

VATSALYA HEALTH POLICY

(COVER FOR SURROGATE MOTHER AND OOCYTE DONOR)

POLICY CLAUSE

1. PREAMBLE:

The POLICY is granted by Us to the holder of any one specified Medclaim policy of the New India Assurance Co. Ltd. based on the information provided by the Intending Couple/Intending Woman (Proposer / Policyholder) covering the person named in the policy schedule (Surrogate mother/Oocyte donor as the case may be), and is subject to the definitions, terms and conditions, exclusions, and endorsements of this policy. The accuracy and completeness of the information provided by the policyholder in respect of the insured person is crucial in determining the POLICY's terms and conditions.

The meanings assigned to the terms defined below apply to their usage throughout the POLICY and as 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 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 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.
- 2.7 CONDITION PRECEDENT** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
- 2.8 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.
- 2.9 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.
- 2.10 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 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.
- 2.13 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.
- 2.14 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 GRACE 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 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.
- 2.17 HOSPITALISATION** means admission as an Inpatient in a Hospital for a minimum period of 24 consecutive hours except for the specified procedures/ treatments.
- 2.18 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.
- 2.19 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.
- 2.20 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

2.21 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.

2.22 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.

2.23 MATERNITY EXPENSES shall mean:

- i. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization),
- ii. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

2.25 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.

2.26 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.

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

2.27 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- as 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.

2.28 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, organization 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, organization 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;

2.29 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.

2.30 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.

2.31 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.

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

2.33 NEW BORN BABY means baby born during the Policy Period and is aged up to 90 days

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 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

2.36 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** means 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 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.
- 2.39 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 CHARGES** 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.
- 2.41 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 ABANDONED CHILD** means a child born out of surrogacy procedure who has been deserted by his intending parents or guardians and declared as abandoned by the appropriate authority after due enquiry.
- 2.46 ALTRUISTIC SURROGACY** means the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses and such other prescribed expenses incurred on surrogate mother and the insurance coverage for the surrogate mother are given to the surrogate mother or her dependents or her representative
- 2.47 COMMERCIAL SURROGACY** means commercialization of surrogacy services or procedures or its component services or component procedures including selling or buying human embryo or trading in the sale or purchase of human embryo or gametes or selling or buying or trading the services of surrogate motherhood by way of giving payment, reward, benefit, fees remuneration or monetary incentive in cash or kind to the surrogate mother or her dependents or her representatives except medical expenses and such other prescribed expenses incurred on the surrogate mother and the insurance coverage for the surrogate mother.
- 2.48 COUPLE** means the legally married Indian man and woman above the age of 21 years and 18 years respectively.
- 2.49 EGG** includes the female gamete
- 2.50 EMBRYO** means a developing or developed organism after fertilization till the end of fifty-six days.

