# THE NEW INDIA ASSURANCE CO. LTD.

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

## Young India Digi Health Policy

**POLICY CLAUSE**

## 1. PREAMBLE

This is Your Young India Digi Health 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 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.

# 2. DEFINITIONS

### STANDARD DEFINITIONS

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

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

**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 Us to You where the payments, of the costs of treatment undergone by You in accordance with the policy terms and conditions, are directly made to the Network provider by Us to the extent of pre-authorization approved.

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

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

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

**2.9 CRITICAL ILLNESSES** mean the following Illnesses:

**2.9.1 CANCER OF SPECIFIED SEVERITY** means

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

**II.** The following are excluded -

**i.** All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
**ii.** Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.
**iii.** Malignant melanoma that has not caused invasion beyond the epidermis.
**iv.** All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
**v.** All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
**vi.** Chronic lymphocytic leukaemia less than RAI stage 3
**vii.** Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of

a lesser classification,

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

ix. All tumors in the presence of HIV infection.

**III. MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIED SEVERITY)**

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

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

ii. New characteristic electrocardiogram changes

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

**IV. The following are excluded:**

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris.

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

### 2.9.2 OPEN CHEST CABG

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

**II. The following are excluded:**

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

### 2.9.3 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

### 2.9.4 COMA OF SPECIFIED SEVERITY

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

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

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

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

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

### 2.9.5 KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

### 2.9.6 STROKE RESULTING IN PERMANENT SYMPTOMS

**I.** Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced

**II. The following are excluded:**

- **i.** Transient ischemic attacks (TIA)
- **ii.** Traumatic injury of the brain
- **iii.** Vascular disease affecting only the eye or optic nerve or vestibular functions.

### 2.9.7 MAJOR ORGAN /BONE MARROW TRANSPLANT

**I.** The actual undergoing of a transplant of:

- **i.** One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- **ii.** Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

**II. The following are excluded:**

- **i.** Other stem-cell transplants
- **ii.** Where only islets of Langerhans are transplanted

### 2.9.8 PERMANENT PARALYSIS OF LIMBS

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

### 2.9.9 MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

**I.** Motor neurone disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico spinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

### 2.9.10 MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

- **i.** Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis and
- **ii.** There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

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

### 2.9.11 THIRD DEGREE BURNS

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

**2.9.12 MAJOR HEAD TRAUMA**

**I.** Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

**II.** The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

**III.** The Activities of Daily Living are:

a. **Washing**: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
b. **Dressing**: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
c. **Transferring**: the ability to move from a bed to an upright chair or wheelchair and vice versa;
d. **Mobility**: the ability to move indoors from room to room on level surfaces;
e. **Toileting**: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
f. **Feeding**: the ability to feed oneself once food has been prepared and made available.

**IV.** The following are excluded:

- Spinal cord injury;

**2.9.13 END STAGE LUNG FAILURE**

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
d. Dyspnea at rest.

**2.9.14 END STAGE LIVER FAILURE**

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

a. Permanent jaundice; and
b. Ascites; and
c. Hepatic encephalopathy.

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

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

**2.11 DAY CARE CENTRE** means any institution established for day care treatment of Illness or Injury, or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- has qualified nursing staff under its employment
- has qualified Medical Practitioner(s) in charge

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

**2.12 DAY CARE TREATMENT** refers to medical treatment or Surgery which are:

- undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a Hospitalisation of more than 24 hours.

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

**2.13 DENTAL TREATMENT** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and Surgery.

**2.14 DISCLOSURE TO INFORMATION NORM**: The policy shall be void and all premium paid thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

**2.15 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 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.

**2.17 HOSPITAL** means any institution established for Inpatient Care and Day Care Treatment of Illness 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 qualified nursing staff under its employment round the clock;
- Has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;
- Has qualified Medical Practitioner(s) in charge round the clock;
- Has a fully equipped operation theatre of its own where Surgery is carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

**2.18 HOSPITALISATION** means admission as an Inpatient in a Hospital for a minimum period of 24 consecutive hours except for the procedures/ treatments mentioned in Annexure I, where such admission could be for a period of less than 24 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 24 hours.

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

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before

suffering the disease/ illness/ injury which leads to full recovery.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
   a. it needs ongoing or long-term monitoring through consultations, examinations, 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

**2.20 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.

**2.21 INPATIENT CARE** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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

**2.23 ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

**2.24 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 Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable, if You had not been Insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

**2.26 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 You;
- 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.

**2.27 MEDICAL PRACTITIONER** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the license.

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

**2.28 MATERNITY EXPENSES** shall mean:

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

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

**2.29 MEDICAL PRACTITIONER** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

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

**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 enlisted by Us, TPA or jointly by Us and TPA to provide medical services to an insured by a cashless facility.

**2.32 NON-NETWORK PROVIDER** means any hospital 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 OPD TREATMENT** is one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

**2.36 PRE-EXISTING DISEASE (PED)** means any condition, ailment, Injury or Illness

**a.** That is/are diagnosed by a physician within 24 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 24 months prior to the effective date of the Policy or its reinstatement.

