</p>

b. 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 prostate (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.

3.3. 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.

3.4. Treatment at home (Domiciliary Hospitalization)

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

- 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
- minimum 3 consecutive days of treatment was received by the Insured

3.5. 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.

3.6. 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.

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

Def 3: Day Care Treatment refers to medical treatment, and/or Surgical Procedure which is:

- undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hrs because of technological advancement, and
- which would have otherwise required a Hospitalization of more than 24 hours.

Treatment normally taken on an out patient basis is not included in the scope of this definition.

Def 4: Migration means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

- 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)		5 Lac	2.5 Lac

3.7. 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	1 st paid Claim		Balance Base Sum Insured	2 nd payable claim	Claim amount paid	Balance Base Sum Insured	3 rd 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 ReAssure)	Nil	11 Lac	10 Lac from ReAssure

3.8. Health Checkup

Available once every Policy Year, from day 1 of the policy, up to the amount as specified in Your Policy Schedule. 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	Liver Function Test (LFT)
Electrocardiogram	Kidney function test	Treadmill test (TMT)
S Cholesterol	Serum Vitamin D	Ultrasound test

4. Claim Cost Sharing

DESCRIPTION (What we pay and what we DON'T)	IMPORTANT TERMS (what it means)
<p>4.1. 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. Note:</p> <ul style="list-style-type: none"> 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 as specified in Your Policy Schedule 	<p>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.</p>
<p>4.2. 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. Note:</p> <ul style="list-style-type: none"> 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 4.1 (b) for admission to higher than eligible category of room 	<p>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.</p>

5. Exclusions

5.1. Standard Exclusions

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

- a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us.
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the Policy after the expiry of 24 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

- a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
- 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 spermatocoele
 - iv. Prolapse uterus and cervix, endometriosis, Fibroids, PCOD, hysterectomy (unless necessitated 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
- III. **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.
- IV. **Investigation & Evaluation (Code-Excl04)**
 - a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
 - b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
- V. **Rest Cure, rehabilitation and respite care (Code-Excl05)**
 Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- VI. **Obesity/ Weight Control (Code-Excl06)**
 Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - a. Surgery to be conducted is upon the advice of the Doctor.
 - b. The surgery/Procedure conducted should be supported by clinical protocols.
 - c. The member has to be 18 years of age or older and;
 - d. Body Mass Index (BMI);
 - i. greater than or equal to 40 or
 - ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 1. Obesity-related cardiomyopathy
 2. Coronary heart disease
 3. Severe Sleep Apnea
 4. Uncontrolled Type2 Diabetes

- VII. **Change-of-Gender treatments (Code-Excl07)**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- VIII. **Cosmetic or plastic Surgery (Code-Excl08)**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- IX. **Hazardous or Adventure sports (Code-Excl09)**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- X. **Breach of law (Code-Excl10)**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- XI. **Excluded Providers (Code-Excl11)**
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
The complete list of excluded providers can be referred to on our website.
- XII. **Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code-Excl12)**
- XIII. **Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13)**
- XIV. **Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure (Code-Excl14)**
- XV. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- XVI. **Unproven Treatments (Code-Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- XVII. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
- XVIII. **Maternity 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

- I. **Personal Waiting Periods:**
Conditions specified for an Insured Person under Personal Waiting Period in the Policy Schedule will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us.
- II. 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.
- III. **Circumcision:**
Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.
- IV. **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.
- V. **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.
- VI. **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.
- VII. **Hormone Replacement Therapy:**
Treatment for any condition / illness which requires hormone replacement therapy.
- VIII. 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.
- IX. **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).
- X. **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.
- XI. Any treatment or medical services received outside the geographical limits of India.
- XII. Any expenses incurred on OPD treatment.
- XIII. **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.
- XIV. Treatment related to intentional self inflicted Injury or attempted suicide by any means.
- XV. Costs which are not Reasonable and Customary and treatments which are not Medically Necessary.
- XVI. 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.

6. General Terms and Clauses

6.1. Standard Terms and Clauses

I. Free Look Period

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

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

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges

II. Cancellation

- i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

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

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

What it means?

Free look is a 15 / 30 days period during which you can return back your policy, if you don't like what you have purchased.

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.

