NEW INDIA ASHA KIRAN POLICY

1. PREAMBLE

This is Your **NEW INDIA ASHA KIRAN Policy**, which has been issued by Us, relying on the information disclosed by You in Your Proposal for this Policy or its preceding Policy/Policies of which this is a renewal.

The terms set out in this Policy and its schedule will be the basis for any claim and/or benefit under this Policy.

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

What We Cover

SECTION I

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

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

In this Policy all the members as stated in the Policy Schedule will be covered under Single Sum Insured. This Sum Insured will be available for all claims by one or more persons covered in this policy.

SECTION II

i. Accidental Death

ii. Loss of one limb and one eye or loss of both eyes or loss of both limbs

iii. Loss of one limb or one eye

Permanent Total Disablement other than mentioned above.

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 forty-five days from the date of last consultation with the Hospital where treatment has 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 representative.

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

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

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

c. 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

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

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

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

a. **CANCER 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,

premalignant, 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.

b. MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIED SEVERITY)

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

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.

II. 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.

c. 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

d. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s).

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.

e. 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.

f. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

g. STROKE RESULTING IN PERMANENT SYMPTOMS

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

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

h. 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

i. 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.

j. 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.

k. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. Investigations including typical MRI 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. Neurological damage such as SLE is excluded.

2.10 CO-PAYMENT A co-payment is a cost-sharing requirement under a Health insurance policy that provides that the Insured Person will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

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

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

2.16 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.

2.17 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.

2.18 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 Inpatient beds in all other places;
- Has qualified Medical Practitioner(s) in charge round the clock;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

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

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

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

   a. it needs ongoing or long-term monitoring through consultations, examinations,

checkups, and / or tests

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

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

d. it continues indefinitely

e. it recurs or is likely to recur

2.21 INJURY means accidental physical bodily harm excluding Illness solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

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

2.23 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(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.24 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.

2.25 MATERNITY EXPENSES shall mean:

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

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

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

2.27 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.

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

- Is required for the medical management of the Illness or Injury suffered by 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.

2.29 MENTAL HEALTH ESTABLISHMENT means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established,

owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends;

2.30 MENTAL HEALTH PROFESSIONAL means

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

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

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

2.31 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 licence.

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

2.32 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.

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

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

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

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

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

b. For which medical advice or treatment was recommended by, or received from, a physiciannot more than 36 months prior to the date of commencement of policy

2.37 PRE-HOSPITALISATION MEDICAL EXPENSES means Medical Expenses incurred during the period of 30 days preceding Your Hospitalisation, provided that:

a. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and

b. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us.

2.38 POST-HOSPITALISATION MEDICAL EXPENSES means Medical Expenses incurred during the period of 60 days immediately after Your discharge from the Hospital provided that:

a. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and

b. The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

2.39 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.

2.40 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.

2.41 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 and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

SPECIFIC DEFINITIONS

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

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

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

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

2.55 PERMANENT TOTAL DISABLEMENT means such disablement of a permanent nature, as incapacities of Insured Person for all work which he/she was capable of performing at the time of the Accident resulting in such disablement.

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 coverages, exclusions and 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** is the maximum amount of coverage under this Policy opted cumulatively for You and all Insured Persons shown in the Schedule.

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

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

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

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. BENEFITS COVERED UNDER THE POLICY

SECTION - I

3.1 Our liability for all claims admitted during the Period of Insurance in respect of all Insured Persons shall not exceed the Sum Insured. Subject to this, for each claim We will reimburse the following Reasonable and Customary and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection/Drugs and Intra venous fluid administration expenses), not exceeding 1% of the Sum Insured per day.
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the Sum Insured per day.
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
3.1 (d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
3.1 (e)	Pre-Hospitalization Medical Expenses, not exceeding thirty days
3.1 (f)	Post-Hospitalization Medical Expenses, not exceeding sixty days
3.1 (g)	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.

3.1 (h) <u>MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:</u>

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

3.1 (i) <u>MEDICAL EXPENSES FOR ORGAN TRANSPLANT:</u>

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 aggregate of the Sum Insured, if any, of the Insured Person receiving the organ.