**2.37 PRE-HOSPITALISATION MEDICAL EXPENSES** means Medical Expenses incurred, for Any One Illness, immediately before the Insured Person is Hospitalised, provided that:

**i.** Such Medical Expenses are incurred 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 Us.

**iii.** Such Medical Expenses are incurred not earlier than sixty days before the Date of Hospitalisation.

**2.38 POST-HOSPITALISATION MEDICAL EXPENSES** means Medical Expenses incurred, for Any One Illness, immediately after the Insured Person is discharged from the Hospital, provided that:

**i.** Such Medical Expenses are incurred for the same condition for which the Insured Person's

Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

iii. Such Medical Expenses are incurred not later than ninety days after the date of discharge from the Hospital.

**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 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.

**2.41 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.

**2.42 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.

**2.43 ROOM RENT** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

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

## SPECIFIC DEFINITIONS

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

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

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

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

**2.50 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.

**2.51 CANCELLATION** defines the terms on which the Policy contract can be terminated either by Us or You by giving sufficient notice to other which is not lower than a period of fifteen days.

**2.52 CLAIM FREE YEAR** means coverage under this 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 any Insured Person under any Clause of SECTION III.

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

**2.54 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;

**2.55 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

**2.56 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.

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

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

**2.59 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

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

**2.61 SUM INSURED** means the amount specified in the Policy Schedule, which represents Our maximum, total and cumulative liability for in respect of the Insured Person for any and all claims incurred during the policy year.

**Note**: Sum Insured as shown in the schedule excluding Cumulative Bonus.

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

**2.63 WAITING PERIOD** means a period from the inception of first 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 Person or the first Insured Person (if more than one) in the Schedule.

# 3.0 HOW MUCH WE WILL REIMBURSE

**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, our liability for claims admitted under this Policy shall not exceed aggregate of Sum Insured and Cumulative Bonus. Subject to this, we will reimburse the following Reasonable and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

| | |
|---|---|
| **3.1 (a)** | Single AC Room including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) as provided by the hospital |
| **3.1 (b)** | Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses. |
| **3.1 (c)** | Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment. |
| **3.1 (d)** | Cost of Pharmacy and Consumables including Anaesthesia, Blood and Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics. |
| **3.1 (e)** | Pre-Hospitalization Medical expenses up to 60 days prior to the date of admission to the hospital |

| | |
|---|---|
| **3.1 (f)** | Post-Hospitalization Medical expenses upto 90 days from the date of discharge from the hospital. |

**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 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 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 under expiring Policy only. Sum Insured of the Renewed Policy will not be considered for the claim event which has commenced in the expiring Policy.

**3.4 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 liability towards expenses incurred on the donor and the Insured recipient shall not exceed the available Sum Insured.

**3.5 HOSPITAL CASH**

We will pay Hospital Cash Rs. 500/- for each day of Hospitalisation admissible under the Policy. The payment under this Clause shall be for maximum five days for Any One Illness.

The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty-four hours. Payment under this Clause will reduce the Sum Insured.

Hospital cash will be payable for completion of every 24 hours and not part thereof.

**3.6 ROAD AMBULANCE CHARGES**

We will pay You the charges incurred towards Ambulance Services Reasonably incurred for shifting any Insured Person to Hospital for admission, or from one Hospital to another Hospital for Any One Illness not exceeding 1% of the Sum Insured up to a maximum of Rs. 5,000/-.

However, if an Insured Person, at the time of discharge from the Hospital, has to be shifted to their place of residence in an Ambulance, such expenses will also be reimbursed additionally at 1% of Sum Insured maximum up to Rs. 5,000, provided the requirement of an Ambulance is certified by the Medical Practitioner.

**3.7 TREATMENT FOR CONGENITAL DISEASES**

**Congenital Internal Disease** or Defects or anomalies, except those related to Genetic disorders, shall be covered up to Sum Insured, after **twelve months** of Continuous Coverage, if it is unknown to You or to the Insured Person at the commencement of such Continuous Coverage.

The requirement for Continuous Coverage for **twelve months** would not apply to a New Born Baby during the year of birth and also in subsequent renewals, provided Premium is paid for such New Born Baby at the time of renewal and the renewals are effected before or within the Grace Period of expiry of the Policy.

**Congenital External Disease** or Defects or anomalies shall be covered after **twenty-four** 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 preceding **twenty-four** months.

**3.8 COVERAGE FOR CATARACT:**

Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye/per insured shall not exceed 10% of the Sum Insured or Rs. 50,000/- whichever is less.

**3.9 COVERAGE FOR HAZARDOUS SPORTS**

We shall be liable to pay expenses incurred towards treatment of any Injury or Illness arising out of the following hazardous sports:

Bobsledding; Bungee Jumping; Canopying; Hang Gliding; Heli-skiing; Horseback Riding; Jet, Snow and Water Skiing; Kayaking; Martial Arts; Motorcycling; Mountain Biking; Mountain Climbing (under 14,000 feet); Paragliding; Parasailing; Safari; Scuba Diving, Skydiving; Snowboarding; Snowmobiling; Spelunking; Surfing; Trekking; White water Rafting; Wind Surfing; Zip Lining, Equestrian; Fencing; Rugby.

Our liability under this Clause shall not exceed 10% of the Sum Insured during a policy period.

