THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI 400001

NEW INDIA MEDICLAIM POLICY

(**UIN**: **NIAHLIP23187V052223**)

1. PREAMBLE

This is Your NEW INDIA MEDICLAIM 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 and conditions set out in this Policy and its Schedule will be the basis for any claim and/or benefit under this Policy.

Please read this Policy carefully and point out discrepancy, if any, in the Schedule. Otherwise, it will be presumed that the Policy and the Schedule correctly represent the cover agreed upon.

If during the Period of Insurance, You or any Insured Person incurs Hospitalisation Expenses and/or services in India which are Reasonable and Customary, and Medically Necessary for treatment of any Illness or Injury, We will reimburse such expense incurred by You, through the Third Party Administrator, in the manner stated herein.

Please note that the above coverage is subject to Limits, Terms and Conditions contained in this Policy and no Exclusion being found applicable.

2. DEFINITIONS

STANDARD DEFINITIONS

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

2.2 **ANY ONE ILLNESS** means continuous period of Illness and includes relapse within forty-five 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 **CASHLESS FACILITY** means a facility extended by the Insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

2.6 **CONDITION PRECEDENT** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.7 **CONGENITAL ANOMALY** means to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

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

2.8 **CO-PAYMENT** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

2.9 **CUMULATIVE BONUS** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

2.10 **DAY CARE CENTRE** means any institution established for Day Care Treatment of Illness and/or Injury or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under 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/s 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.

2.11 DAY CARE TREATMENT refers to medical treatment, and/or Surgical Procedure which is:

- Undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than twenty four hours because of technological advancement, and
- Which would have otherwise required a Hospitalization of more than twenty four hours.

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

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 the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.14 DOMICILIARY HOSPITALISATION means medical treatment for an Illness/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- The patient takes treatment at home on account of non-availability of room in a Hospital.

2.15 EMERGENCY CARE: 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.

2.16 GRACE PERIOD means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

2.17 HOSPITAL means any institution established for Inpatient Care and Day Care Treatment of Illness and/or Injury 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 (s) in charge round the clock;

- has a fully equipped operation theatre of its own where Surgical Procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

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

Note: 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 twenty four consecutive hours.

2.19 ICU (INTENSIVE CARE UNIT) means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.20 ICU CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.21 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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, check-ups, 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

2.22 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.

2.23 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.

2.24 MATERNITY EXPENSES shall mean:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation),

b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

2.26 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or Medical Practitioner in the same locality would have charged for the same medical treatment.

2.27 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.

Note: The Medical Practitioner should not be the insured or close family members.

2.28 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.

2.29 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;

2.30 MENTAL HEALTH PROFESSIONAL means

i. a 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

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

2.32 NETWORK PROVIDER means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The list is available with the insurer/TPA and subject to amendment from time to time.

2.33 NON-NETWORK PROVIDER means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

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

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

2.36 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during thirty days preceding the Hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.37 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during sixty days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

2.38 PORTABILITY means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another of the same insurer.

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

2.40 REASONABLE AND CUSTOMARY CHARGESmean 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 .

2.41 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.

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

2.43 SURGERY means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

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

SPECIFIC DEFINITIONS

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

2.46 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.

2.47 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 CLAIM FREE YEAR means coverage under the New India Mediclaim Policy for a period of one year during which no claim is paid or payable under the terms and conditions of the Policy in respect of Insured Person.

2.50 CUMULATIVE BONUS BUFFER means Bonus, as stated in the Schedule, carried forwarded at commencement of this Policy. CUMULATIVE BONUS BUFFER shall not be treated as part of the Sum Insured for the purposes of reckoning any limit specified in the Policy.

2.51 INSURED PERSON means You and each of the others who are covered under this Policy as shown in the Schedule.

2.52 LEGAL GUARDIAN OR CUSTODIAN is a person who has taken the responsibility of taking care of or protecting the children of deceased parents. This definition is to be used for the sole purpose of taking a Health Insurance Policy. This person shall not be eligible for claiming tax rebate under section 80D of the IT act.

