THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

AROGYA PRAGATI PLUS (TOP-UP REINVENTED)

POLICY DOCUMENT

1. PREAMBLE

This is Your **AROGYA PRAGATI PLUS (TOP-UP REINVENTED)** Policy, which has been issued by Us, relying on the Information disclosed by You in Your Proposal for this Policy or its preceding Policy / Policies of which this is a renewal.

The terms set out in this Policy and its Schedule will be the basis for any claim or benefit under this Policy. If during the **Policy Period, You** or any **Insured Person** undergo **Hospitalisation** for Illness or Injury and incur **Medical Expenses,** by reason of which the **Cumulative Hospitalisation Expenses** for the Insured Persons during such **Policy Period** exceeds the **Threshold** specified in the Schedule, **We** will reimburse subject to terms and conditions of this Policy, the portion of the **Medical Expenses** for such **Hospitalisation** or any **Hospitalisation** thereafter as exceeds the **Threshold,** to the extent specified under **How Much We Will Reimburse** section of this Policy.

Provided,

a) Claim shall be made only for the Hospitalisation for which the Cumulative Medical Expenses exceeds Threshold or for any subsequent Hospitalisation, but not for earlier Hospitalisation or treatment.

b) Claim shall be payable only if the Hospitalisation expenses claimed are within the scope of the Policy subject to terms, conditions, exclusions and limitations.

c) The Insured Person shall not be entitled to claim under this Policy any amount of such Medical Expenses as has been received from any other person or entity, in which event the claim payable by Us would be reduced by such amount as may have been received.

d) We shall in no case be liable to pay more than the Sum Insured, unless otherwise specified.

Also, there are two Plans available under this Policy,

- Gold Plan &
- Platinum Plan

Conditions applicable to Gold Plan and Platinum Plan:

- Change of Plan / Threshold / Sum Insured / Optional Cover is available at the time of Renewal only, subject to the underwriting guidelines.
- If there is any change in one plan to another plan at the time of Renewal, Waiting Period/ Coverage (If any) shall be applicable as per the Plan chosen.
- The nature, scope, waiting periods (if any) and the extent of coverage will depend on the Plan opted and as mentioned in the Policy Schedule.

2. DEFINITIONS

STANDARD DEFINITIONS

2.1 **ACCIDENT** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 **ANY ONE ILLNESS** means continuous Period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment was taken.

2.3 **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 for 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 5 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.

2.4 **AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **BANK RATE** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.

2.6 **CASHLESS FACILITY** means a facility extended by the Insurer to the Insured Person where the payments, of the costs of treatment undergone by the Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent of pre-authorization approved.

2.7 **CONDITION PRECEDENT** means a Policy term or condition upon which Our liability under the Policy is conditional upon.

2.8 **CONGENITAL ANOMALY** refers to a condition which is present since birth, and which is

abnormal with reference to form, structure or position.

i. **CONGENITAL INTERNAL ANOMALY** means a Congenital Anomaly which is not in the visible and accessible parts of the body.

ii. **CONGENITAL EXTERNAL ANOMALY** means a Congenital Anomaly which is in the visible and accessible parts of the body.

2.9 CRITICAL ILLNESSES means the following Illnesses:

2.9.1 CANCER OF SPECIFIED SEVERITY means

I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

II. The following are excluded -

a. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non- invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN- 2 and CIN-3.

b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.

c. Malignant melanoma that has not caused invasion beyond the epidermis.

d. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

f. Chronic lymphocytic leukaemia less than RAI stage 3

g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

i. All tumors in the presence of HIV infection.

2.9.2 MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIED SEVERITY)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

a. History of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g., typical chest pain)

b. New characteristic electrocardiogram changes

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris.

c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2.9.3 OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

2.9.4 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

2.9.5 COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. No response to external stimuli continuously for at least 96 hours;

ii. Life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

2.9.6 KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

2.9.7 STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and emobilisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain.

Evidence of permanent neurological deficit lasting for at least 3 months has to be produced

II. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2.9.8 MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of Langerhans are transplanted

2.9.9 PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

2.9.10 MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

a. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis and

b. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

II. Other causes of neurological damage such as SLE and HIV are excluded.

2.9.11 THIRD DEGREE BURNS

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2.9.12 END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

a. Permanent jaundice; and

b. Ascites; and

c. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

2.9.13 BENIGN BRAIN TUMOR:

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

Cysts, granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

2.9.14 DEAFNESS: Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an ear, nose and throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

2.9.15 LOSS OF SPEECH: Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an ear, nose, and throat (ENT) specialist.

2.10 DAY CARE TREATMENT refers to medical treatment and/or surgical procedure which is:

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

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

2.11 DAY CARE CENTRE means any insititution established for Day Care Treatment of Illness or Injury, or a medical set-up within 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 criteria as under:

- Has qualified nursing staff under its employment
- Has qualified Medical Practitioner in charge
- Has a fully equipped operation theatre of its own where Surgery is carried out
- Maintains daily record of patients and will make these accessible to the Insurance Company's authorized personnel

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DISCLOSURE TO INFORMATION NORM: The policy shall be void and all premium paid

thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.14 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.

2.15 s PERIOD means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage is not available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

2.16 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 Establishment (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 at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- Has qualified nursing staff under its employment round the clock;
- Has qualified Medical Practitioner in charge round the clock;
- Has a fully equipped operation theatre of its own where Surgery is carried out;
- Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

2.17 HOSPITALISATION means admission as an Inpatient in a Hospital for a minimum period of twenty-four consecutive hours except for specified procedures / treatments listed in Annexure I, where such admission could be for a period of less than twenty-four consecutive hours.

2.18 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. **Acute Condition** means 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.

ii. **Chronic Condition** means a disease, Illness, or Injury that has one or more of the following characteristics

   a. it needs ongoing or long-term monitoring through consultations, examinations, checkups, and / or tests

   b. it needs ongoing or long-term control or relief of symptoms

   c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

   d. it continues indefinitely

e. it recurs or is likely to recur

2.19 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.

2.20 INPATIENT CARE means treatment for which the Insured Person has to stay in a Hospital for more than twenty-four hours for a covered event.

2.21 INTENSIVE CARE UNIT (ICU) means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner 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.

2.22 ICU (INTENSIVE CARE UNIT) CHARGES means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

2.23 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

2.24 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury 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.

2.25 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.