3.1 (j) Dental Treatment (Inpatient): We will cover for medical expenses incurred towards dental treatment done under anaesthesia necessitated due to an accident / injury / illness requiring Hospitalization as Inpatient treatment.

3.2 LIMIT ON PAYMENT FOR CATARACT

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

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

3.3 COVERAGE FOR AYUSH TREATMENT

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

3.4 HOSPITAL CASH

We will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation, admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty-four consecutive hours. Payment under this Clause shall reduce the Sum Insured.

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

3.5 CRITICAL CARE BENEFIT

If during the Period of Insurance any Insured Person discovers that he or she is suffering from any Critical Illnesses as defined under 2.9, which results in a claim admissible under this Policy, 10% of the Sum Insured would be paid as Critical Care Benefit along with the admissible claim amount.

Critical Care Benefit is payable only once in the life time of each Insured Person and is not applicable to any Insured Persons for whom it is a Pre- Existing Condition/Disease.

Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

3.6 PAYMENT OF AMBULANCE CHARGES

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

3.7 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

No payment shall be made for any Hospitalisation expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anaesthetist directly and not

included in the Hospital Bill shall be paid provided a numbered Bill is produced in support thereof, for an amount not exceeding Rs. Ten thousand, where such payment is made in cash and for an amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

3.8 TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies shall be covered after twenty-four months of Continuous Coverage. If it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. Exclusion for Congenital Internal Disease or Defects or Anomalies would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

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

3.9 OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

On payment of additional Premium as mentioned in the Schedule, it is hereby agreed and declared that Clause 3.1(g) stands deleted for the members covered in the Policy as stated in the Schedule. This optional cover is available for sum insured of Rs.2 lakhs and above You shall continue to bear the differential between actual and eligible Room Rent.

3.10 OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

On the payment of additional Premium as mentioned in the Schedule, it is hereby agreed and declared that Clause 4.4.15 stands deleted for Insured Person as mentioned in the Schedule. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years. This Optional Cover is available for Sum Insured 5 Lakhs & above.

Special conditions applicable to Maternity Expenses Benefit:

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

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

3.11 OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This optional cover, if opted, will be in addition to limit specified in Clause 3.2. This Optional Cover is available for Sum Insured 8 Lakhs & above.

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

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

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

3.12 OPTIONAL COVER IV: NON-MEDICAL ITEMS (CONSUMABLES)

On payment of additional Premium as mentioned in the 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 Lakhs and above.

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

3.13 SPECIFIC COVERAGES:

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

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

c) **Age Related Macular Degeneration (ARMD)** is covered after 36 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub- limit of 10% of Sum Insured, maximum up to Rs. 75,000 per policy period.

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

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

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

3.14 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)
3.14.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
3.14.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
3.14.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh
3.14.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
3.14.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 1 Lakh.
3.14.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.30,000.
3.14.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 2 Lakh.
3.14.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.14.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.14.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.14.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 25,000.
3.14.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.

3.15 CO-PAYMENT FOR CHANGE IN ZONE:

Where the Insured Person is treated in a hospital situated outside the Area of Coverage as stated in the Schedule, our liability will be:

a) 80% of the admissible claim amount, (or)

b) Sum Insured.

Whichever is less.

SECTION II: PERSONAL ACCIDENT (APPLICABLE TO PROPOSER AND SPOUSE)

3.16 If the Proposer and/or Spouse shall sustain any bodily Injury resulting solely and directly from Accident then We shall pay to dependent daughter(s) as specified in the schedule, the sum hereinafter set forth that is to say:

If such Injury shall within twelve calendar months of its occurrence be the sole and direct cause of

S. No.	COVERAGE		COMPENSATION
3.16.1	Death of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.16.2	Permanent Total Disablement of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.16.3	Loss of both eyes/Loss of both limbs /Loss of one limb and one eye of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.16.4	Loss of one limb / one eye of	Proposer or Spouse	50% of Sum Insured
		Proposer and Spouse	100% of Sum Insured

If the dependent daughter(s) specified in the schedule, is/are minor at the time of claim, then the money will be deposited as fixed deposit in a Nationalized Bank, to be paid to daughter(s) after attaining majority.

