NEW INDIA CANCER GUARD POLICY

POLICY CLAUSE

1. PREAMBLE

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

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

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

If during the **Period of Insurance, You** or any **Insured Person** incurs **Medical Expenses** that are **Reasonable and Customary,** and **Medically Necessary** for treatment of **Cancer**, we will reimburse such expense incurred by You, through the Third Party Administrator, in the manner stated herein.

Please note that the above coverage is subject to Limits and Terms & Conditions contained in this Policy.

The Policy has a waiting period of 90 days. If the Insured contracts or is diagnosed with Cancer during the waiting period, the premiums are returned and policy is cancelled. However, this shall not apply in case of renewal

2. DEFINITIONS

STANDARD DEFINITIONS

2.1 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.

2.2 CANCER OF SPECIFIED SEVERITY means

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

II. The following are excluded -

i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to:

Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.

ii. Any skin cancer other than invasive malignant melanoma

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

iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter

v. Chronic lymphocytic leukaemia less than RAI stage 3

vi. Micro carcinoma of the bladder

vii. All tumours in the presence of HIV infection.

2.3 CASHLESS FACILITY means a facility extended by Us to You where We, to the extent preauthorization approved, directly make the payment of the cost of treatment undergone by You in accordance with the policy terms and conditions, to the network provider.

2.4 CONDITION PRECEDENT shall mean a policy term or condition upon which Our liability under the policy is conditional upon.

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

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

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

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

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

i Undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than twenty-four hours because of technological advancement, and

ii Which would have otherwise required a Hospitalization of more than twenty-four hours.

2.8 DAY CARE CENTRE means any institution established for Day Care Treatment of Cancer or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment;

ii. has qualified Medical Practitioner/s in charge;

iii. Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

iv. Maintains daily record of patients and will make these accessible to the insurance company's authorized personnel.

2.9 DISCLOSURE TO INFORMATION NORM: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or nondisclosure of any material fact.

2.10 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.

2.11 HOSPITAL means any institution established for Inpatient Care and Day Care Treatment of Cancer 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:

i. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

ii. has qualified nursing staff under its employment round the clock;

iii. has qualified Medical Practitioner (s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out

v. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

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

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

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

2.15 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

2.16 INPATIENT CARE means treatment of Cancer for which You have to stay in a Hospital for more than twenty- four hours.

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

2.18 MEDICAL EXPENSES means those expenses that You have necessarily and actually incurred for medical treatment on account of Cancer 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 Medical Practitioner in the same locality would have charged for the same medical treatment.

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

i. is required for the medical management of the Cancer suffered by You;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a Medical Practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.20 MEDICAL PRACTITIONER is a person who holds a valid registration from the medical council

of any state or medical council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a state Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

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

2.21 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.

2.22 NETWORK PROVIDER means Hospitals or health care providers enlisted by Us, TPA or jointly by Us and TPA to provide medical services to You by a cashless facility. The list is available with Us/TPA and subject to amendment from time to time.

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

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

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

2.26 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.

2.27 PRE-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

ii. The Inpatient Hospitalization claim is admissible by Us

2.28 POST-HOSPITALISATION MEDICAL EXPENSES means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The Inpatient Hospitalisation claim is admissible by Us

2.29 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.

2.30 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.

2.31 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

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

SPECIFIC DEFINITIONS

2.34 ASSIGNMENT A transfer or assignment of a policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the transferor or by the assignor or his duly authorized agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made.

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

2.36 ADVANCED METASTATIC CANCER means the diagnosis of Stage IV (based on TNM classification) or advanced metastatic cancer, evidenced by spread of cancer to other organs or parts of the body which are not directly connected with each other basis confirmation by histopathological evidence &/or radiological evidence like PET, CT, MRI. Spread of cancer to lymph nodes only is not covered under this definition.

2.37 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.

2.38 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.

2.39 CANCER: 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, sarcoma and Carcinoma.

Please note the following is Included -

i Any In-situ Cancer, which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.

ii Any pre-cancerous change in the cells that are cytological or histologically classified as high-grade dysplasia or severe dysplasia.

