JANATA MEDICLAIM POLICY

1. PREAMBLE

WHEREAS The Insured designated in the Schedule hereto has by a Proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE CO LTD (hereinafter called the COMPANY) for the Insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the INSURED PERSON) and has paid premium as consideration for such Insurance.

COVERAGE: NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the Policy Period stated in the Schedule or during the continuance of this policy by Renewal any Insured Person shall contract any Illness or sustain any Injury and if such Illness or Injury shall require any such Insured Person, upon the advice of a duly qualified Medical Practitioner / Surgeon to incur Hospitalisation Expenses for Medical Expenses / Surgery at Hospital / Day Care Centre in India as an Inpatient, the Company will pay to the Hospital / Day Care Centre or reimburse the Insured Person the following expenses that are Medically Necessary incurred for the treatment of such Illness or Injury.

2. DEFINITIONS:

STANDARD DEFINITIONS

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

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

2.3 **AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **BANK RATE** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.

2.6 **CASHLESS FACILITY** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Company to the extent pre-authorization approved.

2.7 **CONDITION PRECEDENT** means a policy term or condition upon which the Company's liability under the policy is conditional upon.

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

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

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

2.9 **DAY CARE CENTRE:** A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment;
- Has qualified medical practitioner/s in charge;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.10 **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.

2.11 DENTAL TREATMENT is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

2.12 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.

2.13 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.

2.14 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.

2.15 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 at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

2.16 HOSPITALISATION means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia repair
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an Accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture/dislocation excluding hairline fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct

Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

2.17 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.

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

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

ii. Chronic Condition means a disease, Illness, or Injury that has one or more of the following characteristics

a. it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests

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

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

d. it continues indefinitely

e. it recurs or is likely to recur

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

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

2.21 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.

2.22 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.23 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 the Insured Person had not been Insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.24 MEDICALLY NECESSARY treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Illness or Injury suffered by the Insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

2.26 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.

2.27 NETWORK HOSPITAL means Hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a cashless facility.

2.28 NON-NETWORK HOSPITAL means any Hospital that is not part of the network.

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

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

a. That is/are diagnosed by a physician within 36 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the Policy or its reinstatement.

2.31 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

2.32 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period preceding the Insured Person is Hospitalised, provided that:

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

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

2.33 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period immediately after the Insured Person is discharged from the hospital provided that:

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

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

Insurance Company.

iii.

2.34 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.

2.35 HOME CARE TREATMENT means treatment availed by the Insured Person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

i. The Medical Practitioner advices the Insured Person in writing to undergo treatment at home

ii. There is continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment

iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

iv. Treatment taken at home in case of stroke, spine and/or lower limb accidental injuries only.

2.36 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.

2.37 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.

2.38 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.

2.39 ROOM RENT means the amount charged by a Hospital for the occupancy of a bed per day (24 hours) basis and shall include associated medical expenses.

2.40 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 or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

SPECIFIC DEFINITIONS

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

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

2.43 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.

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

2.45 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.

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

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 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.

2.52 SUM INSURED means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of all Insured Persons during the Policy Year.

Note: Sum Insured means Predefined Limit as shown in the schedule excluding Cumulative Bonus.

2.53 SURGERY OR SURGICAL PROCEDURE

1. **SUPRA MAJOR SURGERY:** Surgery that involves operations on vital organs or expensive radical surgeries, which in normal course endangers the life of patient.
2. **MAJOR SURGERY:** any surgical procedure that requires anaesthesia or respiratory assistance. It involves openings into the great cavities of the body; Major Joint replacement, Major Multiple Fractures, all operations in the course of which hazards of severe haemorrhage are possible.
3. **INTER MEDIATE SURGERY:** Surgery involving the incision of deep fascia or deeper structures but not endangering the life of patient in normal circumstances. It may or may not be done in General Anaesthesia.
4. **MINOR SURGERY:** Surgical procedure that does not involve anaesthesia or respiratory assistance.

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

2.55 **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.

2.56 **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.

3. BENEFITS COVERED UNDER THE POLICY

3.1 Cost of treatment taken in General Ward of the Hospital / Day-Care Centre per day maximum charges Rs. 450/-.

3.2 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.

