NEW INDIA PREMIER MEDICLAIM POLICY

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

The terms set out in this Policy and its Schedule will be the basis for any claim or benefit under this Policy. This Policy states: -

What We Cover

Definitions

How much we will reimburse

What is excluded under this Policy?

Conditions

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.

SECTION I - WHAT WE COVER

If during the Period of Insurance, You or any Insured Person incurs Hospitalisation Expenses which are Reasonable and Customary and Medically Necessary for treatment of any Illness or Injury, We will reimburse such expense incurred by You, in the manner stated herein.

Please note that the above coverage is subject to limits, terms and conditions contained in this Policy and no exclusion being found applicable.

In this Policy all the Insured Members as stated in the Schedule will be covered under single Sum Insured. Our aggregate liability in respect of all the Insured Persons, for all amounts paid or payable under all Clauses of Part I and Part II of Section III except Clause 3.1.9, shall be limited to the Sum Insured.

The nature, scope and extent of coverage will depend on the Plan opted as mentioned in the Schedule.

SECTION II – DEFINITIONS

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

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

2.3 **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.

2.4 **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.

2.5 **CANCELLATION** defines the terms on which the Policy contract can be terminated either by Us or

You by giving sufficient notice to other which is not lower than a period of fifteen days.

2.6 **CASHLESS FACILITY** means a facility extended by Us to the Insured Person where the payments of the costs of treatment undergone by the Insured Person in accordance with the Policy terms and conditions are directly made to the Network Provider by Us to the extent of pre-authorization approved.

2.7 **CLAIM FREE YEAR** means coverage under the New India Premier Mediclaim Policy for a period of one year during which no claim is paid or payable under the terms and conditions of the Policy in respect of any Insured Person under any Clause of SECTION III.

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

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

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

2.9 **CONTINUOUS COVERAGE** means uninterrupted coverage of the Insured Person with Us or any other Insurer, from the time the coverage incepted under any of the Health Insurance policies till the date of commencement of Period of Insurance of 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.

However, the benefit of Continuous Coverage getting carried over from other Policies will not be available for following Coverage:

1. OPD Treatments
2. Maternity and Child Care
3. Treatment for Infertility
4. HIV/AIDS
5. Obesity Treatments

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

2.10.1 CANCER 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 non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.

iii. Malignant melanoma that has not caused invasion beyond the epidermis.

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

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification Micro carcinoma of the bladder

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

ix. All tumors in the presence of HIV infection

2.10.2 MYOCARDIAL INFARCTION (FIRST HEART ATTACK - OF SPECIFIED SEVERITY)

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

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

2.10.3 OPEN CHEST CABG

I. The actual undergoing of open chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

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

ii. Any key-hole or laser Surgery.

2.10.4 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

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

2.10.5 COMA OF SPECIFIED SEVERITY

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

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

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

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

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

2.10.6 KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

2.10.7 STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

   i. Transient ischemic attacks (TIA)

   ii. Traumatic injury of the brain

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

2.10.8 MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

   i. Other stem-cell transplants

   ii. Where only islets of Langerhans are transplanted

2.10.9 PERMANENT PARALYSIS OF LIMBS

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

2.10.10 MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

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

2.10.11 MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

i. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months,

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

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

- has qualified nursing staff under its employment
- has qualified Medical Practitioner(s) in charge
- has a fully equipped operation theatre of its own where Surgery is carried out
- maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

- undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a Hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

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

2.15 GRACE PERIOD means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage is not available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

2.16 HOSPITAL means any institution established for Inpatient Care and Day Care Treatment of Illness or Injury and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

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

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

Note: Procedures/treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours; except for payments admissible under Clause 3.1.10 and 3.1.11(b).

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

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

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

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

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

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

d. it continues indefinitely

e. it recurs or is likely to recur

2.19 INFERTILITY is defined by the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse-

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

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

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

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

2.24 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.

2.25 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 pricing.

2.26 MATERNITY EXPENSES shall mean:

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

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

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

2.28 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.

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

- Is required for the medical management of the Illness or Injury suffered by the Insured Person;

- 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.

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

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

2.31 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.

2.32 NETWORK PROVIDER: All such Hospitals, Day Care Centres or other providers that the Company/TPA has mutually agreed with, to provide services like Cashless access to Insured Person.