Note: The Company shall not be liable under this Policy for Compensation under more than one of the sub-clauses 3.16.1, 3.16.2, 3.16.3 or 3.16.4 in respect of same Injury or disablement.

In the event of unfortunate death of all the Insured Persons specified in the policy, no such benefits shall be payable under this Section.

Any payment under this Clause would be in addition to the Sum Insured mentioned in the Schedule and shall not deplete the Sum Insured.

4. EXCLUSIONS

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

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

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

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

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

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 24 months / 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for preexisting diseases, then the longer of the two waiting periods shall apply.

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

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

i. 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

ii. 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele

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

iii. 36 Months waiting period

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

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4 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 comorbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4.4.4 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 policy holders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

4.4.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such

establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

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

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

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

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

SPECIFIC EXCLUSIONS

4.4.16 Acupressure, acupuncture, magnetic therapies.

4.4.17 Any expenses incurred on Domiciliary Hospitalization.

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

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

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

4.4.21 Convalescence and General debility.

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

4.4.23 External Medical / Non-medical equipment used for diagnosis and/or treatment including CPAP/BIPAP, Oxygen Concentrator, Infusion pump , Ambulatory devices

(walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads) and sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

4.4.24 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

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

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

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

4.4.25 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.14.12.

4.4.26 Treatments such as 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.

4.4.30 Payment or compensation in respect of death, Injury or disablements directly or indirectly arising out of or contributed to or traceable to any disability already existing on the date of commencement of this policy.

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

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

5. GENERAL TERMS AND CLAUSES

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. refunds 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

Not with standing anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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

5.2 CONDITION PRECEDENT TO ADMISSION OF LIABILITY:

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

5.3 COMPLETE DISCHARGE

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

5.4 DISCLOSURE OF INFORMATION

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

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

5.5 FRAUD

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

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

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

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

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

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

iii. any other act fitted to deceive; and

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

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

5.6 FREE LOOK PERIOD

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

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

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

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

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

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

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

5.7 MULTIPLE POLICIES

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

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

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

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

5.8 MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration in health insurance policy), no policy and claim shall be contestable by the insurer on grounds of non-disclosure, mis-representation except on grounds of established fraud. This period of sixty continuous months is called as Moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sum insured only on the enhanced limit.

5.9 NOMINATION:

The policyholder is required at the inception of the policy to make a nomination. In the event of death of the policyholder, the claim proceeds will be paid to the nominee. Nomination can be changed at any time during the term of the policy. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made and in case there is no subsisting nominee, the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

5.10 CLAIM SETTLEMENT (PROVISION FOR PENAL INTEREST)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

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

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

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

5.11 RENEWAL OF POLICY

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

a. The company shall endeavor to give notice for renewal. However, the company is not under obligation to give any notice for renewals.

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

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

d. 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.

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

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

5.12 WITHDRAWAL OF POLICY

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

5.13 POSSIBILITY OF REVISION OF TERMS OF THE POLICY, INCLUDING THE PREMIUM RATES

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

5.14 REDRESSAL OF GRIEVANCE

In case of any grievance the insured person may contact the company through
Website: https://www.newindia.co.in/portal/readMore/Grievances
Toll free telephone no.: 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, waiting period of pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy.

Portability:

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period, waiting period of pre-existing diseases, moratorium period etc. in the previous policy from the existing insurer to the acquiring insurer.

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. Any expense incurred for Diagnostic tests outside India would not be covered under this Policy.

Admissible claims shall be payable only in Indian Rupees.

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

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

5.19 COMMUNICATION:

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

For all other matters relating to the policy, communication must be sent to our Policy issuing office.

Communications you wish to rely upon must be in writing.