3.3 Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

3.4 Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

3.5 Pre-Hospitalisation medical Expenses up to 30 days.

3.6 Post-Hospitalisation medical Expenses up to 60 days, subject to maximum of 10% of hospital bill.

3.7 **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

3.8 **Ambulances services –** actual expenses for transportation of Insured or Rs. 1,000/- whichever is less in case patient has to be shifted from residence to Hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

3.9 **Hospitalisation expenses** (excluding cost of organ) incurred on the donor during the course of organ transplant to the Insured person. The Company's liability towards expenses incurred on the donor and the Insured recipient shall not exceed the Sum Insured of the Insured person receiving the organ.

3.10 The total amount payable under this Policy during the Policy Period will in no case exceed the Sum Insured and will be subject to the limits shown in the following schedule or actual whichever is less.

3.11 SCHEDULE OF PAYMENT FOR SPECIFIED DISEAESE

(Amount in Rupees)

Name of Illness / Operation	Maximum Charges Inclusive of Room / ICU / OT Charges / Surgeons, Anesthetist, doctors' fees, medicines, internal appliances and other charges incurred during Hospitalization period
Cataract with imported foldable lens	10,800/-
Hysterectomy	22,500/-
Appendicectomy	16,200/-
Cholecystectomy	18,000/-
TURP	18,000/-
Hemia-Inguinal	16,200/-
Hernia- Ventral/Incisional	19,800/-
Septoplasty	9,000/-
Haemorrhoidectomy	8,100/-
Fissurectomy	9,000/-
Fistulectomy	10,800/-
Angiography	12,000/-
Angioplasty (imported stent single)	Actual or Sum Insured whichever is less
CABG	Actual or Sum Insured whichever is less
Total Knee replacement	Actual or Sum Insured whichever is less
Total hip replacement	Actual or Sum Insured whichever is less
Tonsillectomy	7,200/-
Tympanoplasty	13,500/-
Kidney stone/lithotripsy	13,500/-
Arthroscopy	10,800/-
PID-Disectomy	31,500/-
Mastectomy (Radical)	36,000/-
Eploratory Laprotomy	13,500/- to 27,000/-
Home care Treatment	10% of Sum Insured over and above the post hospitalization charges for treatment arising out of stroke, spine and/or lower limb accidental injuries
Domiciliary Treatment	15% of Sum Insured
OPD	Rs. 250 and Rs. 375 for a Sum insured of Rs. 50000 and 75000 respectively as follow up charges over and above the pre and post hospitalization charges. This limit is applicable for once in a policy period

DOMICILIARY HOSPITALISATION BENEFIT means Medical treatment for a period exceeding three days for such illness/disease/injury which in the normal course would require care and treatment at a hospital / nursing home but actually taken whilst confined at home in India under any of the following circumstances namely.

i) The condition of the patient is such that he / she cannot be removed to the hospital/nursing home or

ii) The patient cannot be removed to hospital/nursing home for lack of accommodation therein

Subject however that domiciliary hospitalisation benefits shall not cover :-

i) expenses incurred for pre and post hospital treatment and

ii) expenses incurred for treatment for any of the following diseases

1. Asthma
2. Bronchitis
3. Chronic Nephritis and Nephritic Syndrome
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis
5. Diabetes Mellitus and Insipidus
6. Epilepsy
7. Hypertension
8. Influenza, Cough and Cold
9. All Psychiatric or Psychosomatic Disorders
10. Pyrexia of unknown Origin for less than 10 days
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharingitis
12. Arthritis, Gout and Rheumatism

Note : When treatment such as Dialysis, Chemotherapy, Radiotherapy etc. is taken in the Hospital/Nursing Home and the Insured is discharged on the same day, the treatment will be considered to be taken under Hospitalisation Benefit section.

Actual expenses for Other Surgeries / Hospitalisation or given hereunder whichever is less:

PER DAY CHARGES	
Room Rent (inclusive of nursing / treatment charges)	450/-
Minor Surgery (as defined) / Day care Room Rent per day	450/-
Operation Theatre Charges	1,260/-
Anesthesia	630/-
Anesthetist Fees	945/-
Surgeon fees	3,150/-
INTERMEDIATE SURGERY	
Room Rent	450/-
Operation Theatre Charges	1,764/-
Anesthesia	882/-
Anesthetist Fees	1,323/-
Surgeon fees	4,410/-

MAJOR SURGERY	
Room Rent	450/-
Operation Theatre Charges	2,520/-
Anesthesia	1,260/-
Anesthetist Fees	1,890/-
Surgeon fees	6,300/-
SUPRA MAJOR SURGERY	
Room Rent	450/-
Operation Theatre Charges	5,040/-
Anesthesia	2,520/-
Anesthetist Fees	3,780/-
Surgeon fees	12,600/-
ICU Charges (per day with all intensive care infrastructure & facilities)	1,800/-
Ventilator Charges (Per day)	450/-
Visit Charges (Per day irrespective of number of visits)	360/-

b) **Impairment of Persons'** intellectual faculties by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period, subject to it arising during treatment of covered illness.

c) **Artificial life maintenance,** including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

d) **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.

e) **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 upto Rs. 75,000 per policy period.

f) **Behavioural and Neuro developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured.

g) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 36 months waiting periods.

h) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** Our shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 36 months with a sub-limit up to 25% of Sum Insured.