2.33 NON-NETWORK PROVIDER: Any Hospital, Day Care centre or other provider that is not part of the Network.

2.34 NEW BORN BABY means a baby born during the Period of Insurance to a female Insured Person.

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

2.36 PERIOD OF INSURANCE means the period for which this Policy is taken as specified in the Schedule.

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

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

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

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

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

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

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

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

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

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

2.40 PORTABILITY means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

2.41 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.

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

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

2.44 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

2.45 PSYCHIATRIC DISORDERS means clinically significant psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical

Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

2.46 PSYCHOSOMATIC DISORDERS means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

2.47 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.

2.48 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.

2.49 RENEWAL defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of renewing within 30 days from the date of expiry of the Policy for treating the renewal continuous for the purpose of all waiting periods.

2.50 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.

2.51 SUM INSURED is the maximum amount of coverage under this Policy opted cumulatively for You and all Insured Persons shown in the Schedule.

2.52 SURGERY OR SURGICAL PROCEDURE means manual or operative procedure required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of

diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.53 THIRD PARTY ADMINISTRATORS (TPA) means any person who is licensed under the IRDAI (Third Party Administrators-Health Services) Regulations, 2019 by the Authority, and is engaged, for a fee or remuneration by Insurance Company, for the purposes of providing health services.

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

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

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

SPECIFIC COVERAGE

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

2.58 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.

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

2.60 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

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

2.62 CONTINUOUS COVERAGE means uninterrupted coverage of the Insured Person with Us or any other Insurer, from the time the coverage incepted under any of the Health Insurance policies till the date of commencement of Period of Insurance of 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.

However, the benefit of Continuous Coverage getting carried over from other Policies will not be available for following Coverage:

1. OPD Treatments

2. Treatment for Infertility

3. HIV/AIDS

4. Obesity Treatments

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

2.65 POLICY means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person

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

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

2.67 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.

2.68 PSYCHIATRIC DISORDERS means clinically significant psychological or behavioural syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behaviour or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

2.69 PSYCHOSOMATIC DISORDERS means one or more psychological or behavioural problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the Insured Person in respect of whom a claim is lodged.

2.70 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

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

2.72 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.

SECTION III - HOW MUCH WE WILL REIMBURSE

PART I : (COVER APPLICABLE FOR PLAN A AND PLAN B)

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

1.	Room Rent, including boarding and nursing expenses.
2.	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expense.
3.	Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.
4.	Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory/Diagnostic test, X-Ray and other medical expenses related to the treatment.
5.	Pre-Hospitalisation Medical Expenses, upto sixty days
6.	Post-Hospitalisation Medical Expenses, upto ninty days

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.

MEDICAL EXPENSES FOR ORGAN TRANSPLANT:

If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ) incurred on the donor, provided Our liability towards expenses incurred on the donor and the Insured recipient shall not exceed the available Sum Insured.

3.1.2 AYUSH TREATMENTS

We will provide coverage for 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.

3.1.3 HOSPITAL CASH

We will pay Hospital Cash at the rate of Rs. 2,000 per day for Plan A and Rs. 4,000 per day for Plan B for each day of Hospitalisation admissible under the Policy. The payment under this Clause for Any One Illness shall be made for maximum 10 days of Hospitalisation. The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty-four hours. Payment under this Clause will reduce the Sum Insured.

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

3.1.4 PAYMENT OF AMBULANCE CHARGES

We will pay You the charges incurred towards Ambulance services including Air Ambulance, Reasonably, Customarily and Medically Necessarily incurred for shifting any Insured Person to Hospital for admission in emergency ward or ICU, or from one Hospital to another Hospital for better medical facilities maximum up to Rs. 1,00,000 for Any One Illness.

However, if an Insured Person, after the discharge from the Hospital, has to be shifted from Hospital to their place of residence in an Ambulance, such expenses will also be reimbursed additionally up to Rs. 10,000 for Any One Illness, provided the requirement of an Ambulance is certified by the Medical Practitioner.

3.1.5 TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies, except those related to Genetic disorders, shall be covered up to Sum Insured, after twenty-four months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. The requirement for Continuous Coverage for twenty-four months would not apply to a New Born Baby during the year of birth and also in subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

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

3.1.6 COVERAGE FOR MATERNITY & CHILD CARE

Maternity Expenses shall be covered after thirty-six months of Continuous Coverage in New India Premier Mediclaim Policy. Our liability for expenses incurred towards Maternity Expenses, shall be restricted to Rs. 50,000 for Plan A and Rs. 1,00,000 for Plan B.