5.20 NOTICE OF CLAIM:

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

FOR PERSONAL ACCIDENT:

In case of death claim:

1. Nominee under the policy should immediately, but not later than 30 days of the incident, notify the policy issuing office.
2. Submit the claim form along with death certificate, post mortem report, police report and original policy.

In case of Injury claim:

1. Notify the policy issuing office immediately.
2. Submit Police report if any.
3. Submit claim form along with medical certificate certifying the disablement.

FOR HOSPITALISATION

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

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

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

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

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

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

Note: The above stipulations are not intended merely to prejudice Your claims, but their compliance is of utmost importance and necessity for Us to identify and verify all facts and surrounding circumstances relating to a claim and determine whether it is payable.

Waiver of delay may be considered in extreme cases of hardship, but only if it is proved to Our satisfaction, it was not possible for You or any other person to comply with the prescribed time-limit.

5.21 SETTLEMENT/REJECTION OF CLAIM:

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

ii. While efforts will be made by Us to not call for any document not listed in Clause 5.20, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.

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

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

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

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

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

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

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

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

5.22 Proof satisfactory to the Company shall be furnished of all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured Person on the occasion of any alleged Injury or complement when and so often as the same may reasonably be required on behalf of the Company and in the event of death, to make a post- mortem examination of the body of the insured and such evidence as the Company may from time to time require (including a post-mortem examination, if necessary) shall be furnished within the space of fourteen days after demand in writing.

5.23 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.

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

5.25 ENHANCEMENT OF SUM INSURED:

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

Enhancement of Sum Insured shall be allowed based on the following table:

Age <=50 years	Enhancement up to Sum Insured of 15 lakhs without Medical Examination
Age 51-60 Years	Enhancement by two slabs without Medical Examination
Age 51-60 Years	Enhancement up to 15 Lakhs with Medical Examination
Age 61-65 Years	Enhancement by one slab with Medical Examination

Enhancement of Sum Insured will not be considered for:

1) Insured Persons over 65 years of age.

2) Insured Person who had undergone Hospitalization in the preceding two years.

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

a) Any chronic Illness/ailment

b) Any recurring Illness/ailment

c) Any Critical Illness

In respect of any increase in Sum Insured, exclusion 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from the date of such increase.

5.26 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.27 CO-PAYMENT: Where the Insured Person is treated in a hospital situated outside the Area of Coverage (Zone) as stated in the Schedule, our liability will be:

a) 80% of the admissible claim amount, (or)

b) Sum Insured. Whichever is less.

5.28 ZONE CLASSIFICATION:

Each Zone Is Classified as Below: (The Cities mentioned below would include their Urban Agglomeration)

Zone- I	**Greater Mumbai** (includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli, Ulhasnagar, Ambarnath, Badlapur) and **State of Gujarat**
Zone-II	**Delhi NCR** (includes Faridabad, Gurgaon, Mewat, Rohtak, Sonepat, Rewari, Jhajjhar, Panipat and Palwal, Meerut, Ghaziabad, GautamBudha Nagar, Bulandshahr, and Baghpat, Alwar and NCT of Delhi), **Bangalore, Chennai, Hyderabad and Secunderabad, Pune and Kolkata**
Zone-III	**Rest of India (other than those areas specified in Zone I and II)**