2.26 MEDICAL PRACTITIONER is 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 license.

The term Medical Practitioner shall not include any Insured Person or any member of his family.

2.27 MENTAL HEALTH ESTABLISHMENT means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or

otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends;

2.28 MENTAL HEALTH PROFESSIONAL means

i. **Psychiatrist:** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Policy

ii. a professional registered with the concerned State Authority; (or)

iii. a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post- graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam

2.29 MIGRATION means a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

2.30 NETWORK PROVIDER means Hospitals or health care providers enlisted by Us, TPA or jointly by Us and TPA to provide medical services to an insured by a cashless facility.

2.31 NON-NETWORK PROVIDER means any hospital day care centre or other provider that is not part of the network.

2.32 NOTIFICATION OF CLAIM means the process of intimating a claim to Us or TPA through any of the recognized modes of communication.

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

2.34 PRE-EXISTING CONDITION/DISEASE means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of policy issued by the insurer or

b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of policy

2.35 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period preceding Your Hospitalisation, provided that:

- Such Medical Expenses are incurred for the same condition for which the Your Hospitalisation was required, and
- The Inpatient Hospitalisation claim for such Hospitalisation is admissible by Us.

2.36 PORTABILITY means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

2.37 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period immediately after Your discharge from the Hospital provided that:

- Such Medical Expenses are incurred for the same condition for which the Your Hospitalisation was required, and
- The Inpatient Hospitalisation claim for such Hospitalisation is admissible by Us.

2.38 QUALIFIED NURSE is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.39 REASONABLE AND CUSTOMARY EXPENSES mean 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.

2.40 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.

2.41 ROOM RENT Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

2.42 SURGERY OR SURGICAL PROCEDURE means manual or operative procedure required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or Day Care Centre by a Medical Practitioner.

2.43 UNPROVEN/EXPERIMENTAL TREATMENT means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

SPECIFIC DEFINITIONS

2.44 AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

2.45 ASSOCIATE MEDICAL EXPENSES means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

2.46 AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA) number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers.

2.47 AYUSH TREATMENT refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.48 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.

2.49 CUMULATIVE HOSPITALISATION EXPENSES mean the aggregate of all Medical Expenses incurred towards Hospitalisation in respect of one or more Insured Persons (if covered on floater basis) for treatment of any Illness or Injury as reflected in the Hospital Inpatient Hospitalisation Bills, including Pre- Hospitalisation or Post-Hospitalisation Expenses the admission in the Hospital shall have occurred during the Period of Insurance.

2.50 CRITICAL ILLNESS (SPECIFIC DEFINITIONS)

i. Alzheimer's Disease: Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

The following conditions are however not covered:

a. neurosis and neuropsychiatric symptoms without imaging evidence of Alzheimer's disease;

b. alcohol related brain damage; and

c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's disease.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available

ii. Parkinson's Disease: The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to us.

The diagnosis must be supported by all of the following conditions:

- the disease cannot be controlled with medication;
- signs of progressive impairment; and
- inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. **Washing:** the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;

ii. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. **Transferring:** The ability to move from bed to an upright chair or wheelchair and vice versa;

iv. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. **Feeding:** The ability to feed oneself once the food has prepared and made available;

vi. **Mobility:** The ability to move indoors from room to room on level surfaces. Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

iii. Aorta Graft Surgery: The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The insured person understands and agrees that we will not cover:

a. Surgery performed using only minimally invasive or intra-arterial techniques.

b. Angioplasty and all other intra-arterial, catheter-based techniques, "keyhole" or laser procedures.

Aorta graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

2.51 INSURED PERSON means person(s) named in the schedule of the Policy.

2.52 POLICY means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the coverages, exclusions and terms & conditions on which the Policy is issued to The Insured Person.

2.53 POLICY PERIOD means period of one policy year as mentioned in the schedule for which the Policy is issue.

2.54 POLICY SCHEDULE means the Policy Schedule attached to and forming part of Policy.

2.55 POLICY YEAR means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such

twelve-month period, till the policy period, as mentioned in the schedule.

2.56 SUB-LIMIT means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit.

2.57 SUM INSURED means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of all Insured Persons during the Policy Year.

2.58 THRESHOLD is the amount of Cumulative Hospitalisation Expenses specified in the Schedule chosen by the Insured Person up to which 'NO' Medical Expenses can be claimed under Arogya Pragati Plus (TOP- UP Reinvented).

2.59 THIRD PARTY ADMINISTRATORS (TPA) means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

2.60 WAITING PERIOD means a period from the inception of this Policy during which specified diseases / treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

2.61 WE / OUR / US / COMPANY means The New India Assurance Co. Ltd.

2.62 YOU / YOUR means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one) in the Schedule.

2.63 POLICY TERM means the tenure of the policy, which can be 1 Year or 2 Years or 3 Years.

3. BENEFITS COVERED UNDER THE POLICY

3.1 Our liability for all claims admitted during the Policy Period in respect of all Insured Persons, including all payment related to the following, except for benefits specified under 3.14 and 3.15 (Optional Covers), will be only up to Sum Insured as mentioned in the Policy Schedule. Subject to this, we will reimburse Reasonable and Customary and Medically Necessary Expenses admissible as per the terms and conditions of the Policy.

3.1 (a)	Room Rent including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) as provided by the hospital	
	Gold Plan	1% of the Sum Insured or Rs. 15,000 whichever is less
	Platinum Plan	Single AC room
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.	
	Gold Plan	2% Sum Insured or Rs. 25,000 whichever is less
	Platinum Plan	Actuals
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.	
3.1 (d)	Cost of Pharmacy and Consumables including Anaesthesia, Blood, Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics.	
3.1 (e)	Pre-Hospitalization Medical expenses up to 30 Days (Gold Plan) or 60 days (Platinum Plan) prior to the date of admission to the hospital.	
3.1 (f)	Post-Hospitalization Medical expenses up to 60 Days (Gold Plan) or 90 days (Platinum Plan) from the date of discharge from the hospital.	
	Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on • Cost of Pharmacy and Consumables • Cost of Implants and Medical Devices • Cost of Diagnostics. Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.	

3.2 MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS

If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only, after taking the Threshold into consideration. Sum Insured of the renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced

during the expiring Policy. Claim shall be settled on per event basis.