However, if Injury or Illness is related to particular line of employment or occupation (not for recreational purpose), it will be covered up to Sum Insured.

Payment under this Clause is admissible only if the expenses are incurred in Hospital as In-Patient in India.

**3.10 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 25% 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 12 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 24 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub-limit of up to a maximum of 20% of sum insured per policy period.

d) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 24 months 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 24 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 |

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

**3.11 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) |
|---|---|---|
| 3.11.1 | Uterine Artery Embolization and HIFU (High intensity focused ultrasound) | Upto 20% of Sum Insured subject to a Maximum upto Rs. 1 Lakh |
| 3.11.2 | Balloon Sinuplasty | Upto 20% of Sum Insured subject to a Maximum upto Rs. 1 Lakh |
| 3.11.3 | Deep Brain stimulation | Upto 25% of Sum Insured subject to a maximum upto Rs. 2 Lakh |
| 3.11.4 | Oral chemotherapy | Upto 10% of Sum Insured subject to Maximum upto Rs. 50,000 |
| 3.11.5 | Immunotherapy- Monoclonal Antibody to be given as injection | Upto 25% of Sum Insured subject to a Maximum of Rs 2 Lakh. |
| 3.11.6 | Intravitreal injections | Upto 10% of Sum Insured subject to a Maximum of Rs.75,000. |
| 3.11.7 | Robotic surgeries | Upto 25% of Sum Insured subject to Maximum of Rs. 2 Lakh. |
| 3.11.8 | Stereotactic radio surgeries | Upto 25% of Sum Insured subject to Maximum Rs. 2 Lakh. |
| 3.11.9 | Bronchial Thermoplasty | Upto 25% of Sum Insured subject to Maximum of Rs. 1 Lakh. |
| 3.11.10 | Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) | Upto 25% of Sum Insured subject to Maximum of Rs. 1 Lakh. |
| 3.11.11 | IONM - (Intra Operative Neuro Monitoring) | Upto 5% of Sum Insured subject to Maximum of Rs. 30,000. |
| 3.11.12 | Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered | Upto 25% of Sum Insured subject to Maximum of Rs. 1.5 Lakh. |

**3.12 HEALTH CHECK-UP**

The Insured Person(s) shall be entitled for reimbursement of the cost of Medical check-up at the end of a block of every two Claim Free Years. Such payment shall be restricted to Rs. 3,500.

**Note:**

a) Any payment made under this clause shall not be considered as a Claim.
b) The unutilized amount under this benefit cannot be carried forward.
c) In case the Policy is issued on an Individual Sum Insured basis, the above limit shall be available individually to the Insured Person. In case the Policy is on Floater Sum Insured basis, the above limit shall be available to all Family Members on a Floater basis.

**3.13 MEDICAL SECOND OPINION:** In case of any Insured Person requires to undergo Surgery for any of the Critical Illnesses defined under section 2.9 of the Policy Clause, Consultation Expenses incurred on Medical Second Opinion shall be reimbursed up to a Maximum of Rs. 5,000/- during a Policy Period.

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

**3.14 REINSTATEMENT OF SUM INSURED**

If the Sum Insured is exhausted due to a claim(s) admissible and paid under the Policy, then the Sum Insured shall be reinstated, subject to the following conditions:

1. The Reinstatement of Sum Insured shall be upon full utilization of the Sum Insured.

2. The sequence of utilization of Sum Insured will be as below:
   a. Sum Insured;
   b. Cumulative Bonus (if any);
   c. Reinstated Sum Insured
3. The Reinstatement of Sum Insured shall be available for illnesses or Injuries other than for which Claim is paid or admissible during the Policy Period.
4. Such Reinstatement shall only be available once in a Policy Period and only for Policies issued on Individual Sum Insured basis.
5. Reinstatement of Sum Insured is not available for Modern Treatments listed under 3.11 of the Policy Clause.
6. The unutilized amount cannot be carried forward.

**3.15 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.

**3.16 CUMULATIVE BONUS**

Insured Person will be entitled for Cumulative Bonus of 25% at each claim free year of insurance, subject to maximum of 100%. 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.

**Note:**

i. In case where the policy is on individual basis, the CB shall be available individually to the insured person who has not claimed under the expiring policy.
ii. In case where the policy is on floater basis, the CB shall be available to the family on floater basis, provided no claim is reported under the expiring policy.
iii. CB shall be available only if the Policy is renewed within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis and the policy has been Renewed on a floater policy basis, the applicable CB for the renewed policy shall be the Lowest among all the Insured Persons.

v. 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.
vi. 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.
vii. 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 Expiring Policy.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB, if any, shall be reduced suitably.

You also have the option of opting for a premium discount at the time of renewal in lieu of the accrued Cumulative Bonus (if available). If you opt for a discount as above the accrued Cumulative Bonus will become zero. The Cumulative bonus in the range of 25% to 100% will have a discount in the base premium from 2.49% to 5.50%.

**3.17 NEW BORN BABY COVERAGE**

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 24 months Waiting Period. Waiting Period for Congenital Internal Disease would not apply to a New Born Baby during the year of birth and in subsequent renewals also, provided Premium is paid for such New Born Baby at the time of renewal and the renewals are effected before or within the Grace Period of expiry of the Policy.