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

ANNEXURE I: LIST OF DAY CARE PROCEDURES

1	Stapedotomy	2	Reconstruction Of The Middle Ear
3	Mastoidectomy	4	Labyrinthectomy for severe Vertigo
5	Stapedectomy	6	Ossiculoplasty
7	Myringotomy with Grommet Insertion	8	Tympanoplasty
9	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	10	Incision Of The Mastoid Process And Middle Ear
11	Other Microsurgical Operations On The Middle Ear	12	Endolymphatic Sac Surgery for Meniere's Disease
13	Turbinectomy	14	Removal of Tympanic Drain under LA
15	Fenestration of the inner ear	16	Incision and drainage of perichondritis
17	Septoplasty	18	Vestibular Nerve section
19	Thyroplasty	20	Reduction of fracture of Nasal Bone
21	Excision and destruction of lingual tonsils	22	Conchoplasty
23	Excision And Destruction Of Diseased Tissue Of The Nose	24	Tracheostomy
25	Excision of Angioma Septum	26	Turbinoplasty
27	Incision & Drainage of Pharyngeal Abscess	28	Uvulo Palato Pharyngo Plasty
29	Palatoplasty	30	Nasal Sinus Aspiration
31	Adenoidectomy with Grommet insertion	32	Adenoidectomy without Grommet insertion
33	Vocal Cord lateralisation Procedure	34	Tonsillectomy without adenoidectomy
35	Tonsillectomy with adenoidectomy	36	Tracheoplasty
37	Other Operations On The Auditory Ossicles	38	Plastic Surgery To The Floor Of The Mouth
39	Incision Of The Hard And Soft Palate	40	External Incision And Drainage In The Region Of The Mouth, Jaw And Face
41	Other Operations On The Salivary Glands And Salivary Ducts	42	Incision of tear glands
43	Other operation on the tear ducts	44	Incision of diseased eyelids
45	Excision and destruction of the diseased tissue of the eyelid	46	Removal of foreign body from eye
47	Corrective surgery of the entropion and ectropion	48	Operations for pterygium
49	Corrective surgery of blepharoptosis	50	Glaucoma
51	Retinal Detachment	52	Operations on the cornea
53	Operation on the canthus and epicanthus	54	YAG Laser in Ophthalmology
55	Surgery for cataract	56	Treatment of retinal lesion
57	Parenteral Chemotherapy	58	CCRT-Concurrent Chemo + RT
59	SRS- Stereotactic radiosurgery	60	Radiotherapy

61	Radical chemotherapy	62	Chemotherapy
63	AV fistula	64	URSL with stenting
65	URSL	66	DJ Stent removal
67	ESWL	68	Haemodialysis
69	CAPD (Excluding the cost of machine)	70	Cystoscopy (Therapeutic)
71	Follow-up cystoscopy in case of bladder cancer	72	Excision of urethral diverticulum
73	Ureter endoscopy and treatment	74	Surgery for pelvi ureteric junction obstruction
75	Frenular tear repair	76	Meatotomy for meatal stenosis
77	Surgery for fournier's gangrene scrotum	78	Surgery filarial scrotum
79	Surgery for watering can perineum	80	Repair of penile torsion
81	Drainage of prostate abscess	82	TURBT
83	Radical Prostatovesiculectomy	84	Operations On The Prostate
85	D&C	86	Hysteroscopic adhesiolysis
87	Removal of Abnormal Tissue from Cervix	88	Vulval wart excision
89	Cyst Excision / Cystectomy	90	Uterine artery embolization
91	Endometrial ablation	92	Myomectomy
93	Surgery for SUI	94	Pelvic floor repair(excluding Fistula repair)
95	Laparoscopic oophorectomy	96	Incision Of The Ovary
97	Insufflation Of The Fallopian Tubes	98	Dilatation Of The Cervical Canal
99	Hysterotomy	100	Therapeutic Curettage
101	Culdotomy	102	Incision Of The Vagina
103	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas	104	Incision Of The Vulva
105	Infected keloid excision	106	Incision of a pilonidal sinus / abscess
107	Infected sebaceous cyst	108	Infected lipoma excision
109	Maximal anal dilatation	110	Surgical Treatment Of Haemorrhoids
111	Liver Abscess- catheter drainage	112	Fissure in Ano- fissurectomy
113	Surgical Treatment Of Anal Fistulas	114	Fibroadenoma breast excision
115	Oesophageal varices Sclerotherapy	116	ERCP – pancreatic duct stone removal
117	Perianal abscess I&D	118	Excisional Biopsy
119	Perianal hematoma Evacuation	120	Fissure in ano sphincterotomy
121	Therapeutic Endoscopy	122	Breast abscess I& D
123	Feeding Gastrostomy	124	Feeding Jejunostomy
125	ERCP – Bile duct stone removal	126	Ileostomy closure
127	Polypectomy	128	Splenic abscesses Laparoscopic Drainage
129	Sclerotherapy	130	Colostomy