3.3 DENTAL TREATMENT (INPATIENT)

We will cover for medical expenses incurred towards dental treatment done under anaesthesia necessitated due to an accident/injury/illness requiring Hospitalization as Inpatient treatment.

3.4 COVERAGE FOR CATARACT

Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye / per insured shall not exceed the limits mentioned below subject to the condition of Threshold being breached.

Plan	Charges payable (Per Eye)
Gold Plan	Up to a maximum of Rs. 50,000
Platinum Plan	Up to a maximum of Rs. 1,00,000

3.5 MEDICAL EXPENSES FOR ORGAN TRANSPLANT

If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the Insured Person, provided Our liability towards expenses incurred on the donor and the Insured recipient shall not exceed the Sum Insured.

3.6 COVERAGE FOR AYUSH TREATMENT

Expenses incurred for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system of medicines is covered up to 100% of the Sum Insured during each policy year as specified in the policy schedule.

3.7 PAYMENT OF AMBULANCE CHARGES

We will pay You the charges incurred towards Road Ambulance service and/or Air Ambulance expenses that are actually incurred in India. These expenses are payable only if they are Reasonable, Customary and Medically Necessarily for shifting any Insured Person to Hospital for admission in Emergency Ward or ICU, or from one Hospital to another Hospital for better medical facilities. Payment under this benefit will reduce the Sum Insured.

However, if an Insured Person, at the time of discharge from the Hospital, has to be shifted to their place of residence in an Ambulance, such expenses will also be reimbursed, provided the requirement of an Ambulance is certified by the Medical Practitioner.

Note: Air Ambulance Expenses are payable only under Platinum Plan.

3.8 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

No payment shall be made for any Hospitalisation expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anaesthetist directly and not included in the Hospital Bill shall be paid, provided a numbered Bill is produced in support thereof, for an amount not exceeding Rs. Ten thousand, where such payment is made in cash and for an amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

3.9 SPECIFIC COVERAGES:

a) Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 25% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

b) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

c) **Age Related Macular Degeneration (ARMD)** is covered after 36 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub-limit of 20% of Sum Insured.

d) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 36 months waiting.

Note: For the coverages defined in 3.9 (a) to (d), Waiting Period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020 or date of inception of first policy, whichever is later. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

e) **Treatment of Mental Illness:** The Company shall indemnify the Medical Expenses incurred towards treatment of Mental Illness subject to the condition that Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

The following Mental Illnesses are covered after completion of 36 months of Continuous Coverage with a sub-limit up to 25% of Sum Insured per policy period.

ICD Code	ICD Code Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic Disorders
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities

Exclusion: Any kind of Psychological counselling, cognitive/ family/ group/ behaviors/ palliative therapy or psychotherapy shall not be covered.

3.10 COVERAGE FOR MODERN TREATMENTS OR PROCEDURES:

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a Hospital up to the limit specified against each

procedure during the policy period.

S No	Treatment or Procedure	Gold Plan Limit (Per Policy Period)	Platinum Plan
3.10.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Sum Insuredsubject to Maximum Rs. 2Lakh	Up to Sum Insured
3.10.2	Balloon Sinuplasty.	Up to 20% of Sum Insuredsubject to Maximum Rs. 2 Lakh	
3.10.3	Deep Brain stimulation.	Up to 50% of Sum Insured subject to Maximum Rs. 5Lakh	
3.10.4	Oral chemotherapy.	Up to 10% of Sum Insuredsubject to Maximum Rs. 1 Lakh	
3.10.5	Immunotherapy- Monoclonal Antibodyto be given as injection.	Up to 25% of Sum Insured subject to Maximum Rs 3 Lakhs	
3.10.6	Intravitreal injections.	Up to 10% of Sum Insured subject to Maximum Rs.1.50 lakhs	
3.10.7	Robotic surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 5Lakhs	
3.10.8	Stereotactic radio surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 3Lakh	
3.10.9	Bronchial Thermoplasty.	Up to 50% of Sum Insured subject to Maximum Rs. 2.5Lakh.	
3.10.10	Vaporisation of the prostrate (Green laser treatment or holmium lasertreatment).	Up to 50% of Sum Insured subject to Maximum Rs. 2.5Lakh	
3.10.11	IONM - (Intra Operative Neuro Monitoring).	Up to 10% of Sum Insuredsubject to Maximum Rs. 50,000	
3.10.12	Stem cell therapy: Hematopoietic stemcells for bone marrow transplant for haematological conditions to be covered.	Up to 50% of Sum Insured subject to Maximum Rs. 2.5Lakh	

3.11 MEDICAL SECOND OPINION

In case of any Insured Person requires to undergo Surgery for any of the 18 Critical Illnesses defined under 2.9 and 2.50 of the Policy Clause, Consultation Expenses incurred on Medical Second Opinion shall be reimbursed as per the limits mentioned below.

Plan	Charges payable (Per Policy Period)
Gold Plan	Up to a maximum of Rs. 2,500
Platinum Plan	Up to a maximum of Rs. 5,000

Note: In case the Policy is issued on an Individual Sum Insured basis, the above limits shall be available individually to the Insured Persons. In case the Policy is on Floater Sum Insured basis, the above limits shall be available to all Insured persons on a Floater basis.

3.12 TREATMENT FOR CONGENITAL DISEASES

- **Congenital Internal Disease** or Defects or anomalies shall be covered after **twenty-four** months of Continuous Coverage.
- **Congenital External Disease** or Defects or anomalies shall be covered after **thirty-six** months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of **the average Sum Insured in the preceding four years.**

3.13 NON-MEDICAL ITEMS (CONSUMABLES)

Items listed in Annexure II (List 1) shall become payable up to Rs. 25,000/- for Platinum Plan in a policy period. It is an inbuilt cover under Platinum Plan.

Note: For Gold Plan, this cover is not available.

OPTIONAL COVERS

3.14 CRITICAL CARE BENEFIT

If during the Policy Period, any Insured Person is diagnosed with of any of the 18 Critical Illness listed below (as defined under Definitions) for the first time, Lump Sum amount as mentioned below will be paid subject to following conditions.