Note: The definition under 2.2 should be read in conjunction with definition 2.38 for the purpose of Cancer Treatment under this policy.

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

2.41 CLAIM FREE YEAR means coverage under the New India Cancer Guard Policy for a period of a year during which, no claim is paid or shall be payable under the terms and conditions of the Policy in respect of any Insured Person.

2.42 CONTINUOUS COVERAGE means uninterrupted coverage of the Insured Person with Us, from the time the coverage first incepted under this Policy.

A break in insurance for a period not exceeding thirty days shall not be reckoned as an interruption in coverage for the purpose of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.

2.43 DATE OF DIAGNOSIS refers to the date of histopathology report, based on which Medical Practitioner confirms the initial diagnosis of Cancer.

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

2.45 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.

2.46 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.

2.47 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.

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

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

2.50 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.

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

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

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

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

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

2.54 SURGERY OR SURGICAL PROCEDURE means manual and/or operative procedure(s) required for treatment of Cancer, correction of deformities and defects, diagnosis and cure of Cancer, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.55 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.

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

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

3. BENEFITS COVERED UNDER THE POLICY

The policy shall cover treatment for Cancer taken as Inpatient or Outpatient or Day Care. Following Conventional and Advanced Treatment shall be covered in the Policy:

i. Chemotherapy

ii. Radiotherapy

iii. Organ transplant, as part of Cancer treatment

iv. Onco-surgery (Surgeries for excision of cancerous tissue or removal of organs/ tissues)

v. Proton Treatment

vi. Personalised & Targeted therapy

vii. Hormonal Therapy or Endocrine manipulation viii Immunotherapy including immunology agents ix Stem cell transplantation

x. Bone marrow transplantation

3.1 Our liability for all claims admitted during the Period of Insurance shall not exceed the aggregate of the Sum Insured and Cumulative Bonus, if any. Subject to this, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room Rent including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) as provided by the hospital	
	Sum insured of Rs. 5,00,000 /10,00,000/15,00,000	Single AC room
	Sum insured of Rs. 25,00,000 /50,00,000	Deluxe AC room
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.	
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant,Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to Cancer.	
3.1 (d)	Cost of Pharmacy and Consumables including Anaesthesia, Blood, Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics.	
3.1 (e)	Pre-Hospitalization Medical expenses up to 30 days prior to the date of admission to the hospital	
3.1 (f)	Post-Hospitalization Medical expenses up to 60 days from thedate of discharge from the hospital.	

Note:

i. All the above expenses will be available for the treatment of Cancer as defined under 2.36

ii 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.

a. However, it is not applicable on

i. Cost of Pharmacy and Consumables

ii. Cost of Implants and Medical Devices

iii. Cost of Diagnostics.

iii Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

3.2 PAYMENT OF AMBULANCE CHARGES:

We will pay You the charges for Ambulance services not exceeding Rs. 3,000 per Hospitalization, incurred for shifting any Insured Person.

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 MEDICAL EXPENSES FOR ORGAN TRANSPLANT

If treatment involves Organ transplant, as part of Cancer treatment, 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 and Cumulative Bonus, if any, of the Insured Person receiving the organ.

3.5 RECONSTRUCTION OF AFFECTED BODY PART POST SURGERY

We will pay for Medical Expenses incurred for the reconstruction of affected body part to restore your essential physical functioning as a direct result of Cancer Surgery, provided the claim for cancer surgery is admissible and the policy is in force without a break.

3.6 POST TREATMENT FOLLOW UP:

Medical Expenses incurred on follow up check-up shall be payable up to Rs. 10,000 once in a policy period, provided the Insured has gone into a state of complete remission and the treatment for Cancer has been discontinued on recommendation of Medical Practitioner for at least six months with "No evidence of disease (NED)".

3.7 SECOND OPINION FOR SURGERY:

In case any Insured Person requires to undergo a Surgery as advised by a Medical Practitioner, the expenses incurred towards consultation with another Medical Practitioner to seek advice on the Surgery shall be payable, up to Rs. 5,000 for Sum Insured of Rs. 5, 10 & 15 Lakhs and up to Rs. 10,000 for Sum Insured of Rs. 25 & 50 Lakhs. Cashless facility for availing such second opinion may be provided by the TPA with enlisted Network Providers.