Special conditions applicable to Maternity and Child Care Benefit:

i. These benefits are admissible only if the expenses are incurred in Hospital as in patient in India.

ii. Claim under this Clause shall not be admissible if, in respect of any Insured Person, two claims for Maternity have been paid by Us in the preceding / existing New India Premier Mediclaim policies.

3.1.7 NEW INDIA BABY COVER

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy and Plan opted. Congenital External Anomaly of the New Born Baby is not covered under the Policy.

Any expense incurred towards pre-term or pre-mature care or any expense incurred in connection with delivery of such New Born Baby is not covered under this Clause.

No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for Insurance and covered as an Insured Person.

3.1.8 TREATMENT FOR INFERTILITY

We shall provide expenses necessarily incurred for treatment of Infertility (including OPD Treatment) subject to a limit of Rs. 1,00,000 for Plan A and Rs. 2,00,000 for Plan B. This limit shall be our maximum liability in respect of all Insured Persons. If any claim is payable to any

Insured Person under this Clause in any particular Period of Insurance, the benefit under this Clause shall not be available for any subsequent Renewal for any Insured Person irrespective of the amount claimed in the expiring Policy.

Any payment under this Clause shall be paid after the Insured Person has Continuous Coverage of thirty-six months under New India Premier Mediclaim Policy.

3.1.9 CRITICAL CARE BENEFIT

If during the Period of Insurance any Insured Person suffers and diagnosed for the first time from a Critical Illness as defined under Clause 2.8, which results in a claim for Hospitalisation being admissible under this Policy, Rs. 2,00,000 for Plan A and Rs. 5,00,000 for Plan B would be paid as a lump sum Critical Care Benefit in addition to the admissible amount of Hospitalisation Expenses. Critical Care Benefit is payable only once in the life time of each Insured Person and shall not be payable if the Critical Illness is a Pre- Existing Condition / Disease. Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured. This will be paid only if the Hospitalisation is more than 24 hours.

3.1.10 OPD COVER:

After every block of two continuous Claim Free Years, You and all the members covered in this Policy are entitled for OPD coverage for an aggregate amount of Rs. 5,000 for Plan A and Rs. 10,000 for Plan B. The cover can be availed for:

1. Dental Treatment.
2. Health Check-up.
3. Consultation with a Medical Practitioner.
4. Drugs and medicines as prescribed by a Medical Practitioner.
5. Investigations as prescribed by a Medical Practitioner.

The amount will not be carried forward to the next year.

3.1.11 COVER FOR HIV- AIDS

(a) We shall be liable to pay the Hospitalisation expenses incurred towards treatment of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS. Any payment under this Clause shall only be made when the Insured Person was not afflicted with any of these conditions at the time of the proposal and is contracted subsequent to this Insurance, regardless of whether the Insured Person was aware or not of the same. The limit for this cover will be:

Plan A: Rs. 2,00,000 and Plan B: Rs. 5,00,000.

(b) OPD Treatment for the above-mentioned conditions will be payable up to Rs. 20,000 for Plan A and Rs. 50,000 for Plan B per policy period.

(c) Our liability for coverage under 3.1.11 (a) and 3.1.11 (b) shall not exceed Rs. 2,00,000 for Plan A and Rs. 5,00,000 for Plan B.

3.1.12 LIMIT ON PAYMENT OF CATARACT:

Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye shall not exceed the limit as per following table:

Plan A	Actual or Rs. 75,000, whichever is less
Plan B	Actual or Rs. 1,00,000, whichever is less

3.1.13 SECOND OPINION FOR MAJOR SURGERIES

In case any Insured Person requires to undergo a Surgery as advised by a Medical Practitioner, then the expenses incurred towards consultation with another Medical Practitioner to seek advice on the surgery shall be payable up to Rs. 5,000 for Plan A and up to Rs. 8,000 for Plan B. Cashless facility for availing such second opinion will be provided by the TPA with enlisted Network Providers.

3.1.14 COVERAGE FOR HAZARDOUS SPORTS

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

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

Our liability under this Clause shall not exceed 10% of Sum Insured.

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

3.1.15 CONCIERGE SERVICES

This benefit is applicable only for planned Hospitalisation. The services provided will be:

1. Facilitation of Cashless arrangement by the representative of TPA.
2. Facilitation at the time of discharge by the representative of TPA.
3. Pick and drop service for all the claim documents including Pre and Post Hospitalisation bills by the representative of TPA.