Plan	Benefit Payable
Gold Plan	Rs. 5,00,000
Platinum Plan	Rs. 5,00,000 or Rs. 7,50,000

List of 18 Critical Illness

Sr. No.	List of Critical Illnesses
1	Cancer of Specified Severity
2	Kidney Failure Requiring Regular Dialysis
3	End Stage Liver Failure
4	Major Organ Transplant/Bone Marrow Transplant
5	Open Heart Replacement or Repair of Heart Valves
6	Open Chest CABG
7	Stroke resulting in Permanent Symptoms
8	Permanent Paralysis of Limbs
9	Myocardial Infarction (First Heart Attack of Specified Severity)
10	Multiple Sclerosis with Persisting Symptoms
11	Coma of Specified Severity
12	Parkinson's Disease
13	Benign Brain Tumour
14	Alzheimer's Disease
15	Aorta Graft Surgery
16	Deafness
17	Loss of speech
18	Third Degree Burns

Special Conditions

- This Optional Cover of Critical Care Benefit is applicable for the Insured Persons in the age group of 18 years and above.
- This Benefit shall be paid even if the Threshold under the policy is not breached subject to the terms and conditions applicable to this section.
- The benefit shall be payable to the Insured Person, provided the Critical Illness is diagnosed after the first inception of Policy. On Utilization, NO further Sum shall be payable under this section during the policy period for the Insured (in case of Individual Sum Insured) or for other members (in case of Floater Sum Insured).

  Note: This will be paid once in a lifetime of the Insured regardless of the number of critical illness suffered.
- The diagnosis of presence of such Critical Illness needs to be supported by treating doctor's certificate regarding duration of the Critical Illness, clinical, radiological, histological, pathological, histo-pathological and laboratory evidence.
- Any payment under this Clause would be in addition to hospitalisation expenses, if any, and shall not deplete the Sum Insured.
- The coverage under this section shall terminate in the event of claim of a covered Critical Illness becoming accepted and paid by Us.
- **Waiting Period:** For Critical Illness Conditions - We shall not be liable to make any payment in respect of any Critical Illness which is diagnosed within the first 90 days of the Inception Date of First Policy.
- **Survival Period for Critical Illnesses:** Survival period of 'NIL' days shall be applicable from the date of diagnosis of any of the above listed Critical Illnesses to be eligible for this benefit.
- Please note that claim payment will only be made with confirmatory diagnosis of the conditions covered while the Insured Person is alive (i.e., a claim would not be admitted if the diagnosis is made post-mortem).

  Specific Exclusions applicable to this Optional Cover – Critical Care Benefit:

  i. Any Pre-existing Condition, ailment or disease, or its related conditions arising from it.

  ii. We shall not be liable to make any payment in respect of any Critical Illness which is diagnosed within the first 90 days of the Inception Date of First Policy. These 90 days waiting period shall not be applicable on renewals to the extent of sum insured under the previous policy.

  iii. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.

  iv. Any Critical Illness directly caused due to intentional self-injury, suicide or attempted suicide.

  v. Any Critical Illness caused due to and/or treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

  vi. Any Critical Illness caused by any treatment necessitated due to participation as a

professional in hazardous or adventure sport, including but not limited to, para jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving

vii. Any Critical Illness caused by any unproven/ experimental treatment, service and supplies for or in connection with any treatment. Unproven/ experimental treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

viii. Any Critical Illness caused due to 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 reason.

ix. Any Critical Illness caused by treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

x. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,

xi. Participation by the Insured Person in any flying activity, except as a bona fide, fare paying passenger of a recognized airline on regular routes and on a scheduled timetable.

xii. Congenital External Anomalies, or any complications or conditions arising therefrom including any developmental conditions of the Insured.

xiii. Any Critical Illness caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any Critical Illness caused due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

xiv. Any Critical Illness based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he/ she is licensed for.

xv. Any Critical Illness caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.

xvi. Any Critical Illness caused due to cosmetic or plastic surgery or any treatment to change the 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.

xvii. Any critical illness caused due to surgical treatment of obesity that does not fulfil all the below conditions

a. Surgery to be conducted is upon advice of doctor

b. The surgery / procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older

d. Body Mass Index (BMI)

i. Greater than equal to 40 or

ii. Greater than or equal to 35 in conjunction with any of the following sever 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 Type 2 Diabetes

xviii. Any Critical Illness caused by sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

xix. Any Critical Illness resulting from a physical condition which existed prior to first risk inception date which was not disclosed.

xx. Any Critical Illness, caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.

xxi. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

3.15 PERSONAL ACCIDENT BENEFIT

If at any time during the currency of this Policy, the Insured Person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Company shall pay to the Insured or his legal representative(s) or Nominee, as the case may be, the sum hereinafter set forth, that is to say:

i. **Death:** The company shall pay the benefit equal to 50 % of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

ii. **Permanent Total Disablement:** The company shall pay the benefit equal to 50 % of

Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a. Total and irrecoverable loss of sight of both eyes or

b. Physical separation or loss of use of both hands or feet or

c. Physical separation or loss of use of one hand and one foot or

d. loss of sight of one eye and Physical separation or loss of use of hand or foot

e. If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

iii. **Permanent Partial Disablement:** The company shall pay the percentage of Sum Insured (as given in Annexure), specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

Special Conditions applicable to this section:

a) This Optional Cover of PA Benefit is applicable for the Insured Persons in the age group of 18-70 Years.

b) The benefit shall be payable only under any one of the sections stated above.

c) This Benefit shall be paid even if the Threshold under the policy is not breached subject to the terms and conditions applicable to this section.

d) Personal Accident Benefit shall be paid as specified in the Policy Schedule. Once a claim is admitted and paid under this Section, NO further Sum shall be payable under this section during the policy period for other members.

e) Worldwide Coverage.

f) Any Payment under this clause shall not deplete the Sum Insured.

Specific Exclusions applicable to Optional Cover – Personal Accident Benefit

i. Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

ii. Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

- from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
- whilst under the influence of intoxicating liquor or drugs or other intoxicants

except where the insured is not directly responsible for the injury / accident though under influence of intoxication.

- whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.

  [Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]

- arising or resulting from the Insured Person committing any breach of law with criminal intent.

iii. Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person 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.

iv. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

- Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
- Nuclear weapons material
- The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- Nuclear, chemical and biological terrorism

v. Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

4. EXCLUSIONS

No claim will be payable under this Policy for the following:

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

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

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 24 months / 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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 preexisting 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.