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.

**3.18 DENTAL TREATMENT (Inpatient):** We will cover for medical expenses incurred towards dental treatment done under anesthesia necessitated due to an accident/injury/illness requiring Hospitalization as Inpatient treatment.

**3.19 SHARED ACCOMMODATION AS CASH BENEFIT:**

If you opt for a shared room (for which hospitalization claim is paid), we will pay an additional amount for each day's hospitalization. One day is considered as 24 continuous hours of hospitalization.

| Sum Insured Bands in Rs. | Shared Accommodation Cash Benefit |
|---|---|
| 4 lakhs | Rs. 400 per day |
| 8 & 12 lakhs | Rs. 750 per day |

**3.20 OPTIONAL COVER: 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.

# 4.0 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 24 months of continuous coverage after commencement of the policy.
- **b.** In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- **c.** If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- **d.** Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

**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 / 12 / 24 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) 12 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) 24 Months waiting period**

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of Mental Illness (ICD Code: F01-F29 & F60-F79)
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders
6. External Congenital Diseases

**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

**Note**: This cover if admissible will carry a waiting period of 24 months from date of inception with us. Bariatric surgery/treatment performed for cosmetic reasons is excluded.

**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 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 3.11.12

**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 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.

# 5.0 GENERAL TERMS AND CLAUSES

## STANDARD GENERAL TERMS AND CLAUSES

### 5.1 CANCELLATION

The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

**a.** Refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

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

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

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

### 5.2 CONDITION PRECEDENT TO ADMISSION OF LIABILITY:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

**5.3 COMPLETE DISCHARGE**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

**5.4 DISCLOSURE OF INFORMATION**

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

**5.5 FRAUD**

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

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

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

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

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

**iii.** any other act fitted to deceive; and

**iv.** any such act or omission as the law specially declares to be fraudulent

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

**5.6 FREE LOOK PERIOD**

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

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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

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

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

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

**5.7 MULTIPLE POLICIES**

Claims in respect of multiple Policies held by policyholders:

**1. Indemnity Policies:**

a) If a policyholder has more than one health insurance policy from different insurers he/she can file for claim settlement as per his/her choice under any policy.

b) The Insurer of that chosen policy shall be treated as the primary Insurer.

c) In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder, his/her choice of the other insurer(s) and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

2. Benefit based Policies: On occurrence of the insured event the policyholder, can claim from all Insurers under all policies.

**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 15 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.** "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.

**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 provide notice for renewal 30 days in advance from the due date.
- **ii.** Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- **iii.** Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- **iv.** At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
- **v.** No loading shall apply on renewals based on individual claims experience.
- **vi.** There shall be no fresh underwriting unless there is increase in sum insured.

**5.12 WITHDRAWAL OF POLICY**

- **i.** 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.** lnsured 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 can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy.

**Portability:**

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy.

## SPECIFIC TERMS AND CLAUSES

**5.16 BASIS OF INSURANCE:**

This Policy is issued on the basis of the truth and accuracy of statements in the Proposal. If there

is any misrepresentation or non-disclosure, we will be entitled to treat the Policy as void.

**5.17 PREMIUM:**

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

**5.18 PLACE OF TREATMENT AND PAYMENT:**

This Policy covers medical/surgical treatment and/or 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 SETTLEMENT/REJECTION OF CLAIM:**

**i.** We shall settle or reject a claim, as may be the case, within fifteen 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 5.21, 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 seven days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.

- **a.** In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.
- **b.** In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.
- **c.** The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.
- **d.** If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.
- **e.** In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer.

**5.21 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 Hospitalization.

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

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

**i.** Bill, Receipt and Discharge certificate / card from the Hospital.

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

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

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

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

**d.** In case of post-Hospitalisation treatment (limited to sixty days), submit all claim documents within 7 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.

**5.22** 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 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.

**5.24 ENHANCEMENT OF SUM INSURED:**

You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted as per the Company's underwriting guidelines.

Enhancement of Sum Insured will not be considered for:

**1)** Any Insured Person over 65 years of age.

**2)** Any Insured Person suffering from any Critical Illness and Recurring 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 CUMULATIVE BONUS:**

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

**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 PREMIUM PAYMENT IN INSTALLMENTS**

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy).

1. The instalment premium shall be paid on or before the due date as mentioned in the Policy Schedule.
2. Grace Period of 15 days for monthly instalment and 30 days for quarterly and half-yearly mode will be given to pay the installment premium due for the Policy. During such Grace Period, Coverage will be available.
3. If the instalment premium is not paid within the Grace Period, then policy shall cease to exist at midnight of such due date and will be treated as lapsed and company shall not be liable to pay any claim whatsoever.
4. In case of a claim, Policyholder will be liable to pay the balance premium due under the policy before the claim is Intimated.