The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.
3. Schizophrenia - esp. Psychotic episodes.
4. Bipolar disorder - manic phase.

Treatment of any Injury due to Suicidality shall not be covered.

Condition

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.

Exclusions

Any kind of Psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

3.13 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)
3.13.1	Uterine Artery Embolization and HIFU (High intensity focusedultrasound)	Upto 10% of Sum Insured
3.13.2	Balloon Sinuplasty.	Upto 10% of Sum Insured
3.13.3	Deep Brain stimulation.	Upto 10% of Sum Insured
3.13.4	Oral chemotherapy.	Upto 10% of Sum Insured
3.13.5	Immunotherapy- Monoclonal Antibody to be given asinjection.	Upto 10% of Sum Insured
3.13.6	Intravitreal injections.	Upto 10% of Sum Insured
3.13.7	Robotic surgeries.	Upto 10% of Sum Insured
3.13.8	Stereotactic radio surgeries.	Upto 10% of Sum Insured
3.13.9	Bronchial Thermoplasty.	Upto 10% of Sum Insured
3.13.10	Vaporisation of the prostrate (Green laser treatment orholmium laser treatment).	Upto 10% of Sum Insured
3.13.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured
3.13.12	Stem cell therapy: Hematopoietic stem cells for bone marrowtransplant for haematological conditions to be covered.	Upto 10% of Sum Insured

4. EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of:

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

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

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

(i) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

1. Any Skin disorders
2. All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps
3. Benign Ear, Nose, Throat disorders
4. Benign Prostate Hypertrophy
5. Cataract & age-related eye ailments

6. Gastric/ Duodenal Ulcer
7. Gout & Rheumatism
8. Hernia of all types
9. Hydrocele
10. Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of uterus
11. Non-Infective Arthritis
12. Piles, Fissure and Fistula in Anus
13. Pilonidal Sinus, Sinusitis and related disorders
14. Prolapse Inter Vertebral Disc unless arising from Accident
15. Stone in Gall Bladder & Bile duct
16. Stones in Urinary Systems
17. Unknown Congenital Internal Anomaly
18. Varicose Veins and Varicose Ulcers
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia

(iii) 36 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders
6. External Congenital Diseases

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

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

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

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

4.4 PERMANENT EXCLUSIONS: Any medical expenses incurred for or arising out 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

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

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.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

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

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

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

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

d. Body Mass Index (BMI);

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

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

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

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

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

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

4.4.7 BREACH OF LAW (Code- Excl10)

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

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

4.4.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

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

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

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

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

SPECIFIC EXCLUSIONS

4.4.16 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.

4.4.17 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.

4.4.18 Circumcision unless required to treat Injury or Illness.

4.4.19 Vaccination & Inoculation.

4.4.20 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.4.21 All types of Dental treatments except arising out of an Accident.

4.4.22 Convalescence, general debility.

4.4.23 Bodily injury or sickness due to wilful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, suicide or attempt thereat.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

4.4.24 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.25 Stem cell implantation / surgery for other than those treatments mentioned in clause 3.13.12.

4.4.26 Treatment - taken outside India.

4.4.27 Change of treatment from one system of medicine to another unless recommended by the Medical practitioner / Hospital under whom the treatment is taken.

4.4.28 Service charges or any other charges levied by hospital, except registration/admission charges.

4.4.29 Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 FRAUD, MISREPRESENTATION, CONCEALMENT: The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particular if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his / her behalf.

5.2 CANCELLATION CLAUSE:

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

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

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

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

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

5.3 RENEWAL OF POLICY: The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

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

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

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

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

5.4 FREE LOOK PERIOD:

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

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

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

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

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

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

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

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

5.5 MULTIPLE POLICIES

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

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

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.