(i) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions
4. Critical Care Benefit

(ii) 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age-related eye ailments
5. Gastric/ Duodenal Ulcer

6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele
9. Non-Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Puberty and Menopause related Disorders
19. Internal Congenital Diseases

(iii) 36 Months waiting period

1. Congenital External Disease
2. Joint Replacement due to Degenerative Condition
3. Age-related Osteoarthritis & Osteoporosis
4. Treatment of Mental Illness
5. Age Related Macular Degeneration (ARMD)
6. Genetic diseases or disorders

4.3 FIRST THIRTY DAYS 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.

4.4 INVESTIGATION & EVALUATION (Code- Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

4.5 REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non- skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6 OBESITY / WEIGHT CONTROL (Code- Excl06) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or

2. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4.7 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.

4.8 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.

4.9 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.

4.10 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.

4.11 EXCLUDED PROVIDERS (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its 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.

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

4.13 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)**

4.14 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)**

4.15 REFRACTIVE ERROR (Code- Excl15)

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

4.16 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.

4.17 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

4.18 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.

SPECIFIC EXCLUSIONS

4.19 Acupressure, acupuncture and magnetic therapies.

4.20 Any expenses incurred on Domiciliary Hospitalization.

4.21 Service charges, Surcharges, Luxury Tax, Admission fees, Registration fees, Record Charges and Telephone Charges levied by the Hospital.

4.22 Bodily Injury or Illness due to intentional self-inflicted Injury and attempted suicide.

4.23 Circumcision unless Medically Necessary or as may be necessitated due to an Accident.

4.24 Convalescence and General debility.

4.25 Cost of braces, equipment or external prosthetic devices, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants.

4.26 External Medical / Non-medical equipment used for diagnosis and/or treatment including CPAP/BIPAP, Oxygen Concentrator, Infusion pump, Ambulatory devices (walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads) and sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, Alpha / Water Bed and medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

4.27 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the

loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.28 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.10.12

4.29 Expenses incurred for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

4.30 Treatments or Investigations or Services taken outside the geographical limits of India.

4.31 Vaccination and/or inoculation

4.32 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.33 Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.

4.34 Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours.

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 CANCELLATION

The policyholder 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 policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

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.

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.

5.2 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.

5.3 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.

5.4 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).

5.5 FRAUD

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party

acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

ii. the active concealment of a fact by the insured person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

iv. 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.

5.6 FREE LOOK PERIOD

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies of less than a year, renewals or at the time of porting/migrating the policy.

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, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder 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. This option is available in case of policies with a term of one year or more.

lf 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 or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

5.7 MULTIPLE POLICIES

i. ln 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. ln 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. lnsured 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

Note: The Insured Person must disclose such other Insurance at the time of making a claim under this Policy.

5.8 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 grounds of non-disclosure, mis-representation except on grounds of established fraud. This period of sixty continuous months is called as Moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limit.

5.9 NOMINATION:

The policyholder is required at the inception of the policy to make a nomination. In the event of death of the policyholder, the claim proceeds will be paid to the nominee. Nomination can be changed at any time during the term of the policy. 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 and in case there is no subsisting nominee, 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.

5.10 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. ln 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. ln such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. ln 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.

v. "Bank rate" shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due.

5.11 RENEWAL OF POLICY

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by

the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

vi. There shall be no fresh underwriting unless there is increase in sum insured.

5.12 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.

5.13 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.

5.14 REDRESSAL OF GRIEVANCE

In case of any grievance the insured person may contact the company through

Website: https://www.newindia.co.in/portal/readMore/Grievances

Toll free: 1800-209-1415

E-mail, Fax and Courier: As mentioned in the above address Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

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 https://www.newindia.co.in/portal/readMore/Grievances For updated details of grievance officer, kindly refer the link https://www.newindia.co.in/portal/readMore/Grievances

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. Please refer to Annexure III.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irdai.gov.in

5.15 PORTABILITY AND MIGRATION:

Migration: You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then you can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy.

Portability:

You 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 policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. from the existing insurer to the acquiring insurer in the previous policy.

SPECIFIC TERMS AND CLAUSES

5.16 BASIS OF INSURANCE:

This Policy is issued on the basis of the truth and accuracy of statements in the Proposal. If there is any misrepresentation or non-disclosure, we will be entitled to treat the Policy as void.

5.17 PREMIUM:

Unless premium is paid before commencement of risk, this Policy shall have no effect.

5.18 PLACE OF TREATMENT AND PAYMENT:

This Policy covers medical/surgical treatment and/or Investigations and/or services rendered only in India.

Admissible claims shall be payable only in Indian Rupees.

Payment shall be made directly to Network Hospital if Cashless facility is applied for before treatment and accepted by TPA. If request for Cashless facility is not accepted by TPA/insurers, bills shall be submitted to the TPA after payment of Hospital bills by you.

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. If we/TPA have doubts regarding admissibility of a claim at the initial stage, which cannot be decided without further verification of treatment records, request for Cashless facility may be declined. Such decision by TPA or Us shall be final. Denial of Cashless facility would not imply denial of claim. If Cashless facility is denied, you may submit the papers on completion of treatment and admissibility of the claim would be subject to the terms, conditions and exceptions of the Policy.

5.19 COMMUNICATION:

You must send all communications and papers regarding a claim to the TPA at the address shown in the Schedule.

For all other matters relating to the policy, communication must be sent to our Policy issuing office. Communications you wish to rely upon must be in writing.

5.20 NOTICE OF CLAIM:

If You intend to make any claim under this Policy You must:

a. Intimate TPA in writing on detection of any Illness/Injury being suffered immediately or forty-eight hours before Hospitalisation.

b. Intimate within twenty-four hours from the time of Hospitalisation in case of Hospitalisation due to medical emergency.

c. Submit following supporting documents TPA relating to the claim within Fifteen days from the date of discharge from the Hospital:

   i. First Consultation Letter from the Doctor

   ii. Original Bills, Receipt and Discharge certificate/card from the Hospital.

   iii. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.

   iv. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.

   v. Original Money Receipt, duly signed with a Revenue Stamp, Wherever applicable.

   vi. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.

   vii. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.

   viii. In case of Cataract Operation, IOL sticker shall have to be enclosed.

   ix. Claim settlement from the other Insurer, if any.

   x. Originals of Hospital bills, Hospital receipts and discharge summary relating to the previous Hospitalisations occurring during the Period of Insurance.

d. In case of Post-Hospitalisation treatment, submit all claim documents within 15 days after completion of such treatment.

e. Provide TPA with authorization to obtain medical and other records from any Hospital, Laboratory or other agency.