   In case of omission by the TPA to arrange to provide this service, Our liability for such omission will be limited to Rs. 5,000 per Hospitalisation.

   Conditions: The benefits under this Clause shall be applicable only where the Insured Person provides advance notice to TPA as mentioned in the Schedule at least seventy-two hours prior to date of Hospitalisation. This benefit will not be available for any claim for Hospitalisation for a Day Care Procedure.

3.1.16 SPECIFIC COVERAGES

a) **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 per policy period, subject to it arising during treatment of covered Illness.

b) **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).

c) 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.

d) 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 Rs. 1,00,000 per policy period.

e) 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.

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

3.1.17 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
3.1.17.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto Rs. 2 Lakh
3.1.17.2	Balloon Sinuplasty	Upto Rs. 2 Lakh
3.1.17.3	Deep Brain stimulation	Upto Rs. 5 Lakh
3.1.17.4	Oral chemotherapy	Upto Rs. 1 Lakh
3.1.17.5	Immunotherapy- Monoclonal Antibody to be given as injectio	Upto Rs. 2 Lakh
3.1.17.6	Intravitreal injections	Upto Rs. 75,000
3.1.17.7	Robotic surgeries	Upto Rs. 5 Lakh
3.1.17.8	Stereotactic radio surgeries	Upto Rs. 3 Lakh
3.1.17.9	Bronchial Thermoplasty	Upto Rs. 2.5 Lakh
3.1.17.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Upto Rs. 2.5 Lakh
3.1.17.11	ONM - (Intra Operative Neuro Monitoring)	Upto Rs. 50,000
3.1.17.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	Upto Rs. 2.5 Lakh

PART II: (COVER AVAILABLE ONLY FOR PLAN B)

3.2.1 COVER FOR PSYCHIATRIC AND PSYCHOSOMATIC DISORDERS

All the Psychiatric and Psychosomatic disorders diagnosed for the first time during the Continuous Coverage under the New India Premier Mediclaim Policy will be covered up to 5% of Sum Insured. The Insured needs to be admitted as in-patient. This treatment will not be covered under a Day-care procedure.

3.2.2 TREATMENT FOR OBESITY

Hospitalisation for treatment related to or for obesity is covered up to Rs. 5,00,000 where Body Mass Index of the Insured Person is greater than 35 and the Insured Person is diagnosed with co-morbidities mentioned below.

1. Respiratory: Obstructive sleep apnea, Pickwickian syndrome (obesity hypoventilation syndrome)
2. Cardiovascular: Coronary artery disease, left ventricular hypertrophy, coronary pulmonale, obesity-associated cardiomyopathy, accelerated atherosclerosis, and pulmonary hypertension of obesity

   Any payment under this Clause shall be paid after the Insured has:

   a) Continuous Coverage of thirty-six months in New India Premier Mediclaim Policy

   b) Such a treatment is payable only after prior clearance of Medical Practitioner authorized by the Company or the TPA mentioned in the Schedule.

3.2.3 DIETICIAN COUNSELING

Expenses incurred towards Dietician counseling for all Insured Person in a policy shall be restricted to a maximum of Rs. 5,000 subjects to actuals for all the admissible claims under the policy.

SECTION IV - WHAT IS EXCLUDED UNDER THIS POLICY

NO CLAIM WILL BE PAYABLE UNDER THIS POLICY FOR THE FOLLOWING:

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 u

4.2 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.

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

7. Hernia of all types

8. Hydrocele

9. Non Infective Arthritis

10. Piles, Fissures and Fistula in anus

11. Pilonidal sinus, Sinusitis and related disorders

12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident

13. Renal Disorders

14. Skin Disorders

15. Stone in Gall Bladder and Bile duct, excluding malignancy

16. Stones in Urinary system

17. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus

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

21. Internal Congenital Diseases

Note: Even after twenty-four months of Continuous Coverage, the above Illnesses will not be covered if they arise from a Pre-existing Condition, until 36 months of Continuous Coverage have elapsed since inception of the first Policy with the Company.

(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

4.4. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis

and treatment.

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 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.

4.4.4 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.

4.4.5 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.

4.4.6 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.

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

4.4.8 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).

4.4.9 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)

4.4.10 REFRACTIVE ERROR (Code- Excl15)

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

4.4.11 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

SPECIFIC EXCLUSIONS

4.4.12 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.