2.53 NEW BORN BABY means a baby born during the Period of Insurance to a female Insured Person, who has twenty four months of Continuous Coverage.

2.54 PREFERRED PROVIDER NETWORK (PPN) means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

2.55 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 extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

2.56 POLICY PERIOD means period of one policy year as mentioned in the schedule for which the Policy is issued

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

2.58 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.

2.59 RENAL FAILURE is a condition in which the kidneys lose the ability to remove waste and balance fluids

- **ACUTE RENAL FAILURE (ARF)** is the abrupt loss of kidney function, resulting in the retention of metabolic waste products and dysregulation of volume and electrolytes of body fluids. The

medical term Acute Kidney Injury (AKI) has now largely replaced ARF in the medical communities (Injury not necessarily related to Accidents), reflecting the recognition that smaller decrements in kidney function that do not result in overt organ failure are of substantial clinical relevance and are associated with increased morbidity and mortality.

- **CHRONIC RENAL FAILURE:** End stage kidney disease characterized by irreversible failure of both kidneys to function normally, as a result of which either regular dialysis (hemodialysis or peritoneal dialysis) is instituted or a renal transplantation becomes necessary. The diagnosis has to be confirmed by a specialist medical practitioner.
- **RENAL TRANSPLANTATION:** Kidney transplantation is a surgical procedure to remove a healthy and functioning kidney from a living or brain-dead donor and implant it into a patient with non-functioning kidneys.

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

2.61 SUM INSURED is the maximum amount of coverage opted for each Insured Person and as shown in the Schedule.

Note: Sum Insured means pre-defined limit as shown in the schedule excluding Cumulative Bonus/Buffer.

2.62 TPA (THIRD PARTY ADMINISTRATORS) means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulation, 2016 notified by the Authority, and is engaged, for a fee or remuneration by Us, for the purposes of providing Health Services defined in those Regulations.

2.63 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.

2.64 WARD who are under the care or protection of the Legal Guardian or Custodian. The definition of Children shall be applicable for Ward.

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

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

3. BENEFITS COVERED UNDER THE POLICY

3.1 Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus/Buffer, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus/Buffer. Subject to this, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of the Sum Insured per day
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses not exceeding 2% of the Sum Insured per day.
3.1 (c)	Associate 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.
3.1 (d)	Cost of Pharmacy and Consumables, Cost of Implants, Artificial Limbs and Medical Devices and Cost of Diagnostics
3.1 (e)	Pre-Hospitalization Medical expenses for up to 30 days
3.1 (f)	Post-Hospitalization Medical expenses for up to 60 days

Note:

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.

3.2 PROPORTIONATE DEDUCTION

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

1. Cost of Pharmacy and Consumables
2. Cost of Implants, Artificial Limbs and Medical Devices
3. 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.

3.3 LIMIT ON PAYMENT FOR CATARACT:

Our liability for payment of any claim relating to Cataract, for each eye, shall not exceed 20% of the Sum Insured subject to a maximum of Rs. 50,000.

The limit mentioned above shall be applicable per event for all the Policies of Our Company including Group Policies. Even if two or more Policies of New India are invoked, sublimit of the Policy chosen by Insured shall prevail and our liability is restricted to stated sublimit.

3.4 COVERAGE UNDER AYUSH TREATMENT

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

3.5 HOSPITAL CASH

For those Insured Persons, whose Sum Insured is more than or equal to Rs. three lakhs, we will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty-four consecutive hours. Payment under this clause shall reduce the Sum Insured.

Hospital Cash will be payable for completion of every twenty-four hours and not part thereof.

3.6 HEALTH CHECK-UP

The Insured Person shall be entitled for reimbursement of the cost of Medical check-up at the end of a block of every three Claim Free Years. Such payment shall be restricted to Rs. 5,000 or 1% of the average Sum Insured of the Insured Person in the preceding three years, whichever is less. This benefit is available only once in three years.