Note:

- The above stipulations are not intended merely to prejudice Your claims, but their compliance is of utmost importance and necessity for Us to identify and verify all facts and surrounding circumstances relating to a claim and determine whether it is payable.
- Waiver of delay may be considered in extreme cases of hardship, but only if it is proved to Our satisfaction it was not possible for You or any other person to comply with the prescribed time-limit.
- In case any of these documents are not available due to the reason that they have been submitted to any other Insurer or the employer or to any other entity, copies of these documents certified by the Insurer or the employer or the entity, to

whom the originals have been submitted, needs to be furnished confirming the status of the claim and settlement details, if any.

- In case of Hospitalisation where the expenses are likely to involve the TPAs of both regular Health Policy and New India Top-Up Mediclaim Policy, the intimation/pre-authorisation request with regard to a Hospitalisation is to be given to both the TPAs of these Policies.
- In the case of a covered Hospitalisation, the costs of which were not initially estimated to exceed the Threshold but were subsequently found likely to exceed the Threshold, the intimation to the named TPA should be submitted along with a copy of intimation made to the Primary Health Policy TPA/Reimbursement Provider immediately on knowing that the Threshold is likely to be exceeded.

5.21 SETTLEMENT/REJECTION OF CLAIM:

i. We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.

ii. Where any additional documents or clarifications are necessary to take a decision on the claim, such additional documents will be called for.

iii. All necessary claim documents pertaining to Hospitalization should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within fifteen days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.

a. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

b. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

c. The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

d. If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

e. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer.

5.22 The Insured person shall submit to the TPA all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/Us such additional information and assistance as the TPA / We may require.

5.23 Any Medical Practitioner authorised by the TPA/Us shall be allowed to examine the Insured Person, at our cost, if We deem Medically Necessary in connection with any claim.

5.24 ENHANCEMENT OF SUM INSURED

Enhancement of Sum Insured shall be allowed as per the underwriting guidelines. However, it is not allowed:

- If the Person is suffering from or has suffered from any Critical/Chronic/Recurring Illnesses
- If the Person has undergone more than two hospitalizations in the past 2 years for any conditions except Cataract, Haemorroidectomy, Inguinal Hernia without complications and Simple Fractures without Implants.

Note:

1. In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from such date.
2. In case of increase in S.I., Enhanced benefit shall be applicable on completion of Waiting period under respective S.I. and Plan chosen at the time of renewal.

5.25 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations,2024.

5.26 The expenses that are not covered in this policy are placed under List-I of Annexure-II. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-II respectively.

5.27 CONDITIONS APPLICABLE FOR LONG TERM POLICIES

- Policy Term, Discounts, Sum Insured and Threshold applicable are illustrated with example as follows:

Policy Term	Policy Period	Threshold	Sum Insured	Discount in %
One year	1.1.2024 to 31.12.2024	5,00,000	10,00,000	0
Two years	1.1.2024 to 31.12.2024	5,00,000	10,00,000	5
	1.1.2025 to 31.12.2025	5,00,000	10,00,000	
Three years	1.1.2024 to 31.12.2024	5,00,000	10,00,000	7
	1.1.2025 to 31.12.2025	5,00,000	10,00,000	
	1.1.2026 to 31.12.2026	5,00,000	10,00,000	

- No modifications during midterm of policy term for the following is allowed:
  i. Increase of Threshold or Sum Insured
  ii. Decrease of Threshold or Sum Insured
  iii. Plan Change
  iv. Opting in or out of optional covers
  v. Addition of members except newly wedded spouse of new born baby (after completion of 3 months).
- In cases where the policy term exceeds one year, Threshold, Sum Insured, Sub-limits (if applicable) are reckoned separately for each year.
- There is no provision for carrying over these benefits from one policy year to another. It's essential to understand that benefits and coverages specific to the second or third year cannot be utilized during the first year itself meaning the benefits are not cumulative.
- The terms, conditions, and exclusions stipulated in the Policy or any associated

Endorsements are integral to the contract and must be adhered to. These provisions apply separately to each policy year.

5.28 SINGLE POLICY: You are allowed to take only Single Policy of Arogya Pragati Plus (TOP-UP Reinvented) Policy.

ANNEXURE I: LIST 1 OF DAY CARE PROCEDURES

1	Stapedotomy	2	Reconstruction Of The Middle Ear
3	Mastoidectomy	4	Labyrinthectomy for severe Vertigo
5	Stapedectomy	6	Ossiculoplasty
7	Myringotomy with Grommet Insertion	8	Tympanoplasty
9	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	10	Incision Of The Mastoid Process And MiddleEar
11	Other Microsurgical Operations On The Middle Ear	12	Endolymphatic Sac Surgery for Meniere'sDisease
13	Turbinectomy	14	Removal of Tympanic Drain under LA
15	Fenestration of the inner ear	16	Incision and drainage of perichondritis
17	Septoplasty	18	Vestibular Nerve section
19	Thyroplasty	20	Reduction of fracture of Nasal Bone
21	Excision and destruction of lingual tonsils	22	Conchoplasty
23	Excision And Destruction Of Diseased TissueOf The Nose	24	Tracheostomy
25	Excision of Angioma Septum	26	Turbinoplasty
27	Incision & Drainage of Pharyngeal Abscess	28	Uvulo Palato Pharyngo Plasty
29	Palatoplasty	30	Nasal Sinus Aspiration
31	Adenoidectomy with Grommet insertion	32	Adenoidectomy without Grommet insertion
33	Vocal Cord lateralisation Procedure	34	Tonsillectomy without adenoidectomy
35	Tonsillectomy with adenoidectomy	36	Tracheoplasty
37	Other Operations On The Auditory Ossicles	38	Plastic Surgery To The Floor Of The Mouth
39	Incision Of The Hard And Soft Palate	40	External Incision And Drainage In The RegionOf The Mouth, Jaw And Face
41	Other Operations On The Salivary Glands AndSalivary Ducts	42	Incision of tear glands
43	Other operation on the tear ducts	44	Incision of diseased eyelids
45	Excision and destruction of the diseased tissue of the eyelid	46	Removal of foreign body from eye
47	Corrective surgery of the entropion and ectropion	48	Operations for pterygium
49	Corrective surgery of blepharoptosis	50	Glaucoma