- 2.51 EMBRYOLOGIST** means a person who possesses any post graduate medical qualification or doctoral degree in the field of embryology or clinical embryology from a recognized university with not less than two years of clinical experience
- 2.52 FERTILIZATION** means the penetration of the ovum by the spermatozoan and the fusion of the genetic materials resulting in the development of a zygote.
- 2.53 FOETUS** means a human organism during the period of its development beginning on the fifty seventh day following fertilization or creation (excluding any time in which its development has been suspended) and ending at the birth.
- 2.54 GAMETE** means sperm and oocyte
- 2.55 GYNEACOLOGIST** shall have the same meaning as assigned to it in the Pre conception and pre-natal diagnostic techniques (Prohibition of Sex selection) Act 1994.
- 2.56 IMPLANTATION** means the attachment and subsequent penetration by the Zona free blastocyst which starts five to seven days following fertilization.
- 2.57 INSURED PERSON** means the surrogate mother or Oocyte donor covered under this Policy as shown in the Schedule.
- 2.58 INTENDING COUPLE** means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy who belongs to the age group of 23-50 years in case of females, 26-55 years in case of males on the day of certification
- 2.59 INTENDING WOMAN** means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy.
- 2.60 LIFE THREATENING MEDICAL CONDITION** means a medical condition suffered by the Insured Person which has any of the following characteristics:
- i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or
 - ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or
 - iii. Critical care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or
 - iv. Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department; and
 - v. Is certified by the attending Medical Practitioner as a Life-Threatening Medical Condition.
- 2.61 OOCYTE** means naturally ovulating oocyte in the female genetic tract.
- 2.62 OOCYTE DONOR** means a fertile woman who donated her eggs to the Intending Couple to help her conceive as part of an assisted reproduction.
- 2.63 OOCYTE DONATION** is the process by which a fertile woman donates eggs to another woman to help her conceive as part of an assisted reproduction.
- 2.64 PAEDIATRICIAN** means a person who possesses a post graduate qualification in paediatrics as recognized under the Indian Medical Council Act 1956.
- 2.65 PRESCRIBED** means prescribed by rules made under this Act THE SURROGACY (REGULATION) ACT, 2021 and subsequent amendments.
- 2.66 REGISTERED MEDICAL PRACTITIONER** means a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of Section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and whose name has been entered in a State Medical Register;
- 2.67 SEX SELECTION** shall have the same meaning as assigned to it in clause (o) of section 2 of Pre conception and Pre-Natal Diagnostic techniques (Prohibition of sex selection) Act, 1994
- 2.68 SPECIFIED POLICY** means Yuva Bharat Mediclaim Policy, New India Mediclaim Policy, New India

Floater Mediclaim Policy and New India Premier Mediclaim Policy issued by Us.

- 2.69 STATE BOARD** means the State Assisted Reproductive Technology and Surrogacy Board Constituted under Section 26.
- 2.70 STATE GOVERNMENT** in relation to Union territory with Legislature means the Administrator of the Union territory appointed by the President under article 239 of the Constitution.
- 2.71 SURROGACY** means a practice whereby one woman bears and gives birth to a child for an intending couple or intending woman with the intention of handing over such child to the intending couple after the birth.
- 2.72 SURROGACY CLINIC** means surrogacy clinic, centre or laboratory conducting assisted reproductive technology services, in vitro fertilization services genetic counselling centre, genetic laboratory, Assisted Reproductive Technology banks conducting surrogacy procedures in any form.
- 2.73 SURROGATE MOTHER** means a woman who agrees to bear a child (who is genetically related to the intending couple or the intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause of clause (iii) of section 4 of the Surrogacy (Regulations) Act, 2021.
- A married woman having a child of her own
 - Who is between the ages of 25 to 35 years of age as on the day of implantation
 - Shall not provide her own gametes
 - Shall not act as a surrogate mother for more than thrice in her lifetime.
 - Shall possess a certificate of Medical and Psychological fitness for Surrogacy and Surrogacy procedures from a registered Medical Practitioner.
- 2.74 SURROGACY PROCEDURES** means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling or human gametes and human embryo in surrogacy.
- 2.75 ZYGOTE** means the fertilized oocyte prior to the first cell division.

3. BENEFITS COVERED UNDER THIS POLICY:

3.1

OPTION I : SURROGACY COVER

(a) COMPLICATIONS ARISING OUT OF PREGNANCY THROUGH ALTRUISTIC SURROGACY including Medical termination of pregnancy in case of:

- i. Medical termination of Pregnancy when the continuance of the pregnancy would involve a risk to the life of the SURROGATE MOTHER (pregnant woman) or of grave injury to her physical or mental health.**
- ii. or there is a substantial risk that if the child were born, it would suffer from any serious physical or mental abnormality.**

(b) POST PARTUM DELIVERY COMPLICATIONS IN RESPECT OF THE SURROGATE MOTHER ONLY. ONE SURROGACY PROCEDURE SHALL BE COVERED UNDER THIS POLICY PERIOD OF THREE (3) YEARS

Option II: OOCYTE RETRIEVAL COVER

COMPLICATIONS ARISING DUE TO OOCYTE RETRIEVAL IN RESPECT OF THE OOCYTE DONOR.