Any payment made under this clause shall not be considered as a claim.

3.7 PAYMENT OF AMBULANCE CHARGES

We will pay You the charges for Ambulance services not exceeding 1% of the Sum Insured per Insured event, Reasonably and Medically Necessarily incurred for shifting any Insured Person to Hospital for admission in Emergency Ward or ICU, or from one Hospital to another Hospitalfor better medical facilities.

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 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, provided Our liabilitytowards expenses incurred on the donor and the insured recipient shall not exceed the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ.

3.10 REINSTATEMENT OF SUM INSURED

If the Sum Insured is exhausted due to a claim admissible under the Policy, then the Sum Insured shall be reinstated to the Sum Insured stated in the Schedule, provided our liability under the Reinstated Sum Insured shall be subject to the following conditions:

1. Such Reinstatement of Sum Insured shall be effected only where the Sum Insured is Rs. Five Lakhs or more.
2. Such Reinstatement shall take effect only after the Date of Discharge from the Hospital and for the subsequent Hospitalisation
3. No Illness or Injury, for a Hospitalisation occurring during the Period of Insurance till the Date of Reinstatement, for which a Claim is paid or admissible, shall be considered under the Reinstated Sum Insured.

4. Such Reinstatement shall be available only once for each Insured Person during a Period of Insurance.
5. The sequence of utilization of Sum Insured will be as below:
   a. Sum Insured;
   b. Cumulative Bonus/Buffer (if any);
   c. Reinstated Sum Insured
6. This benefit is not available for Modern Treatments listed in 3.20 below.

3.11 DAY ONE BABY COVER

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy. Any expense incurred towards post-natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered.

Congenital External Anomaly of the New Born Baby is covered only after 36 months Waiting Period. Waiting Period for Congenital Internal Disease would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

Any Illness or Disease will be covered within the Sum Insured of the mother till the expiry of the Policy and No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for insurance and covered as an Insured Person.

Note: New Born Baby means a baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.

3.12 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. Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & PostHospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

3.13 OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 3.2 stands deleted for the members covered in the Policy as stated in the Schedule.

You shall continue to bear the differential between actual and eligible Room Rent.

3.14 OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

On the payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 4.4.15 stands deleted for the members as mentioned in the Schedule. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

Special conditions applicable to Maternity Expenses Benefit:

1. These Benefits are admissible only if the expenses are incurred in Hospital as inpatients in India.
2. A waiting period of thirty-six months is applicable, from the date of opting this cover, for payment of any claim relating to normal delivery or caesarian section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of miscarriage or abortion induced by accident or other medical emergency.
3. Claim in respect of delivery for only first two children and / or surgeries associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof.
4. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there.

3.15 OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This optional cover, if opted, will be in addition to limit specified in Clause 3.3

On payment of additional Premium as mentioned in Schedule, it is declared and agreed that following additional amount for Cataract shall become payable but not exceeding the actual expenses incurred:

Sum Insured	Additional Cataract limit
Rs. 8,00,000	Rs. 80,000
Rs. 10,00,000	Rs. 1,00,000
Rs. 12,00,000	Rs. 1,20,000
Rs. 15,00,000	Rs. 1,50,000

Note: Benefit of this cover will be available after the expiry of thirty-six months from the date of opting this cover.

3.16 OPTIONAL COVER IV: VOLUNTARY CO-PAY

If the Insured person opts for voluntary co-pay of 20%, a discount of 15% shall be of given on the premium payable for the Insured Person.

3.17 OPTIONAL COVER V: NON-MEDICAL ITEMS (CONSUMABLES)

On payment of additional Premium as mentioned in Schedule, it is declared and agreed that items listed in Annexure II (List 1) shall become payable up to Rs. 15,000/- in a policy period. This Optional Cover is available for Sum Insured of 8 L & above.

Once this optional cover is opted and a claim has been admitted under the policy, You cannot opt out of this optional cover.