131	Ileostomy	132	Colostomy closure
133	Pancreatic Pseudocysts Endoscopic Drainage	134	Subcutaneous mastectomy
135	Excision of Ranula under GA	136	Hydrocele Repair
137	Scrotoplasty	138	Surgical treatment of varicocele
139	Epididymectomy	140	Circumcision for Trauma
141	Meatoplasty	142	Abscess incision and drainage
143	TIPS procedure for portal hypertension	144	PAIR Procedure of Hydatid Cyst liver
145	Excision of Cervical RIB	146	Surgery for fracture Penis
147	Laparoscopic cardiomyotomy(Hellers)	148	Laparoscopic pyloromyotomy(Ramstedt)
149	Orchidectomy	150	Operations On The Nipple
151	Incision And Excision Of Tissue In The Perianal Region	152	Division Of The Anal Sphincter (Sphincterotomy)
153	Glossectomy	154	Reconstruction Of The Tongue
155	Incisio, Excision And Destruction Of Diseased Tissue Of The Tongue	156	Operations On The Seminal Vesicles
157	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens	158	Operations On The Penis
159	Other Excisions Of The Skin And Subcutaneous Tissues	160	Other Incisions Of The Skin And Subcutaneous Tissues
161	Free Skin Transplantation, Donor Site	162	Free Skin Transplantation, Recipient Site
163	Reconstruction Of The Testis	164	Incision Of The Scrotum And Tunica Vaginalis Testis
165	Revision Of Skin Plasty	166	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues
167	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	168	Arthroscopic Repair of ACL tear knee
169	Arthroscopic repair of PCL tear knee	170	Tendon shortening
171	Tendon lengthening	172	Arthroscopic Meniscectomy – Knee
173	Treatment of clavicle dislocation	174	Arthroscopic meniscus repair
175	Haemarthrosis knee- lavage	176	Abscess knee joint drainage
177	Repair of knee cap tendon	178	ORIF with K wire fixation- small bones
179	ORIF with plating- Small long bones	180	Arthrotomy Hip joint
181	Syme's amputation	182	Arthroplasty
183	Partial removal of rib	184	Treatment of sesamoid bone fracture
185	Amputation of metacarpal bone	186	Repair / graft of foot tendon
187	Revision/Removal of Knee cap	188	Remove/graft leg bone lesion
189	Repair/graft achilles tendon	190	Biopsy elbow joint lining
191	Biopsy finger joint lining	192	Surgery of bunion
193	Tendon transfer procedure	194	Removal of knee cap bursa

195	Treatment of fracture of ulna	196	Treatment of scapula fracture
197	Removal of tumor of arm/ elbow under RA/GA	198	Repair of ruptured tendon
199	Revision of neck muscle (Torticollis release)	200	Treatment fracture of radius & ulna
201	Incision On Bone, Septic And Aseptic	202	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
203	Reduction Of Dislocation Under Ga	204	Vaginoplasty
205	Dilatation of accidental caustic stricture oesophageal	206	Presacral Teratomas Excision
207	Removal of vesical stone	208	Excision Sigmoid Polyp
209	Sternomastoid Tenotomy	210	High Orchidectomy for testis tumours
211	Excision of cervical teratoma	212	Rectal-Myomectomy
213	Rectal prolapse (Delorme's procedure)	214	Orchidopexy for undescended testis
215	Detorsion of torsion Testis	216	Lap. Abdominal exploration in cryptorchidism
217	Coronary Angiography	218	Ultrasound Guided Aspirations
219	Digital subtraction Angiography (DSA)	220	Anti Rabies Vaccination
221	Pace maker- Battery replacement	222	Plasmapheresis
223	Radio Iodine therapy post thyroidectomy	224	Barrage laser/ Pan retinal photocoagulation
225	Keratoconus	226	BCG Intravesicular injection for carcinoma bladder

ANNEXURE II:

List I - Items for which coverage is not available in the policy

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

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

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

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

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

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

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

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

ANNEXURE III: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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

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