Only ONE OOCYTE DONATION SHALL BE COVERED UNDER THIS POLICY PERIOD OF ONE (1) YEAR.

IMPORTANT:

Provided that:

- Policy must incept prior to the commencement of Surrogacy Procedure or Oocyte Retrieval.
- Surrogacy and Oocyte donation is carried out in recognized centers registered with the National ART and Surrogacy Registry at <https://registry.artsurrogacy.gov.in/>, under the supervision of registered Medical Practitioner as per the applicable law.
- The Surrogacy/ART procedures and treatments is carried out in accordance with the Surrogacy (Regulation) Act, 2021, Surrogacy (Regulation) Rules, 2022, Assisted Reproductive Technology Act, 2021, Assisted Reproductive Technology (Rules), 2022 and its subsequent amendments as may be applicable.
- Purpose of Surrogacy and surrogacy procedures must be in compliance with The Surrogacy (Regulation Act) 2021 and its subsequent amendments as may be applicable.
- The intending couple is in possession of a certificate of essentiality issued by the appropriate authority, after satisfying itself, for the reasons to be recorded in writing, about the fulfillment of the conditions, specified in The Surrogacy (Regulation Act) 2021 and its subsequent amendments as may be applicable.

- The surrogate mother is in possession of an eligibility certificate issued by the appropriate authority on fulfillment of the conditions specified in The Surrogacy (Regulation Act) 2021 and its subsequent amendments as may be applicable.
- Consent of surrogate mother has been obtained in the form specified in the Surrogacy (Regulation) Rules, 2022 and its subsequent amendments as may be applicable.
- An eligibility certificate for intending couple is issued separately by the appropriate authority on fulfillment of the conditions specified in The Surrogacy (Regulation Act) 2021 and its subsequent amendments as may be applicable.
- No surrogacy clinic, registered medical practitioner, gynecologist, pediatrician, embryologist, intending couple or any other person shall conduct or cause abortion during the period of surrogacy without the written consent of the surrogate mother and on authorisation of the same by the appropriate authority concerned provided in The Surrogacy (Regulation Act) 2021 and its subsequent amendments as may be applicable.: Provided that the authorisation of the appropriate authority shall be subject to, and in compliance with, the provisions of the Medical Termination of Pregnancy Act, 1971 (34 of 1971);

3.1.a	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) in a single AC room not exceeding Rs.8000 per day.
3.1.b	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses - Actuals.
3.1.c	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Operating Theatre Charges and Procedure Charges & 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
3.1.g	Road Ambulance charges @ 1% of sum insured subject to a maximum of Rs.5000/- per event. Ambulance charges Reasonably and Medically Necessary incurred for shifting any Insured Person from residence to Hospital for admission in Emergency Ward or ICU, or from one Hospital to another Hospital for better medical facilities

3

3.2 PROPORTIONATE DEDUCTION

Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than the 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, Artificial Limbs and Medical Devices
- Cost of Diagnostics.

Proportionate Deduction shall also not be applied in respect of ICU charges and 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 COVERAGE FOR AYUSH TREATMENT:

We will cover Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an AYUSH Hospital/ AYUSH day care centre, for a covered event, in a room category maximum up to Single Private Room and applicable Associated Medical Expenses.

This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 30 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period up to 60 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit.

Claims under this section shall be assessed as per the applicable insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (<https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush>).

3.4 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.

4. EXCLUSIONS

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

STANDARD EXCLUSIONS

4.1 Initial Waiting Period: Expenses related to the treatment of the covered event within 30 days from the Policy commencement date shall be excluded.

4.2 Investigation and evaluation (Code- Excl 04):

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

4.3 Rest cure, rehabilitation and respite care (Code- Excl 05):

4.4 Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.