3.18 CUMULATIVE BONUS

The Sum Insured under Policy shall be increased by 25% at each renewal in respect of each claim free year of insurance, subject to maximum of 50%. If a claim is made in any particular year; the cumulative bonus accrued shall be reduced at the same rate at which it is accrued.

Cumulative bonus will be lost if policy is not renewed before or within 30 days from the date of expiry. In case sum insured under the policy is reduced at the time of renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.

In case the insured is having more than one policy, the Cumulative Bonus shall be reduced from the policy/policies in which claim is made irrespective of number of policies.

Note 1: Unless otherwise specified, Cumulative Bonus shall not be treated as part of the Sum Insured for the purposes of reckoning any limit specified in the Policy.

Note 2:

i. Cumulative Bonus shall be applicable for persons having Sum Insured of 2 Lakh & above.
ii. The Cumulative Bonus Buffer under the expiring policy having Sum Insured of 2 Lakh & above, if any, shall be converted to Cumulative Bonus.
iii. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person who has not claimed under the expiring policy.
iv. CB shall be available only if the Policy is renewed within the Grace Period.
v. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.
vi. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies, the same CB of the expiring policy shall be applicable to each Individual of such Renewed Policies.
vii. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.
viii. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
ix. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

3.19 SPECIFIC COVERAGES:

a) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of normal state of Health under any circumstances. We cover the expenses up to 10% of the Sum Insured and for a maximum of 15 days per policy period for covered illness. This sub limit is applicable only for person who is declared to be in a vegetative state as certified by the treating medical practitioner.

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 48 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 75,000 per policy period.

d) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

Note: For the coverages defined in 3.19(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. 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 48 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/ behaviour/ palliative therapy or psychotherapy shall not be covered.

3.20 **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	Limit (Per Policy Period)
3.20.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3.20.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh

3.20.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to a maximum upto Rs. 5 Lakh
3.20.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 1 Lakh
3.20.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to a Maximum of Rs 2 Lakh.
3.20.6	Intravitreal injections.	Upto 10% of Sum Insured subject to a Maximum of Rs.75,000.
3.20.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum of Rs. 5 Lakh.
3.20.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
3.20.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.20.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.20.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum of Rs. 50,000.
3.20.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.

3.21 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.**

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 48 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 48 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 / 36/ 48 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 pre-existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

(i) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(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. Renal Failure
19. Puberty and Menopause related Disorders
20. Internal Congenital Diseases

(iii) 36 Months waiting period

1. Congenital External Disease

(iv) 48 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of Mental Illness
4. Age Related Macular Degeneration (ARMD)
5. 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 EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.4.1 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

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

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

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

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

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

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

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

d. Body Mass Index (BMI);

1. greater than or equal to 40 or
2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   - **i.** Obesity-related cardiomyopathy
   - **ii.** Coronary heart disease
   - **iii.** Severe Sleep Apnea
   - **iv.** Uncontrolled Type2 Diabetes

4.4.4 CHANGE-OF-GENDER TREATMENTS (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

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

4.4.7 BREACH OF LAW (Code- Excl10)

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

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by 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.

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

4.4.10 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)**

4.4.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SPECIFIC EXCLUSIONS

4.4.16 Acupressure, acupuncture, magnetic therapies.

4.4.17 Any expenses incurred on Domiciliary Hospitalization.

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

4.4.19 Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.

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

4.4.21 Convalescence and General debility.

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

4.4.23 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 and equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

4.4.24 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.

4.4.25 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.20.12

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

4.4.27 Treatment and/or services taken outside the geographical limits of India

4.4.28 Vaccination and/or inoculation

4.4.29 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.

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 CANCELLATION

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

Period On Risk	Rate of Premium To Be Charged (Retained By The Insurer)
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

In the event of death of insured in the middle of policy year/during the course of policy period, the premium for the unexpired policy period shall be refunded proportionately.

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.

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

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 and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days 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.

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.

None of the provisions of this Clause shall apply for payments under Clause 3.5 of the Policy.