<p>III. Renewal of Policy</p> <p>The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.</p> <ol style="list-style-type: none"> The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period. No loading shall apply on renewals based on individual claims experience. 	<p>Pay your 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.</p> <p>NOTE: You are NOT insured during the grace period.</p>
<p>IV. Possibility of Revision of Terms of the Policy Including the Premium Rates</p> <p>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.</p>	
<p>V. Nomination</p> <p>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.</p>	
<p>VI. Fraud</p> <p>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.</p> <p>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.</p>	<p>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</p> <ul style="list-style-type: none"> 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.

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.

Note: Non standard decisions are:

- o Loading – We ask for additional premium
- o Exclusions – We apply a additional waiting period for health conditions or treatments
- o 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

VII. **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 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.

If we withdraw any product, we will inform you at least 90 days before. You will also have the option to shift your policy with all accrued benefits to another similar health insurance product available with us.

VIII. **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 : customercare@nivabupa.com

(Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)

Fax : +91 11 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

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

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.: +91 11 41743397

Email ID: customercare@nivabupa.com

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 - <https://igms.irda.gov.in/>

IX. **Claim settlement (Provision for Penal interest)**

- I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- 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 last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

We will provide our decision on claim within 30 days (45 days for investigated cases) 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.

X. **Moratorium Period**

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

After 8 years, no health insurance claim shall be contestable except for proven fraud and permanent exclusions.

<p>XI. Multiple Policies</p> <ol style="list-style-type: none"> 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 his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy. II. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy. III. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount. IV. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy. 	<p>In case you have multiple policies, you can choose the policy from which you want to claim first.</p> <p>If claim amount exceeds the Sum Insured of first policy you claim from; then you can claim the balance amount from the second policy.</p>
<p>XII. Migration</p> <p>The Insured Person will have the option to migrate the Policy to other health insurance products / plans offered by the Company policy by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product / plan offered by the Company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.</p> <p>For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1</p>	<p>You can shift your policy to any other health insurance product / plan offered by us as per migration guidelines.</p>
<p>XIII. Portability</p> <p>The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General / Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.</p> <p>For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1</p>	<p>You can also shift your policy to any other insurer as per portability guidelines.</p>
<p>XIV. Disclosure of Information</p> <p>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.</p> <p>(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)</p>	<p>The policy shall be considered void in case of misrepresentation, mis-description or non-disclosure of any material fact.</p>

<p>XV. Condition Precedent to Admission of Liability</p> <p>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.</p> <p>XVI. Complete Discharge</p> <p>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.</p> <p>6.2. Specific terms and clauses</p> <p>I. Automatic Cancellation:</p> <p>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 (II) 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.</p> <p>II. Additional premium (Risk Loading)</p> <ol style="list-style-type: none"> 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. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual. Once applied, Risk loading continues even for all renewals <p>III. Other Renewal Conditions:</p> <ol style="list-style-type: none"> 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. 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. 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. <p>IV. Policy Disputes</p> <p>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.</p> <p>V. Territorial Jurisdiction</p> <p>All claims shall be payable in India in Indian Rupees only.</p>	
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VI. Notices

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

- i. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.
- ii. Us at the following address:
Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301
Fax No.: +91 11 41743397
- iii. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
- iv. 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.

VII. 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.

VIII. 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.

IX. Assignment

The Policy can be assigned subject to applicable laws.

X. 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 within 30 days from discharge.
 - 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. 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.

**Annexure I –
The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment
List I – Expenses not covered**

Sl. No.	Item	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	Trolley 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 II
List of Insurance Ombudsmen

Office Details	Jurisdiction
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, Dadra & Nagar Haveli, Daman and Diu
BENGALURU - Mr Vipin Anand 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 R. M. Singh Insurance Ombudsman 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 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh
BHUBANESWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH - Mr Atul Jerath 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 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
CHENNAI - Shri Segar Sampathkumar Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
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, Sonapat & Bahadurgarh

GUWAHATI - Shri Somnath Ghosh 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 N. Sankaran 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 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR - Shri Rajiv Dutt Sharma 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 - Shri G. Radhakrishnan Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
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 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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 Bharatkumar S. Pandya Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 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 Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 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, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

Council for Insurance Ombudsmen,

3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022 -69038800/69038812
Email: inscoun@cioins.co.in