**5.28 PROTECTION OF POLICY HOLDERS' INTEREST:**

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

**5.29 ZONE CLASSIFICATION**: For the purpose of policy issuance, the premium will be computed based on the Zone Opted by the Insured Person in the proposal form. Classification of Zones are as follows:

**Zone 1:** Delhi, National Capital Region (NCR), Mumbai, Mumbai Suburban, Thane and Navi Mumbai, Surat, Ahmedabad and Vadodara

**Zone 2:** Rest of India

**Conditions:**

**a.** Insured Person opting for Zone I can avail treatment anywhere in India and No Co-pay shall be applicable.

**b.** In case the Insured Person opting Zone II takes treatment in Zone I, Co-pay of 10% shall be

applicable on admissible claim.

**c.** Co-Pay shall not be applicable for immediate hospitalization arising out of Accident.

**d.** Co-Pay shall also not be applicable for Illness or Treatments having sub-limits.

**5.30** 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:**

| No | LIST OF DAY-CARE TREATMENTS | No | LIST OF DAY-CARE TREATMENTS |
|---|---|---|---|
| ENT | | General Surgery | |
| 1 | Stapedotomy | 148 | Infected keloid excision |
| 2 | Myringoplasty(Type I Tympanoplasty) | 149 | Incision of a pilonidal sinus / abscess |
| 3 | Revision stapedectomy | 150 | Infected sebaceous cyst |
| 4 | Labyrinthectomy for severe Vertigo | 151 | Infected lipoma excision |
| 5 | Stapedectomy under GA | 152 | Maximal anal dilatation |
| 6 | Ossiculoplasty | 153 | Surgical Treatment Of Haemorrhoids |
| 7 | Myringotomy with Grommet Insertion | 154 | Liver Abscess- catheter drainage |
| 8 | Tympanoplasty (Type III) | 155 | Fissure in Ano- fissurectomy |
| 9 | Stapedectomy under LA | 156 | Fibroadenoma breast excision |
| 10 | Revision of the fenestration of the inner ear. | 157 | Oesophageal varices Sclerotherapy |
| 11 | Tympanoplasty (Type IV) | 158 | ERCP – pancreatic duct stone removal |
| 12 | Endolymphatic Sac Surgery for Meniere's Disease | 159 | Perianal abscess I&D |
| 13 | Turbinectomy | 160 | Perianal hematoma Evacuation |
| 14 | Removal of Tympanic Drain under LA | 161 | Fissure in ano sphincterotomy |
| 15 | Endoscopic Stapedectomy | 162 | UGI scopy and Polypectomy oesophagus |
| 16 | Fenestration of the inner ear | 163 | Breast abscess I& D |
| 17 | Incision and drainage of perichondritis | 164 | Feeding Gastrostomy |
| 18 | Septoplasty | 165 | Oesophagoscopy and biopsy of growth oesophagus |
| 19 | Vestibular Nerve section | 166 | ERCP – Bile duct stone removal |
| 20 | Thyroplasty Type I | 167 | Ileostomy closure |
| 21 | Tympanoplasty (Type II) | 168 | Polypectomy colon |
| 22 | Reduction of fracture of Nasal Bone | 169 | Splenic abscesses Laparoscopic Drainage |
| 23 | Excision and destruction of lingual tonsils | 170 | UGI SCOPY and Polypectomy stomach |
| 24 | Conchoplasty | 171 | Rigid Oesophagoscopy for FB removal |
| 25 | Thyroplasty Type II | 172 | Feeding Jejunostomy |
| 26 | Tracheostomy | 173 | Colostomy |
| 27 | Excision of Angioma Septum | 174 | Ileostomy |
| 28 | Turbinoplasty | 175 | Colostomy closure |
| 29 | Incision & Drainage of Retro Pharyngeal Abscess | 176 | Submandibular salivary duct stone removal |
| 30 | Uvulo Palato Pharyngo Plasty | 177 | Pancreatic Pseudocysts Endoscopic Drainage |
| 31 | Palatoplasty | 178 | Subcutaneous mastectomy |
| 32 | Tonsillectomy without adenoidectomy | 179 | Excision of Ranula under GA |
| 33 | Adenoidectomy with Grommet insertion | 180 | Rigid Oesophagoscopy for dilation of benign Strictures |
| 34 | Adenoidectomy without Grommet insertion | 181 | Eversion of Sac |
| 35 | Vocal Cord lateralisation Procedure | 182 | 1. a) Unilateral |
| 36 | Incision & Drainage of Para Pharyngeal Abscess | 183 | b)Bilateral |
| 37 | Transoral incision and drainage of a pharyngeal abscess | 184 | Lord's plication |
| 38 | Tonsillectomy with adenoidectomy | 185 | Jaboulay's Procedure |
| 39 | Tracheoplasty | 186 | Scrotoplasty |
| 40 | Reconstruction Of The Middle Ear | 187 | Surgical treatment of varicocele |
| 41 | Mastoidectomy | 188 | Epididymectomy |
| 42 | Excision And Destruction Of Diseased Tissue Of The Nose | 189 | Circumcision for Trauma |