3.8 CANCER CARE BENEFIT:

If during the Period of Insurance, any Insured Person is first time diagnosed for Cancer and is in Stage IV (based on TNM classification) or Advanced Metastatic Cancer, 50% of the Sum Insured would be paid as Critical Care Benefit in addition to the admissible claim amount.

Cancer Care Benefit is payable only once in the lifetime of each Insured Person. It will not be applicable for whom it is a Pre- Existing Condition. Any payment under this Clause would be in addition to the Sum Insured.

3.9 CUMULATIVE BONUS:

The Sum Insured under Policy shall be increased by 10% at each renewal in respect of each claim free year of Insurance, subject to maximum of 50%. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it is accrued.

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

You also have the option of opting for a premium discount at the time of renewal in lieu of the accrued Cumulative Bonus (if available). If you opt for a discount as above the accrued Cumulative Bonus will become zero. The Cumulative bonus in the range of 10% to 50% will have a discount in the base premium from 1.21% to 4.12%.

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4. WHAT ARE EXCLUDED UNDER THIS POLICY

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

SPECIFIC EXCLUSIONS

4.1 Any Treatment other than for Cancer.

4.2 Pre-Existing Condition for Cancer for which Insured Person had signs or symptoms, and/or was diagnosed, and/or received medical advice / treatment prior to the first policy issued by Us (as mentioned in the Schedule).

4.3 Cancer diagnosed / contracted by the Insured person during the first ninety days of the commencement date of first Policy.

4.4 Any treatment for Cancer directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not), nuclear weapon/ ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel.

4.5 Plastic Surgery, cosmetic, aesthetic treatment.

4.6 Cost of external prosthetic devices, non-durable implants, external medical equipment.

4.7 Dental treatment or Surgery of any kind unless necessitated due to treatment of Cancer.

4.8 Kaposi Sarcoma.

4.9 Charges incurred at Hospital primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of Cancer for which confinement is required at a hospital.

4.10 Expenses on vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner.

4.11 Any expenses relating to cost of items detailed in Annexure II.

4.12 Unproven/Experimental Treatment and pharmacological regimens.

4.13 Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

4.14 Treatment including investigation/diagnostic services availed outside India.

4.15 Rest Cure, Rehabilitation and Respite care.

4.16 Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home, or in a hospital / nursing facility for personal care either by skilled nurses or assistants or unskilled persons.

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

4.17 Specified healthcare providers

i. Treatment rendered by a Medical Practitioner, which is outside his discipline or the discipline for which he is licensed.

ii. Treatments rendered by a Medical Practitioner, who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

iii. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments that are not supported by treating doctor's prescription.

iv. Charges related to a hospital stay not expressly mentioned as being covered in this Policy, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

v. Any non-medical expenses mentioned on our website and or attached with this policy.

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

5 CONDITIONS GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 CANCELLATION OF POLICY

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.

Note: No refund of premium will be allowed, if a claim is paid in any of the year for long term policy.

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

5.2 CONDITION PRECEDENT TO ADMISSION OF LIABILITY:

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

5.3 COMPLETE DISCHARGE

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

5.4 DISCLOSURE OF INFORMATION

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

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

5.5 FRAUD

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

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

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

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

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

iii. any other act fitted to deceive; and

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

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

5.6 FREE LOOK PERIOD

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

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

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with

any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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

a. 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

b. 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

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

5.7 MULTIPLE POLICIES

Claims in respect of multiple Policies held by policyholders:

1. Indemnity Policies:

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

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

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

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

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

5.8 MORATORIUM PERIOD

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

5.9 NOMINATION:

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

or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

5.10 CLAIM SETTLEMENT (PROVISION FOR PENAL INTEREST)

i. Settlement of claims (other than cashless) shall be settled within fifteen days from submission of claim.

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

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

5.11 RENEWAL OF POLICY

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

i. The company shall provide notice for renewal 30 days in advance from the due date.