5.8 MORATORIUM PERIOD

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would

however be subject to all limits, sub limits, co-payments as per the policy.

5.9 NOMINATION:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

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.

5.12 WITHDRAWAL OF POLICY

i. ln 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 lRDAl, 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 will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

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 such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an India General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

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 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, 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. Claim Form duly filled and signed by the claimant
ii. All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history
iii. Numbered Bill/Receipt and Discharge certificate / card from the Hospital.
iv. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
v. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
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. Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

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.

5.21 <u>SETTLEMENT/REJECTION OF CLAIM:</u>

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. While efforts will be made by Us to not call for any document not listed in Clause 5.20, where any additional document or clarification is 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.

iv. In the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

v. However, where the circumstances of a claim warrant an investigation in the opinion of the Insurer, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document.

vi. In case of delay beyond stipulated 45 days, We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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 <u>ENHANCEMENT OF SUM INSURED:</u>

You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum Insured, We have the right to have You examined by a Medical Practitioner authorized by Us or the TPA. Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner and subject to limits as stated below:

Age <= 50 years	Up to Sum Insured of 15 lakhs without Medical Examination.
Age 51-60 Years	By two slabs without Medical Examination
Age 51-60 Years	Up to 15 L with Medical Examination
Age 61 – 65 Years	By one slab with Medical Examination

Enhancement of Sum Insured shall not be considered for:

1) Any Insured Person over 65 years of age.

2) Any Insured Person who had undergone more than one Hospitalisation in the preceding two years.

3) Any Insured Person suffering from one or more of the following Illnesses/Conditions:

- **a)** Any chronic Illness
- **b)** Any recurring Illness
- **c)** Any Critical Illness

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.

5.25 <u>CUMLATIVE BONUS/BUFFER:</u>

Cumulative Bonus/Buffer could be carried over to the next year only if the renewal is effected before, or within thirty days of, expiry of the Policy.

Cumulative Bonus earned in the previous year/s will be available as Cumulative Bonus Buffer in this policy. The CB buffer, if any, is applicable only for 1 L Sum Insured and will be carried forward unless and until it is completely utilized.

5.26 ARBITRATION:

If We admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration.

The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

No reference to Arbitration shall be made unless We have admitted Our liability for a claim in writing.

If a claim is declined and within twelve calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.27 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interests) Regulation, 2017.

5.28 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.

ANNEXURE I: LIST 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 Middle Ear
11	Other Microsurgical Operations On The Middle Ear	12	Endolymphatic Sac Surgery for Meniere's Disease
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 Tissue Of 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 Region Of The Mouth, Jaw And Face
41	Other Operations On The Salivary Glands And Salivary 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 Diseased Tissue 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 Vaginalis Testis
165	Revision Of Skin Plasty	166	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues
167	Destruction Of Diseased Tissue In The Skin And 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 Or Epiphyseolysis 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 carcinoma bladder

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	PULSEOXYMETER 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 III: CONTACT DETAILS OF INSURANCE OMBUDSMEN