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|---|---|---|---|
| 43 | Incision (Opening) And Destruction (Elimination) Of The Inner Ear | 190 | Meatoplasty |
| 44 | Incision Of The Mastoid Process And Middle Ear | 191 | Intersphincteric abscess incision and drainage |
| 45 | Nasal Sinus Aspiration | 192 | Psoas Abscess Incision and Drainage |
| 46 | Other Microsurgical Operations On The Middle Ear | 193 | Thyroid abscess Incision and Drainage |
| 47 | Other Operations On The Auditory Ossicles | 194 | TIPS procedure for portal hypertension |
| 48 | Plastic Surgery To The Floor Of The Mouth | 195 | PAIR Procedure of Hydatid Cyst liver |
| 49 | Incision Of The Hard And Soft Palate | 196 | Excision of Cervical RIB |
| 50 | External Incision And Drainage In The Region Of The Mouth, Jaw And Face | 197 | Surgery for fracture Penis |
| 51 | Other Operations On The Salivary Glands And Salivary Ducts | 198 | Parastomal hernia |
| **Ophthalmology** | | 199 | Revision colostomy |
| 52 | Incision of tear glands | 200 | Prolapsed colostomy- Correction |
| 53 | Other operation on the tear ducts | 201 | Laparoscopic cardiomyotomy( Hellers) |
| 54 | Incision of diseased eyelids | 202 | Laparoscopic pyloromyotomy( Ramstedt) |
| 55 | Excision and destruction of the diseased tissue of the eyelid | 203 | Orchiectomy |
| 56 | Removal of foreign body from the lens of the eye. | 204 | Incision Of The Breast |
| 57 | Corrective surgery of the entropion and ectropion | 205 | Operations On The Nipple |
| 58 | Operations for pterygium | 206 | Incision And Excision Of Tissue In The Perianal Region |
| 59 | Corrective surgery of blepharoptosis | 207 | Surgical Treatment Of Anal Fistulas |
| 60 | Removal of foreign body from conjunctiva | 208 | Division Of The Anal Sphincter (Sphincterotomy) |
| 61 | Removal of Foreign body from cornea | 209 | Glossectomy |
| 62 | Incision of the cornea | 210 | Reconstruction Of The Tongue |
| 63 | Other operations on the cornea | 211 | Incision, Excision And Destruction Of Diseased Tissue Of The Tongue |
| 64 | Operation on the canthus and epicanthus | 212 | Operations On The Seminal Vesicles |
| 65 | Removal of foreign body from the orbit and the eye ball. | 213 | Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens |
| 66 | Surgery for cataract | 214 | Local Excision And Destruction Of Diseased Tissue Of The Penis |
| 67 | Treatment of retinal lesion | 215 | Other Operations On The Penis |
| 68 | Removal of foreign body from the posterior chamber of the eye | 216 | Other Excisions Of The Skin And Subcutaneous Tissues |
| **Oncology** | | 217 | Other Incisions Of The Skin And Subcutaneous Tissues |
| 69 | IV Push Chemotherapy | 218 | Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues |
| 70 | Continuous Infusional Chemotherapy | 219 | Free Skin Transplantation, Donor Site |
| 71 | Infusional Chemotherapy | 220 | Free Skin Transplantation, Recipient Site |
| 72 | CCRT-Concurrent Chemo + RT | 221 | Reconstruction Of The Testis |
| 73 | SRS- Stereotactic radiosurgery | 222 | Incision Of The Scrotum And Tunica Vaginalis Testis |
| 74 | TBI- Total Body Radiotherapy | 223 | Excision In The Area Of The Epididymis |
| 75 | Adjuvant Radiotherapy | 224 | Revision Of Skin Plasty |
| 76 | Radical chemotherapy | 225 | Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues |
| 77 | Neoadjuvant radiotherapy | 226 | Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues |
| 78 | Palliative Radiotherapy | **Orthopedics** | |