4.4.13 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.

4.4.14 Any expenses incurred on Domiciliary Hospitalization.

4.4.15 Treatment taken outside the geographical limits of India.

4.4.16 Vaccination and/or inoculation.

4.4.17 Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation.

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

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.

4.4.19 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), Sleep Apnoea Syndrome, CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home.

4.4.20 Stem cell implantation / Surgery for other than those treatments mentioned in clause 3.1.17.12.

4.4.21 Acupressure, acupuncture, magnetic therapies.

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

4.4.23 Convalescence, General debility and Venereal disease.

4.4.24 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.

4.4.25 Circumcision unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an accident.

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

SECTION V - CONDITIONS

5.1 BASIS OF INSURANCE:

This Policy is issued on the basis of the truth and accuracy of statements in the Proposal. If there is a misrepresentation or non-disclosure, we will be entitled to treat the Policy as void ab-initio.

5.2 PREMIUM:

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

5.3 PLACE OF TREATMENT AND PAYMENT:

This Policy covers only medical/surgical treatment taken in India. Any expense incurred outside India would not be covered under this Policy. Admissible claims shall be payable only in Indian

Rupees.

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

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

5.4 COMMUNICATION:

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

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

Communications you wish to rely upon must be in writing.

5.5 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. In case of Hospitalisation due to medical emergency, intimate TPA within twenty-four hours from the time of Hospitalisation.

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

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

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

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

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

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

d. In case of post-Hospitalisation treatment (limited to ninety days), submit all claim documents within 7 days after completion of such treatment.

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

Note: The above stipulations are not intended merely to prejudice Your claims, but their

compliance is of utmost importance and necessity for Us to identify and verify all facts and surrounding circumstances relating to a claim and determine whether it is payable.

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

5.6 You shall submit to the TPA all original bills, receipts and other documents upon which a claim is based and shall also give the TPA / Company such additional information and assistance as the TPA / Company may require.

5.7 Any Medical Practitioner authorised by the TPA / Company shall be allowed to examine the Insured Person, at Our cost, if We deem necessary in connection with any claim.

5.8 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.

5.9 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.

None of the provisions of this Clause shall apply for payments under Section III, Clause 3.1.3 and Clause 3.1.9 of the Policy.

5.10 RENEWAL CLAUSE:

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.

5.11 Proof satisfactory to the Company shall be furnished on all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured Person on the occasion of any alleged Injury when and so often as the same may reasonably be required on behalf of the Company.

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

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

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

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

5.13 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;

5.14 ENHANCEMENT OF SUM INSURED:

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

Enhancement of Sum Insured will not be considered for:

1) Any Insured Person over 65 years of age.

2) Any Insured Person who had undergone more than one Hospitalisation in the preceding two years.

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

a) Any chronic Illness

b) Any recurring Illness

c) Any Critical Illness

Note:

i. In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from such date.

ii. Migration from Plan A to Plan B will only be considered up to 60 years of age

iii. On migration from Plan A to Plan B the covers available under Plan B will trigger only after competition of respective waiting periods.

iv. On migration from Plan A to Plan B the enhanced limits available under Plan B will be applicable only on completion of the waiting periods mentioned therein.

5.15 ARBITRATION:

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

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

No reference to Arbitration shall be made unless We Have Admitted Our liability for a claim in writing.

If a claim is declined and within 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.

5.16 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.

5.17 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.

5.18 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

5.19 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.

5.20 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.21 PAYMENT OF CLAIM:

We shall settle the claim, including rejection, within thirty days of the receipt of the last necessary document.

On receipt of the duly completed documents either from You or Hospital the claim shall be processed as per the conditions of the Policy. Upon acceptance of claim by You for settlement, we shall make payment of admissible amount within seven working days (which will be a part of thirty days period for settlement of Claim). In case of any delay, such claims shall be paid by Us with a penal interest as provided under Regulations of IRDAI (Protection of Policyholders' Interest) Regulations, 2017, as amended from time to time.

Payment shall be subject to admissibility of claim being made out by the documents. In the event of any delay by You in responding to Our queries or submitting documents, no interest shall be payable for the period of delay.

All admissible claims shall be payable in Indian Currency.

5.22 REPUDIATION OF CLAIMS:

A claim, which is not covered under the Policy conditions, can be rejected.