51	Retinal Detachment	52	Operations on the cornea
53	Operation on the canthus and epicanthus	54	YAG Laser in Ophthalmology
55	Surgery for cataract	56	Treatment of retinal lesion
57	Parenteral Chemotherapy	58	CCRT-Concurrent Chemo + RT
59	SRS- Stereotactic radiosurgery	60	Radiotherapy
61	Radical chemotherapy	62	Chemotherapy
63	AV fistula	64	URSL with stenting
65	URSL	66	DJ Stent removal
67	ESWL	68	Haemodialysis
69	CAPD (Excluding the cost of machine)	70	Cystoscopy (Therapeutic)
71	Follow-up cystoscopy in case of bladder cancer	72	Excision of urethral diverticulum
73	Ureter endoscopy and treatment	74	Surgery for pelvi ureteric junction obstruction
75	Frenular tear repair	76	Meatotomy for meatal stenosis
77	Surgery for fournier's gangrene scrotum	78	Surgery filarial scrotum
79	Surgery for watering can perineum	80	Repair of penile torsion
81	Drainage of prostate abscess	82	TURBT
83	Radical Prostatovesiculectomy	84	Operations On The Prostate
85	D&C	86	Hysteroscopic adhesiolysis
87	Removal of Abnormal Tissue from Cervix	88	Vulval wart excision
89	Cyst Excision / Cystectomy	90	Uterine artery embolization
91	Endometrial ablation	92	Myomectomy
93	Surgery for SUI	94	Pelvic floor repair (excluding Fistula repair)
95	Laparoscopic oophorectomy	96	Incision Of The Ovary
97	Insufflation Of The Fallopian Tubes	98	Dilatation Of The Cervical Canal
99	Hysterotomy	100	Therapeutic Curettage
101	Culdotomy	102	Incision Of The Vagina
103	Local Excision And Destruction Of DiseasedTissue Of The Vagina And The Pouch Of Douglas	104	Incision Of The Vulva
105	Infected keloid excision	106	Incision of a pilonidal sinus / abscess
107	Infected sebaceous cyst	108	Infected lipoma excision
109	Maximal anal dilatation	110	Surgical Treatment Of Haemorrhoids
111	Liver Abscess- catheter drainage	112	Fissure in Ano- fissurectomy
113	Surgical Treatment Of Anal Fistulas	114	Fibroadenoma breast excision
115	Oesophageal varices Sclerotherapy	116	ERCP – pancreatic duct stone removal

117	Perianal abscess I&D	118	Excisional Biopsy
119	Perianal hematoma Evacuation	120	Fissure in ano sphincterotomy
121	Therapeutic Endoscopy	122	Breast abscess I& D
123	Feeding Gastrostomy	124	Feeding Jejunostomy
125	ERCP – Bile duct stone removal	126	Ileostomy closure
127	Polypectomy	128	Splenic abscesses Laparoscopic Drainage
129	Sclerotherapy	130	Colostomy
131	Ileostomy	132	Colostomy closure
133	Pancreatic Pseudocysts Endoscopic Drainage	134	Subcutaneous mastectomy
135	Excision of Ranula under GA	136	Hydrocele Repair
137	Scrotoplasty	138	Surgical treatment of varicocele
139	Epididymectomy	140	Circumcision for Trauma
141	Meatoplasty	142	Abscess incision and drainage
143	TIPS procedure for portal hypertension	144	PAIR Procedure of Hydatid Cyst liver
145	Excision of Cervical RIB	146	Surgery for fracture Penis
147	Laparoscopic cardiomyotomy (Hellers)	148	Laparoscopic pyloromyotomy (Ramstedt)
149	Orchidectomy	150	Operations On The Nipple
151	Incision And Excision Of Tissue In The Perianal Region	152	Division Of The Anal Sphincter (Sphincterotomy)
153	Glossectomy	154	Reconstruction Of The Tongue
155	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	156	Operations On The Seminal Vesicles
157	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens	158	Operations On The Penis
159	Other Excisions Of The Skin And Subcutaneous Tissues	160	Other Incisions Of The Skin And Subcutaneous Tissues
161	Free Skin Transplantation, Donor Site	162	Free Skin Transplantation, Recipient Site
163	Reconstruction Of The Testis	164	Incision Of The Scrotum And Tunica VaginalisTestis
165	Revision Of Skin Plasty	166	Other Restoration And Reconstruction OfThe Skin And Subcutaneous Tissues
167	Destruction Of Diseased Tissue In The SkinAnd Subcutaneous Tissues	168	Arthroscopic Repair of ACL tear knee
169	Arthroscopic repair of PCL tear knee	170	Tendon shortening
171	Tendon lengthening	172	Arthroscopic Meniscectomy – Knee
173	Treatment of clavicle dislocation	174	Arthroscopic meniscus repair
175	Haemarthrosis knee- lavage	176	Abscess knee joint drainage
177	Repair of knee cap tendon	178	ORIF with K wire fixation- small bones

179	ORIF with plating- Small long bones	180	Arthrotomy Hip joint
181	Syme's amputation	182	Arthroplasty
183	Partial removal of rib	184	Treatment of sesamoid bone fracture
185	Amputation of metacarpal bone	186	Repair / graft of foot tendon
187	Revision/Removal of Knee cap	188	Remove/graft leg bone lesion
189	Repair/graft achilles tendon	190	Biopsy elbow joint lining
191	Biopsy finger joint lining	192	Surgery of bunion
193	Tendon transfer procedure	194	Removal of knee cap bursa
195	Treatment of fracture of ulna	196	Treatment of scapula fracture
197	Removal of tumor of arm/ elbow under RA/GA	198	Repair of ruptured tendon
199	Revision of neck muscle (Torticollis release)	200	Treatment fracture of radius & ulna
201	Incision On Bone, Septic And Aseptic	202	Closed Reduction On Fracture, Luxation OrEpiphyseolysis With Osteosynthesis
203	Reduction Of Dislocation Under Ga	204	Vaginoplasty
205	Dilatation of accidental caustic stricture oesophageal	206	Presacral Teratomas Excision
207	Removal of vesical stone	208	Excision Sigmoid Polyp
209	Sternomastoid Tenotomy	210	High Orchidectomy for testis tumours
211	Excision of cervical teratoma	212	Rectal-Myomectomy
213	Rectal prolapse (Delorme's procedure)	214	Orchidopexy for undescended testis
215	Detorsion of torsion Testis	216	Lap.Abdominal exploration in cryptorchidism
217	Coronary Angiography	218	Ultrasound Guided Aspirations
219	Digital subtraction Angiography (DSA)	220	Anti Rabies Vaccination
221	Pace maker- Battery replacement	222	Plasmapheresis
223	Radio Iodine therapy post thyroidectomy	224	Barrage laser/ Pan retinal photocoagulation
225	Keratoconus	226	BCG Intravesicular injection for carcinomabladder