This also includes:

- i. 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.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- 4.5 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12).**
- 4.6 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)
- 4.7 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)
- 4.8 Unproven treatments (Code- Excl 16):** 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.
- 4.9 Sterility and Infertility (Code- Excl 17):** Expenses related to Sterility and infertility. This includes:
- i. Any type of contraception, sterilization
 - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - iii. Reversal of sterilization.
 - iv. Gestational Surrogacy

SPECIFIC EXCLUSIONS

- 4.10** Any illness, sickness or disease other than complications arising out of pregnancy and post-partum delivery for the surrogate mother or complications arising out of oocyte retrieval for the oocyte donor.
- 4.11** Medical Expenses incurred towards:
- a. Delivery Expenses (Normal Delivery or caesarean section) of the Surrogate Mother;
 - b. Foetus /New Born baby through Surrogacy to the Surrogate Mother
 - c. Treatment of any pre-existing conditions/disease of the Insured including its complications;
 - d. Surrogacy Treatment Procedure cost including but not limited to Injection, tests, Ultra Sound, Embryo transfer, Ovum pickup;
- 4.12** Complication of Pregnancy to the Surrogate Mother, which is for other than 'Altruistic Surrogacy' and / or for the second Surrogacy and / or if the Surrogate Mother donates her own gametes.
- 4.13** Complications arising due to oocyte retrieval, if the insured is donating for the second time.
- 4.14** Treatment taken on OPD basis.
- 4.15** Complications of pregnancy resulting from the Surrogacy procedure conducted in a Clinic which is not registered as per the provisions of The Surrogacy (Regulation) Act, 2021.

- 4.16** Surrogacy which is for commercial purposes or for commercialization of surrogacy or surrogacy procedures.
- 4.17** Surrogacy which is for producing children for sale or any other form of exploitation
- 4.18** Any claim arising due to non-compliance of the provisions stated in the respective Surrogacy law, The Surrogacy (Regulation) Act, 2021, The Surrogacy (Regulation) Rules, 2022, the Assisted Reproductive Technology Law, The Assisted Reproductive Technology (Regulation) Act, 2021, The Assisted Reproductive Technology (Regulation) Rules, 2022 and any subsequent additions / modifications to the Law / Act / Rules.
- 4.19** Expenses which are either not supported by a prescription of a Medical Practitioner or are not related to Illness or disease for which claim is admissible under the Policy.
- 4.20** Any other illness/conditions which are specifically excluded under Surrogacy (Regulation) Act, 2021, Surrogacy (Regulation) Rules, 2022, ART Act, 2021 and ART (Regulation) Rules, 2022 and its subsequent amendments.
- 4.21** Any other line of treatment other than Allopathy and AYUSH.
- 4.22** Treatment of any pre-existing condition/disease of the Insured including its complications.
- 4.23** All preventive care, vaccination including inoculation and immunisations;
- 4.24** Durable medical equipment (including but not limited to wheelchairs, crutches, artificial limbs and the like), (namely that equipment used externally from the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose; is generally not useful in the absence of an Illness or Injury and is usable outside of a Hospital) unless required for the treatment of Illness or Accidental Bodily Injury.
- 4.25** Independent personal comfort and convenience items or services which are non-medical in nature and are charged separately unless they form part of the room rent.
- 4.26** Voluntary Termination of Pregnancy.
- 4.27** Non-medical Expenses incurred during Hospitalization. The list of such Non-Medical Expenses is placed at Annexure 1– List 1 – Items for which coverage is not available in the policy’.
- 4.28** Treatment of any internal and external Congenital Anomaly, or Illness or defects or anomalies or treatment relating to internal and external birth defects.
- 4.29** Prostheses, corrective devices, medical appliances, external medical equipment used at home as post hospitalization care including cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.
- 4.30** Cost associated with cryopreservation and storage of sperms, eggs and embryos.
- 4.31** Selective termination of an embryo.
- 4.32** Treatment rendered by a Medical Practitioner which is outside his discipline.
- 4.33** Doctor’s fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person’s family.
- 4.34** War or any act of war, invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, revolution, insurrection, mutiny, martial law.

4.35 Intentional self-injury or attempted suicide whether sane or insane.

4.36 All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exclusion:

- 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
- 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.
- 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.