Communication of repudiation shall be sent to You by Us or the TPA with Our prior approval, explicitly mentioning the grounds of repudiation.

5.23 GRIEVANCE REDRESSAL:

In the event of Your having any grievance relating to this Policy, you may contact any of the Grievance Cells at the Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact details of the office of the Insurance Ombudsman are provided in the Annexure III.

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

ANNEXURE I: LIST OF DAY CARE PROCEDURES:

1	Stapedotomy	**2**	Excision And Destruction Of A Lingual Tonsil
3	Stapedectomy	**4**	Other Operations On The Tonsils And Adenoids
5	Revision Of A Stapedectomy	**6**	Incision On Bone, Septic And Aseptic
7	Other Operations On The Auditory Ossicles	**8**	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
9	Myringoplasty (Type -I Tympanoplasty)	**10**	Suture And Other Operations On Tendons And Tendon Sheath
11	Tympanoplasty (Closure Of An Eardrum Perforation / Reconstruction Of The Auditory Ossicles)	**12**	Reduction Of Dislocation Under GA
13	Revision Of A Tympanoplasty	**14**	Arthroscopic Knee Aspiration
15	Other Microsurgical Operations On The Middle Ear	**16**	Incision Of The Breast
17	Myringotomy	**18**	Operations On The Nipple
19	Removal Of A Tympanic Drain	**20**	Incision And Excision Of Tissue In The Perianal Region
21	Incision Of The Mastoid Process And Middle Ear	**22**	Surgical Treatment Of Anal Fistulas
23	Mastoidectomy	**24**	Surgical Treatment Of Haemorrhoids
25	Reconstruction Of The Middle Ear	**26**	Division Of The Anal Sphincter (Sphincterotomy)
27	Other Excisions Of The Middle And Inner Ear	**28**	Other Operations On The Anus
29	Fenestration Of The Inner Ear	**30**	Ultrasound Guided Aspirations
31	Revision Of A Fenestration Of The Inner Ear	**32**	Sclerotherapy Etc
33	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	**34**	Incision Of The Ovary
35	Other Operations On The Middle And Inner Ear	**36**	Insufflation Of The Fallopian Tubes
37	Excision And Destruction Of Diseased Tissue Of The Nose	**38**	Other Operations On The Fallopian Tube
39	Operations On The Turbinates (Nasal Concha)	**40**	Dilatation Of The Cervical Canal
41	Other Operations On The Nose	**42**	Conisation Of The Uterine Cervix
43	Nasal Sinus Aspiration	**44**	Other Operations On The Uterine Cervix
45	Incision Of Tear Glands	**46**	Incision Of The Uterus (Hysterotomy)
47	Other Operations On The Tear Ducts	**48**	Therapeutic Curettage
49	Incision Of Diseased Eyelids	**50**	Culdotomy

51	Excision And Destruction Of Diseased Tissue Of The Eyelid	**52**	Incision Of The Vagina
53	Operations On The Canthus And Epicanthus	**54**	Local Excision And Destruction Of DiseasedTissue Of The Vagina And The Pouch Of Douglas
55	Corrective Surgery For Entropion And Ectropion	**56**	Incision Of The Vulva
57	Corrective Surgery For Blepharoptosis	**58**	Operations On Bartholin'S Glands (Cyst)
59	Removal Of A Foreign Body From The Conjunctiva	**60**	Incision Of The Prostate
61	Removal Of A Foreign Body From The Cornea	**62**	Transurethral Excision And Destruction Of Prostate Tissue
63	Incision Of The Cornea	**64**	Transurethral And Percutaneous Destruction Of Prostate Tissue
65	Operations For Pterygium	**66**	Open Surgical Excision And Destruction Of Prostate Tissue
67	Other Operations On The Cornea	**68**	Radical Prostatovesiculectomy
69	Removal Of A Foreign Body From The Lens Of The Eye	**70**	Other Excision And Destruction Of Prostate Tissue
71	Removal Of A Foreign Body From The Posterior Chamber Of The Eye	**72**	Operations On The Seminal Vesicles
73	Removal Of A Foreign Body From The Orbit And Eyeball	**74**	Incision And Excision Of Periprostatic Tissue
75	Operation Of Cataract	**76**	Other Operations On The Prostate
77	Incision Of A Pilonidal Sinus	**78**	Incision Of The Scrotum And Tunica Vaginalis Testis
79	Other Incisions Of The Skin And Subcutaneous Tissues	**80**	Operation On A Testicular Hydrocele
81	Parenteral Chemotherapy	**82**	Excision And Destruction Of Diseased Scrotal Tissue
83	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues	**84**	Plastic Reconstruction Of The Scrotum And Tunica Vaginalis Testis
85	Other Excisions Of The Skin And Subcutaneous Tissues	**86**	Other Operations On The Scrotum And Tunica Vaginalis Testis
87	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues	**88**	Incision Of The Testes
89	Free Skin Transplantation, Donor Site	**90**	Excision And Destruction Of Diseased Tissue Of The Testes
91	Free Skin Transplantation, Recipient Site	**92**	Unilateral Orchidectomy
93	Revision Of Skin Plasty	**94**	Bilateral Orchidectomy
95	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	**96**	Orchidopexy
97	Chemosurgery To The Skin	**98**	Abdominal Exploration In