ANNEXURE II:

LIST I – ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY

S. No.	ITEM
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

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

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

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

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

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

ANNEXURE IV: CONTACT DETAILS OF INSURANCE OMBUDSMEN

AHMEDABAD - **Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor,** **Tilak Marg, Relief Road, Ahmedabad – 380 001.** **Tel.: 079 - 25501201/02/05/06** **Email: bimalokpal.ahmedabad@ecoi.co.in**	BHOPAL - **Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462003.** **Tel.: 0755 - 2769201 / 2769202** **Fax: 0755 - 2769203** **Email: bimalokpal.bhopal@ecoi.co.in**
BHUBANESHWAR - **Office of the Insurance Ombudsman,** **62, Forest park, Bhubneshwar – 751 009.** **Tel.: 0674 - 2596461 /2596455** **Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@ecoi.co.in**	CHANDIGARH - **Office of the Insurance Ombudsman,** **S.C.O. No. 101, 102 & 103, 2nd Floor,** **Batra Building, Sector 17 – D, Chandigarh – 160 017.Tel.: 0172 - 2706196 / 2706468** **Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@ecoi.co.in**
CHENNAI - **Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,** **Anna Salai, Teynampet, CHENNAI – 600 018.** **Tel.: 044 - 24333668 / 24335284** **Fax: 044 - 24333664** **Email: bimalokpal.chennai@ecoi.co.in**	DELHI - **Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,** **Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504** **Email: bimalokpal.delhi@ecoi.co.in**
GUWAHATI - **Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,** **Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).** **Tel.: 0361 - 2632204 / 2602205** **Email: bimalokpal.guwahati@ecoi.co.in**	HYDERABAD - **Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool,Hyderabad - 500 004.** **Tel.: 040 - 67504123 / 23312122** **Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@ecoi.co.in**
ERNAKULAM - **Office of the Insurance Ombudsman,** **2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.** **Tel.: 0484 - 2358759 / 2359338** **Fax: 0484 - 2359336** **Email: bimalokpal.ernakulam@ecoi.co.in**	KOLKATA **Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.** **Tel.: 033 - 22124339 / 22124340** **Fax : 033 - 22124341** **Email: bimalokpal.kolkata@ecoi.co.in**
LUCKNOW - **Office of the Insurance Ombudsman,** **6th Floor, Jeevan Bhawan, Phase-II,** **Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331** **Fax: 0522 - 2231310** **Email: bimalokpal.lucknow@ecoi.co.in**	MUMBAI - **Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,** **S. V. Road, Santacruz (W), Mumbai - 400 054.** **Tel.: 022 - 26106552 / 26106960** **Fax: 022 - 26106052** **Email: bimalokpal.mumbai@ecoi.co.in**

JAIPUR - **Office of the Insurance Ombudsman,** **Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.** **Tel.: 0141 - 2740363** **Email: bimalokpal.jaipur@ecoi.co.in**	PUNE - **Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor,** **C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune –411 030.** **Tel.: 020-41312555** **Email: bimalokpal.pune@ecoi.co.in**
BENGALURU - **Office of the Insurance Ombudsman,** **Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road,** **JP Nagar, Ist Phase, Bengaluru – 560 078.Tel.: 080 - 26652048 / 26652049** **Email: bimalokpal.bengaluru@ecoi.co.in**	NOIDA - **Office of the Insurance Ombudsman,** **Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.** **Tel.: 0120-2514250 / 2514252 / 2514253** **Email: bimalokpal.noida@ecoi.co.in**
PATNA - **Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,,** **Bazar Samiti Road, Bahadurpur, Patna 800 006.** **Tel.: 0612-2680952** **Email: bimalokpal.patna@ecoi.co.in**	

ANNEXURE:

Description of benefits	Gold Plan	Platinum Plan
Room rent	1% of the Sum Insured (or) Rs. 15,000, whichever is less	Single AC Room
ICU charges	2% of the Sum Insured (or) Rs. 25,000, whichever is less	Actuals
Pre hospitalization expenses	30 days	60 days
Post hospitalization expenses	60 days	90 days.
Cataract surgery	Upto Rs.50,000 per Eye	Upto Rs.1,00,000 per Eye
Modern Treatments	As per the limits mentioned in 3.10 of the Policy Clause	Up to 100% of the Sum Insured
Medical second opinion for Critical illnesses	Up to Rs.2500 in a Policy Period	Up to Rs.5000 in a Policy Period
Road Ambulance	Actuals	Actuals
Air ambulance	Not available	Actuals once in a policy period.
Non-Medical items (consumables)	Not Available	Inbuilt cover upto Rs.25000
Benefits under Optional covers (On payment of Additional Premium)		
Critical Care benefit	Rs.5,00,000	Rs.5,00,000 or Rs. 7,50,000
Personal Accident benefit	50% of Sum Insured	

ANNEXURE

Optional Cover – Personal Accident

Permanent Partial Disablement – Amount of Benefit Payable under PPD

	Loss Covered	Percentage of Sum Insured
1.	Loss of Use/ Physical Separation:	
	One entire hand	25%
	One entire foot	25%
	Loss of Sight of one eye	25%
	Loss of toes – all Great both phalanges Great – one phalanx Other than great if more than one toe lost	10% 2.5% 1% 0.5%
2.	Loss of Use of both ears	25%
3.	Loss of Use of one ear	10%
4.	Loss of four fingers and thumb of one hand	20%
5.	Loss of four fingers	17.5%
6.	Loss of thumb - both phalanges - one phalanx	 12.5% 5%
7.	Loss of Index finger - three phalanges two phalanges one phalanx	 5% 4% 2%
8.	Loss of middle finger - three phalanges two phalanges one phalanx	 3% 2% 1%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 2.5% 2% 1%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 2% 1.5% 1%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 1.5% 1%
12.	Any other permanent partial disablement	Percentage as assessed bythe independent Medical Practitioner