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|---|---|---|---|
| 79 | Radical Radiotherapy | 227 | Arthroscopic Repair of ACL tear knee |
| 80 | Palliative chemotherapy | 228 | Arthroscopic repair of PCL tear knee |
| 81 | Neoadjuvant chemotherapy | 229 | Tendon shortening |
| 82 | Adjuvant chemotherapy | 230 | Arthroscopic Meniscectomy – Knee |
| 83 | Induction chemotherapy | 231 | Treatment of clavicle dislocation |
| 84 | Consolidation chemotherapy | 232 | Arthroscopic meniscus repair |
| 85 | Maintenance chemotherapy | 233 | Haemarthrosis knee- lavage |
| **Urology** | | 234 | Abscess knee joint drainage |
| 86 | AV fistula | 235 | Repair of knee cap tendon |
| 87 | URSL with stenting | 236 | ORIF with K wire fixation- small bones |
| 88 | URSL with lithotripsy | 237 | ORIF with plating- Small long bones |
| 89 | ESWL | 238 | Arthrotomy Hip joint |
| 90 | Haemodialysis | 239 | Syme's amputation |
| 91 | Cystoscopy and removal of polyp | 240 | Arthroplasty |
| 92 | Excision of urethral diverticulum | 241 | Partial removal of rib |
| 93 | Removal of urethral Stone | 242 | Treatment of sesamoid bone fracture |
| 94 | Ureter endoscopy and treatment | 243 | Amputation of metacarpal bone |
| 95 | Surgery for pelvi ureteric junction obstruction | 244 | Repair / graft of foot tendon |
| 96 | Injury prepuce- circumcision | 245 | Revision/Removal of Knee cap |
| 97 | Frenular tear repair | 246 | Remove/graft leg bone lesion |
| 98 | Meatotomy for meatal stenosis | 247 | Repair/graft achilles tendon |
| 99 | Surgery for fournier's gangrene scrotum | 248 | Biopsy elbow joint lining |
| 100 | Surgery filarial scrotum | 249 | Biopsy finger joint lining |
| 101 | Surgery for watering can perineum | 250 | Tendon lengthening |
| 102 | Repair of penile torsion | 251 | Surgery of bunion |
| 103 | Drainage of prostate abscess | 252 | Tendon transfer procedure |
| 104 | Cystoscopy and removal of FB | 253 | Removal of knee cap bursa |
| 105 | Transurethral Excision And Destruction Of Prostate Tissue | 254 | Treatment of fracture of ulna |
| 106 | Transurethral And Percutaneous Destruction Of Prostate Tissue | 255 | Treatment of scapula fracture |
| 107 | Open Surgical Excision And Destruction Of Prostate Tissue | 256 | Removal of tumor of arm/ elbow under RA/GA |
| 108 | Radical Prostatovesiculectomy | 257 | Repair of ruptured tendon |
| 109 | Other Excision And Destruction Of Prostate Tissue | 258 | Revision of neck muscle ( Torticollis release ) |
| 110 | Incision Of The Prostate | 259 | Treatment fracture of radius & ulna |
| 111 | Incision And Excision Of Periprostatic Tissue | 260 | Incision On Bone, Septic And Aseptic |
| 112 | Other Operations On The Prostate | 261 | Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis |
| **Gynaecology** | | 262 | Reduction Of Dislocation Under Ga |
| 113 | Hysteroscopic removal of myoma | **Paediatric surgery** | |
| 114 | D&C | 263 | Vaginoplasty |
| 115 | Hysteroscopic resection of septum | 264 | Dilatation of accidental caustic stricture oesophageal |
| 116 | Hysteroscopic adhesiolysis | 265 | Presacral Teratomas Excision |
| 117 | Polypectomy Endometrium | 266 | Removal of vesical stone |
| 118 | Hysteroscopic resection of fibroid | 267 | Excision Sigmoid Polyp |
| 119 | LLETZ | 268 | Sternomastoid Tenotomy |
| 120 | Conization | 269 | High Orchidectomy for testis tumours |
| 121 | Polypectomy cervix | 270 | Excision of cervical teratoma |
| 122 | Hysteroscopic resection of endometrial polyp | 271 | Rectal-Myomectomy |
| 123 | Vulval wart excision | 272 | Rectal prolapse (Delorme's procedure) |
| 124 | Laparoscopic paraovarian cyst excision | 273 | Orchidopexy for undescended testis |

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|---|---|---|---|
| 125 | Uterine artery embolization | 274 | Detorsion of torsion Testis |
| 126 | Bartholin Cyst excision | 275 | Lap.Abdominal exploration in cryptorchidism |
| 127 | Laparoscopic cystectomy | 276 | EUA + biopsy multiple fistula in ano |
| 128 | Endometrial ablation | 277 | Excision of fistula-in-ano |
| 129 | Vaginal wall cyst excision | Others | |
| 130 | Vulval cyst Excision | 278 | Coronary Angiography |
| 131 | Laparoscopic paratubal cyst excision | 279 | Ultrasound Guided Aspirations |
| 132 | Hysteroscopy, removal of myoma | 280 | Chemosurgery To The Skin |
| 133 | TURBT | | |
| 134 | Laparoscopic Myomectomy | | |
| 135 | Surgery for SUI | | |
| 136 | Pelvic floor repair( excluding Fistula repair) | | |
| 137 | Laparoscopic oophorectomy | | |
| 138 | Incision Of The Ovary | | |
| 139 | Insufflation Of The Fallopian Tubes | | |
| 140 | Dilatation Of The Cervical Canal | | |
| 141 | Conisation Of The Uterine Cervix | | |
| 142 | Hysterotomy | | |
| 143 | Therapeutic Curettage | | |
| 144 | Culdotomy | | |
| 145 | Incision Of The Vagina | | |
| 146 | Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas | | |
| 147 | Incision Of The Vulva | | |

**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 |

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|---|---|
| 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

The updated details of Insurance Ombudsman are available on **https://www.cioins.co.in/Ombudsman**