AHMEDABAD - **Shri Collu Vikas Rao** **Office of the Insurance Ombudsman,** **Jeevan Prakash Building, 6th floor,** **Tilak Marg, Relief Road, Ahmedabad – 380 001.** **Tel.: 079 - 25501201/02/05/06** **Email: bimalokpal.ahmedabad@cioins.co.in**	BHOPAL - **Shri R. M. Singh** **Office of the Insurance Ombudsman,** **Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office,** **Near New Market, Bhopal – 462 003.** **Tel.: 0755 - 2769201 / 2769202** **Fax: 0755 - 2769203** **Email: bimalokpal.bhopal@cioins.co.in**
BHUBANESHWAR - **Shri Manoj Kumar Parida** **Office of the Insurance Ombudsman,** **62, Forest park, Bhubneshwar – 751 009.** **Tel.: 0674 - 2596461 /2596455** **Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@cioins.co.in**	CHANDIGARH - **Mr Atul Jerath** **Office of the Insurance Ombudsman,** **S.C.O. No. 101, 102 & 103, 2nd Floor,** **Batra Building, Sector 17 – D, Chandigarh – 160 017.** **Tel.: 0172 - 2706196 / 2706468** **Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@cioins.co.in**
CHENNAI - **Shri Segar Sampathkumar** **Office of the Insurance Ombudsman,** **Fatima Akhtar Court, 4th Floor, 453,** **Anna Salai, Teynampet, CHENNAI – 600 018.** **Tel.: 044 - 24333668 / 24335284** **Fax: 044 - 24333664** **Email: bimalokpal.chennai@cioins.co.in**	DELHI - **Ms Sunita Sharma** **Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,** **Asaf Ali Road, New Delhi – 110 002.** **Tel.: 011 - 23232481/23213504** **Email: bimalokpal.delhi@cioins.co.in**
GUWAHATI - **Shri Somnath Ghosh** **Office of the Insurance Ombudsman,** **Jeevan Nivesh, 5th Floor,** **Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).** **Tel.: 0361 - 2632204 / 2602205** **Email: bimalokpal.guwahati@cioins.co.in**	HYDERABAD - **Shri N. Sankaran** **Office of the Insurance Ombudsman,** **6-2-46, 1st floor, "Moin Court",** **Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.** **Tel.: 040 - 23312122** **Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@cioins.co.in**
ERNAKULAM - **Shri G. Radhakrishnan** **Office of the Insurance Ombudsman,** **2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,** **Ernakulam - 682 015.** **Tel.: 0484 - 2358759 / 2359338** **Fax: 0484 - 2359336** **Email: bimalokpal.ernakulam@cioins.co.in**	KOLKATA - **Ms Kiran Sahdev** **Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.** **Tel.: 033 - 22124339 / 22124340** **Fax : 033 - 22124341** **Email: bimalokpal.kolkata@cioins.co.in**
LUCKNOW - **Shri. Atul Sahai** **Office of the Insurance Ombudsman,** **6th Floor, Jeevan Bhawan, Phase-II,** **Nawal Kishore Road, Hazratganj, Lucknow - 226 001.** **Tel.: 0522 - 2231330 / 2231331** **Email: bimalokpal.lucknow@cioins.co.in**	MUMBAI - **Shri Bharatkumar S. Pandya** **Office of the Insurance Ombudsman,** **3rd Floor, Jeevan Seva Annexe,** **S. V. Road, Santacruz (W), Mumbai - 400 054.** **Tel.: 022 - 69038821/23/24/25/26/27/28/28/29/30/31** **Email: bimalokpal.mumbai@cioins.co.in**
JAIPUR - **Shri Rajiv Dutt Sharma** **Office of the Insurance Ombudsman,** **Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg,** **Jaipur - 302 005.** **Tel.: 0141 - 2740363** **Email: bimalokpal.jaipur@cioins.co.in**	PUNE - **Shri Sunil Jain** **Office of the Insurance Ombudsman,** **Jeevan Darshan Bldg., 3rd Floor,** **C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.** **Tel.: 020-41312555** **Email: bimalokpal.pune@cioins.co.in**
BENGALURU - **Mr Vipin Anand** **Office of the Insurance Ombudsman,** **Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road,** **JP Nagar, Ist Phase, Bengaluru – 560 078.** **Tel.: 080 - 26652048 / 26652049** **Email: bimalokpal.bengaluru@cioins.co.in**	NOIDA - **Shri Bimbadhar Pradhan** **Office of the Insurance Ombudsman,** **Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.** **Tel.: 0120-2514252 / 2514253** **Email: bimalokpal.noida@cioins.co.in**
PATNA - **Ms Susmita Mukherjee** **Office of the Insurance Ombudsman,** **2nd Floor, Lalit Bhawan,** **Bailey Road,** **Patna 800 001. Tel.: 0612-2547068** **Email: bimalokpal.patna@cioins.co.in**	