5.6 GRIEVANCE REDRESSAL:

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

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

Toll free: 1800-209-1415

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

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

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

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

If Insured person is not satisfied with the redressal of grievance through above methods, the

insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Please refer to Annexure III.

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

5.7 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 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 for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous 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.

SPECIFIC TERMS AND CLAUSES

5.10 CONTRACT: The proposal form, declaration, Health Certificate, and policy issued shall constitute complete contract of insurance.

5.11 COMMUNICATION: Every notice or communication to be given or made under this Policy other than that relating to claim shall be delivered in writing at the address of the policy issuing office as shown in the schedule. The claim shall be reported to the TPA appointed for providing health care services as per the procedure mentioned in the guidelines circulated by the T.P.A.to the policyholders. In case TPA services are not availed then claim shall be reported to policy issuing Office.

5.12 PREMIUM PAYMENT: The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under the Policy, no waiver of any terms, provision, conditions and endorsement of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

5.13 PHYSICAL EXAMINATION: Any Medical Practitioner authorized by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged disease/illness/injury requiring Hospitalization. Non-co-operation by the Insured Person will result into rejection of his/her claim.

5.14 DISCLAIMER OF CLAIM: If the TPA / Company shall disclaim liability to the Insured for any claim hereunder and if the insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the TPA / Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.15 All Medical Expenses/Surgery under this policy shall have to be taken in India.

5.16 CUMULATIVE BONUS: The Sum Insured under Policy shall be increased by 5% at each renewal in respect of each claim free year of insurance, subject to maximum of 30%. If a claim is made in any particular year; the Cumulative Bonus accrued may be reduced at the same rate at which it is accrued.

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

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

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 5% to 30% will have a discount in the base premium from 0.73% to 2.86%.:

5.17 COMPANY'S LIABILITY: The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured including Cumulative Bonus.

5.18 COST OF HEALTH CHECK UP: In addition to Cumulative Bonus the Insured shall be entitled for reimbursement of cost of medical checkup once at the end of a block of every four consecutive underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average Sum Insured under the policies excluding Cumulative Bonus. This benefit will be allowed only when the insurance has been continued with our company for 4 claim free years.

IMPORTANT:

Both Health Check-up and Cumulative Bonus provisions are applicable only in respect of continuous insurance without break. In exceptional circumstances, the break beyond 30 days could be condoned by the Company subject to medical examination and exclusion of Illness / Injury originating or suffered during the break in the period of cover.

5.19 NOTICE OF CLAIM: Preliminary notice of claim with particulars relating to Policy Numbers, name of insured person in respect of whom claim is to be made, nature of Illness / Injury and Name and Address of the attending Medical Practitioner / Hospital should be given to the Company / TPA within 7 days from the date of Hospitalization in respect of reimbursement claims.

Final claim along with Hospital receipted original Bills / Cash memos, claim form and list of documents as listed below etc. should be submitted to the Policy issuing Office / TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Waiver: Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the Company/TPA that under the Circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

5.20 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICE: Claims in respect of Cashless access services will be through the agreed list of network of hospital / nursing home and is subject to pre-admission authorization. The TPA shall upon getting the related medical information from the insured person /network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital /nursing home mentioning the sum guaranteed as payable also

the ailment for which the person is seeking to be admitted as a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his /her treating doctor's advice and later on submit the full claim papers to the TPA for reimbursement.

5.21 REPUDIATION OF CLAIMS:

A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by the Company for settlement and denial of the claims by the appropriate authority.

With Our prior approval Communication of repudiation shall be sent to Insured Person, explicitly mentioning the grounds for repudiation, through Our TPA.

5.22 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.23 PAYMENT OF CLAIM:

i. The Company 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 the Company to not call for any document not listed in Clause 5.18, 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 Hospitalisation should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within thirty 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.

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.

All admissible claims shall be payable in Indian Currency.

5.24 ARBITRATION:

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

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

No reference to Arbitration shall be made unless the Company has Admitted liability for a claim in writing.

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.25 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.

ANNEXURE I:

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

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

37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticalspayable)
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 II: 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**

JAIPUR – **Office of the Insurance Ombudsman,** **Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.** **Tel.: 0141 - 2740363** **Email: bimalokpal.jaipur@ecoi.co.in**	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@ecoi.co.in**
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@ecoi.co.in**	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@ecoi.co.in**
PATNA - **Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,,** **Bazar Samiti Road, Bahadurpur, Patna 800 006.** **Tel.: 0612-2680952** **Email: bimalokpal.patna@ecoi.co.in**	