| | |
|---|---|
| AHMEDABAD –<br>**Office of the Insurance Ombudsman,Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road,**<br>**Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06**<br>Email: bimalokpal.ahmedabad@cioins.co.in<br>Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu. | BHOPAL -<br>**Office of the Insurance Ombudsman,**<br>**Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar,**<br>**Opp. Airtel Office, Near New Market, Bhopal – 462 003.**<br>**Tel.: 0755 - 2769201 / 2769202**<br>**Fax: 0755 - 2769203**<br>**Email: bimalokpal.bhopal@cioins.co.in**<br>Jurisdiction : Madhya Pradesh, Chhattisgarh. |
| BHUBANESHWAR –<br>**Office of the Insurance Ombudsman,**<br>**62, Forest park, Bhubneshwar – 751 009.**<br>**Tel.: 0674 - 2596461 /2596455**<br>**Fax: 0674 - 2596429**<br>**Email: bimalokpal.bhubaneswar@cioins.co.in**<br>Jurisdiction : Odisha | CHANDIGARH –<br>**Office of the Insurance Ombudsman,**<br>**S.C.O. No. 101, 102 & 103, 2nd Floor,**<br>**Batra Building, Sector 17 – D, Chandigarh – 160 017.**<br>**Tel.: 0172 - 2706196 / 2706468**<br>**Fax: 0172 - 2708274**<br>**Email: bimalokpal.chandigarh@cioins.co.in**<br>Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh. |
| CHENNAI –<br>**Office of the Insurance Ombudsman,**<br>**Fatima Akhtar Court, 4th Floor, 453,**<br>**Anna Salai, Teynampet, CHENNAI – 600 018.**<br>**Tel.: 044 - 24333668 / 24335284**<br>**Fax: 044 - 24333664**<br>**Email: bimalokpal.chennai@cioins.co.in**<br>Jurisdiction : Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry). | DELHI -<br>**Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,**<br>**Asaf Ali Road, New Delhi – 110 002.**<br>**Tel.: 011 - 23232481/23213504**<br>**Email: bimalokpal.delhi@cioins.co.in**<br>Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh. |
| GUWAHATI –<br>**Office of the Insurance Ombudsman,**<br>**Jeevan Nivesh, 5th Floor,**<br>**Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).**<br>**Tel.: 0361 - 2632204 / 2602205**<br>**Email: bimalokpal.guwahati@cioins.co.in**<br>Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. | HYDERABAD –<br>**Office of the Insurance Ombudsman,**<br>**6-2-46, 1st floor, "Moin Court",**<br>**Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.**<br>**Tel.: 040 - 67504123 / 23312122**<br>**Fax: 040 - 23376599**<br>**Email: bimalokpal.hyderabad@cioins.co.in**<br>Jurisdiction : Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry. |
| ERNAKULAM –<br>**Office of the Insurance Ombudsman,**<br>**2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,**<br>**Ernakulam - 682 015.**<br>**Tel.: 0484 - 2358759 / 2359338**<br>**Fax: 0484 - 2359336**<br>**Email: bimalokpal.ernakulam@cioins.co.in**<br>Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. | KOLKATA -<br>**Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.**<br>**Tel.: 033 - 22124339 / 22124340**<br>**Fax : 033 - 22124341**<br>**Email: bimalokpal.kolkata@cioins.co.in**<br>Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands. |
| LUCKNOW –<br>**Office of the Insurance Ombudsman,**<br>**6th Floor, Jeevan Bhawan, Phase-II,**<br>**Nawal Kishore Road, Hazratganj, Lucknow - 226 001.**<br>**Tel.: 0522 - 2231330 / 2231331**<br>**Fax: 0522 - 2231310**<br>**Email: bimalokpal.lucknow@cioins.co.in**<br>**Jurisdiction : Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur,** | MUMBAI –<br>**Office of the Insurance Ombudsman,**<br>**3rd Floor, Jeevan Seva Annexe,**<br>**S. V. Road, Santacruz (W), Mumbai - 400 054.**<br>**Tel.: 022 - 26106552 / 26106960**<br>**Fax: 022 - 26106052**<br>**Email: bimalokpal.mumbai@cioins.co.in**<br>**Jurisdiction :** List of wards **under Mumbai Metropolitan Region excluding wards in Mumbai –** |

| | |
|---|---|
| **Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.** | **i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.** |
| JAIPUR –<br>**Office of the Insurance Ombudsman,**<br>**Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg,**<br>**Jaipur - 302 005.**<br>**Tel.: 0141 - 2740363**<br>**Email: bimalokpal.jaipur@cioins.co.in**<br>**Jurisdiction : Rajasthan** | PUNE -<br>**Office of the Insurance Ombudsman,**<br>**Jeevan Darshan Bldg., 3rd Floor,**<br>**C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.**<br>**Tel.: 020-41312555**<br>**Email: bimalokpal.pune@cioins.co.in**<br>**Jurisdiction : State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region** |
| BENGALURU –<br>**Office of the Insurance Ombudsman,**<br>**Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road,**<br>**JP Nagar, Ist Phase, Bengaluru – 560 078.**<br>**Tel.: 080 - 26652048 / 26652049**<br>**Email: bimalokpal.bengaluru@cioins.co.in**<br>**Jurisdiction :Karnataka.** | NOIDA –<br>**Office of the Insurance Ombudsman,**<br>**Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.**<br>**Tel.: 0120-2514250 / 2514252 / 2514253**<br>**Email: bimalokpal.noida@cioins.co.in**<br>**Jurisdiction : State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.** |
| PATNA -<br>**Office of the Insurance Ombudsman,**<br>**1st Floor,Kalpana Arcade Building,,**<br>**Bazar Samiti Road, Bahadurpur, Patna 800 006.**<br>**Tel.: 0612-2680952**<br>**Email: bimalokpal.patna@cioins.co.in**<br>**Jurisdiction : Bihar, Jharkhand.** | THANE –<br>**Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604**<br>**Email: bimalokpal.thane@cioins.co.in Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District**<br>**and wards of Mumbai, M/East, M/West, N, S and T."** |