4.37 Expenses which are either not supported by a prescription of a Medical Practitioner or are not related to illness or disease for which claim is admissible under the Policy.

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

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

5. 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 (Including death of Surrogate mother/Oocyte Donor). 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.

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

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

In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

- i. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

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

- ii. 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. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
- v. "BANK RATE" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
- vi. There shall be no fresh underwriting unless there is increase in sum insured.

5.11 WITHDRAWAL OF POLICY

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.

5.12 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.

5.13 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 II.

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

SPECIFIC TERMS AND CLAUSES

5.14 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.

5.15 PREMIUM:

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

5.16 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.

5.17 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.

5.18 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 15days 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.

5.19 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. 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 T PA (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.

5.20 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.

5.21 Any Medical Practitioner authorized 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.

5.22 PROTECTION OF POLICY HOLDERS' INTEREST:

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

ANNEXURE I:

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

Sr. 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

Sr. 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 II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

<p>AHMEDABAD –</p> <p>Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor,</p> <p>Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06</p> <p>Email: bimalokpal.ahmedabad@ecoi.co.in</p>	<p>BHOPAL -</p> <p>Office of the Insurance Ombudsman,</p> <p>Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462003.</p> <p>Tel.: 0755 - 2769201 / 2769202</p> <p>Fax: 0755 - 2769203</p> <p>Email: bimalokpal.bhopal@ecoi.co.in</p>
<p>BHUBANESHWAR –</p> <p>Office of the Insurance Ombudsman,</p> <p>62, Forest park, Bhubneshwar – 751 009.</p> <p>Tel.: 0674 - 2596461 /2596455</p> <p>Fax: 0674 - 2596429</p>	<p>CHANDIGARH –</p> <p>Office of the Insurance Ombudsman,</p> <p>S.C.O. No. 101, 102 & 103, 2nd Floor,</p> <p>Batra Building, Sector 17 – D, Chandigarh – 160</p> <p>017.Tel.: 0172 - 2706196 / 2706468</p>

<p>Email: bimalokpal.bhubaneswar@ecoi.co.in</p>	<p>Fax: 0172 - 2708274</p> <p>Email: bimalokpal.chandigarh@ecoi.co.in</p>
<p>CHENNAI –</p> <p>Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,</p> <p>Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284</p> <p>Fax: 044 - 24333664</p> <p>Email: bimalokpal.chennai@ecoi.co.in</p>	<p>DELHI -</p> <p>Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,</p> <p>Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504</p> <p>Email: bimalokpal.delhi@ecoi.co.in</p>
<p>GUWAHATI –</p> <p>Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,</p> <p>Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).</p> <p>Tel.: 0361 - 2632204 / 2602205</p> <p>Email: bimalokpal.guwahati@ecoi.co.in</p>	<p>HYDERABAD –</p> <p>Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court",</p> <p>Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.</p> <p>Tel.: 040 - 67504123 / 23312122</p> <p>Fax: 040 - 23376599</p> <p>Email: bimalokpal.hyderabad@ecoi.co.in</p>
<p>ERNAKULAM –</p> <p>Office of the Insurance Ombudsman,</p> <p>2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard,</p> <p>M. G. Road,Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338</p> <p>Fax: 0484 - 2359336</p> <p>Email: bimalokpal.ernakulam@ecoi.co.in</p>	<p>KOLKATA -</p> <p>Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.</p> <p>Tel.: 033 - 22124339 / 22124340</p> <p>Fax : 033 - 22124341</p> <p>Email: bimalokpal.kolkata@ecoi.co.in</p>

<p>LUCKNOW –</p> <p>Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II,</p> <p>Nawal Kishore Road, Hazratganj, Lucknow - 226 001.Tel.: 0522 - 2231330 / 2231331</p> <p>Fax: 0522 - 2231310</p> <p>Email: bimalokpal.lucknow@ecoi.co.in</p>	<p>MUMBAI –</p> <p>Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,</p> <p>S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960</p> <p>Fax: 022 - 26106052</p> <p>Email: bimalokpal.mumbai@ecoi.co.in</p>
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