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

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

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

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

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

5.12 WITHDRAWAL OF POLICY

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

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

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

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

changes are effected.

5.14 REDRESSAL OF GRIEVANCE

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

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

Toll free: 1800-209-1415

E-mail, Fax and Courier: As mentioned in the above address

Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

Network Hospital details : https://www.newindia.co.in/portal/readMore/HospitalsList

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at https://www.newindia.co.in/portal/readMore/Grievances For updated details of grievance officer, kindly refer the link https://www.newindia.co.in/portal/readMore/Grievances

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Please refer to Annexure III.

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

5.15 PORTABILITY AND MIGRATION:

Migration:

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

Portability:

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

SPECIFIC TERMS AND CLAUSES

5.16 BASIS OF INSURANCE:

This Policy is issued based on the truth and accuracy of statements in the Proposal. If there is any misrepresentation or non-disclosure of material facts, we will treat the Policy as void ab initio.

5.17 PREMIUM:

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

5.18 PLACE OF TREATMENT AND PAYMENT:

This Policy covers Medical/ Surgical treatment and/or services rendered only in India. Admissible claims shall be payable only in Indian Rupees.

Payment shall be made directly to Network Hospital if Cashless facility is availed. If request for Cashless facility is not availed/approved, bills needs to be submitted for reimbursement.

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. If We 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 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 exclusions 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 Policy Schedule.

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

5.20 NOTICE OF CLAIM:

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

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

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

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

   i. Claim Form duly filled and signed by the claimant

   ii. All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history

   iii. Numbered Bill/Receipt and Discharge certificate / card from the Hospital.

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

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

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

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

viii. Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

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

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

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

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

5.21 Any Independent 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.

5.22 MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS

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

5.23 ENHANCEMENT OF SUM INSURED:

You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted subject to the underwriting guidelines. Enhancement of Sum Insured shall be allowed based on the following table:

Age<=50 years	Enhancement up to Sum Insured of 50 Lakhs
Age 51-55 Years	Enhancement up to Sum Insured of 15 Lakhs
Age 56-60 Years	Enhancement up to Sum Insured of 10 Lakhs

Enhancement of Sum Insured will not be considered for:

i. Insured Persons over 60 years of age.

ii. Insured Person who diagnosed for Cancer (including Cancer survivors).

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

5.24 CONDITIONS APPLICABLE FOR LONG TERM POLICIES

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

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

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

5.25 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.26 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. 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.

iii. 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.

iv. 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.

v. While efforts will be made by Us to not call for any document not listed in Clause 5.11, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.

vi. All necessary claim documents pertaining to Hospitalisation should be furnished by the

Insured Person in original to the TPA (as mentioned in the Schedule), within fifteen (15) 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. 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.

5.27 SINGLE POLICY:

You are not allowed to take multiple policies of New India Cancer Guard. This condition shall be applicable to all the Insured persons taking New India Cancer Guard Policy.

ANNEXURE I: LIST OF DAY CARE PROCEDURES:

S. No.	Treatment	S. No.	Treatment
1	2D Radiotherapy	30	Interstitial Brachytherapy
2	3D Brachytherapy	31	Intracavity Brachytherapy
3	3D Conformal Radiotherapy	32	Intraluminal Brachytherapy
4	Adjuvant Chemotherapy	33	Intravesical Brachytherapy
5	Adjuvant Radiotherapy	34	IV Push Chemotherapy
6	After loading Catheter Brachytherapy	35	LDR Brachytherapy
7	Cancer Chemotherapy	36	Maintenance Chemotherapy
8	CCRT concurrent Chemo + RT	37	Muscle Biopsy
9	Conditioning Radiotherapy For BMT	38	Neoadjuvant Chemotherapy
10	Consolidation Chemotherapy	39	Neoadjuvant Radiotherapy
11	Continuous Infusional Chemotherapy	40	Nerve Biopsy
12	Electron Therapy	41	Palliative Chemotherapy
13	Epidural Steroid Injection	42	Palliative Radiotherapy
14	External Mould Brachytherapy	43	Radical Chemotherapy
15	Extracorporeal Irradiation Of Blood Products	44	Radical Radiotherapy
16	Extracorporeal Irradiation To The Homologous Bone Grafts	45	Radiotherapy For Cancer
17	FSRT fractionated SRT	46	Rotational Arc Therapy
18	Gamma knife SRS	47	SBRT stereotactic Body Radiotherapy
19	HBI hemi body Radiotherapy	48	SC Administration Of Growth Factors
20	HDR Brachytherapy	49	SRS stereotactic Radiosurgery
21	Helical Tomotherapy	50	SRT stereotactic ARC Therapy
22	IGRT Image Guided Radiotherapy	51	TBI Total Body Radiotherapy
23	Implant Brachytherapy	52	Tele Gamma Therapy
24	IMRT DMLC	53	Telecesium Therapy
25	IMRT Step & Shoot	54	Telecobalt Therapy
26	Induction Chemotherapy	55	Template Brachytherapy
27	Infusional Bisphosphonates	56	TSET total Electron Skin Therapy
28	Infusional Chemotherapy	57	VMAT volumetric Modulated Arc Therapy
29	Infusional Targeted Therapy	58	X knife SRS

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

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

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@cioins.co.in Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu.**	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@cioins.co.in Jurisdiction : Madhya Pradesh, Chhattisgarh.**
BHUBANESHWAR – **Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in Jurisdiction : Odisha**	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@cioins.co.in Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.**
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@cioins.co.in Jurisdiction : Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).**	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@cioins.co.in Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.**
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@cioins.co.in Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.**	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@cioins.co.in Jurisdiction : Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.**
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**	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.ernakulam@cioins.co.in **Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.**	**Email: bimalokpal.kolkata@cioins.co.in** **Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands.**
LUCKNOW - **Office of the Insurance Ombudsman, 6th Floor,** **Jeevan Bhawan, Phase-II,** **Nawal Kishore Road, Hazratganj, Lucknow - 226 001.** **Tel.: 0522 - 2231330 / 2231331** **Email: bimalokpal.lucknow@cioins.co.in** **Jurisdiction : Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.**	MUMBAI – **Office of the Insurance Ombudsman, 3rd Floor,** **Jeevan Seva Annexe,** **S. V. Road, Santacruz (W), Mumbai - 400 054.** **Tel.: 022 - 69038821/23/24/25/26/27/28/28/29/30/31** **Email: bimalokpal.mumbai@cioins.co.in** **Jurisdiction :** List of wards **under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.**
JAIPUR – **Office of the Insurance Ombudsman,** **Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.** **Tel.: 0141 - 2740363** **Email: bimalokpal.jaipur@cioins.co.in** **Jurisdiction : Rajasthan**	PUNE - **Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor,** **C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune –411 030.** **Tel.: 020-41312555** **Email: bimalokpal.pune@cioins.co.in** **Jurisdiction : State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region**

BENGALURU – **Office of the Insurance Ombudsman,** **Jeevan Soudha Building,PID No. 57-27-N-19** **Ground Floor, 19/19, 24th Main Road,** **JP Nagar, Ist Phase, Bengaluru – 560 078.Tel.: 080 - 26652048 / 26652049** **Email: bimalokpal.bengaluru@cioins.co.in** **Jurisdiction :Karnataka.**	NOIDA – **Office of the Insurance Ombudsman,** **Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.** **Tel.: 0120-2514250 / 2514252 / 2514253** **Email: bimalokpal.noida@cioins.co.in** **Jurisdiction : State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.**
PATNA - **Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,,** **Bazar Samiti Road, Bahadurpur, Patna 800 006.** **Tel.: 0612-2680952** **Email: bimalokpal.patna@cioins.co.in** **Jurisdiction : Bihar, Jharkhand.**	THANE – **Office of the Insurance Ombudsman,** **2nd Floor,Jeevan Chintamani Building,** **Vasantrao Naik Mahamarg,** **Thane (West)** **Thane - 400604** **Email: bimalokpal.thane@cioins.co.in** **Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District and** wards of Mumbai**, M/East, M/West, N, S and T."**