			Cryptorchidism
99	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	**100**	Surgical Repositioning Of An Abdominal Testis
101	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	**102**	Reconstruction Of The Testis
103	Partial Glossectomy	**104**	Implantation, Exchange And Removal Of A Testicular Prosthesis
105	Glossectomy	**106**	Other Operations On The Testis
107	Reconstruction Of The Tongue	**108**	Surgical Treatment Of A Varicocele And A Hydrocele Of The Spermatic Cord
109	Other Operations On The Tongue	**110**	Excision In The Area Of The Epididymis
111	Incision And Lancing Of A Salivary Gland And A Salivary Duct	**112**	Epididymectomy
113	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct	**114**	Reconstruction Of The Spermatic Cord
115	Resection Of A Salivary Gland	**116**	Reconstruction Of The Ductus Deferens And Epididymis
117	Reconstruction Of A Salivary Gland And A Salivary Duct	**118**	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
119	Other Operations On The Salivary Glands And Salivary Ducts	**120**	Operations On The Foreskin
121	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	**122**	Local Excision And Destruction Of Diseased Tissue Of The Penis
123	Incision Of The Hard And Soft Palate	**124**	Amputation Of The Penis
125	Excision And Destruction Of Diseased Hard And Soft Palate	**126**	Plastic Reconstruction Of The Penis
127	Incision, Excision And Destruction In The Mouth	**128**	Other Operations On The Penis
129	Plastic Surgery To The Floor Of The Mouth	**130**	Cystoscopical Removal Of Stones
131	Palatoplasty	**132**	Lithotripsy
133	Other Operations In The Mouth	**134**	Coronary Angiography
135	Transoral Incision And Drainage Of A Pharyngeal Abscess	**136**	Haemodialysis
137	Tonsillectomy Without Adenoidectomy	**138**	Radiotherapy For Cancer
139	Tonsillectomy With Adenoidectomy		

ANNEXURE II: LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")

S.NO	LIST OF EXPENSES EXCLUDED ("NON-MEDICAL")	SUGGESTIONS
	TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicosevein surgery and should be considered for these conditionswhere surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable

33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD isspecifically sought by In surer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling incase of upper arm fractures should be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Not Payable
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not Payable
62	HORMONE REPLACEMENT THERAPY	Not Payable
63	HOME VISIT CHARGES	Not Payable
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Not Payable
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Not Payable

66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Not Payable
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Not Payable
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Not Payable
69	DONOR SCREENING CHARGES	Not Payable
70	ADMISSION/REGISTRATION CHARGES	Not Payable
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not Payable
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the Hospital payable. Purchase of Instruments Not Payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antisepticordisinfectant lotions	Not Payable - Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable -Part of Dressing Charges

89	COTTON BANDAGE	Not Payable- Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable – Part of Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable
93	TORNIQUET	Not Payable
94	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable, Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by governmentis payable. Part of room charge for sub limits
97	HVAC	Part of room charge, Not Payable separately
98	HOUSE KEEPING CHARGES	Part of room charge, Not Payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge, Not Payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Part of room charge, Not Payable separately
101	SURCHARGES	Part of room charge, Not Payable separately
102	ATTENDANT CHARGES	Part of room charge, Not Payable separately
103	IM IV INJECTION CHARGES	Part of nursing charge, Not Payable separately
104	CLEAN SHEET	Part of Laundry / Housekeeping, Not Payable separately
105	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by Hospital is payable
106	BLANKET/WARMER BLANKET	Part of room charge, Not Payable separately
ADMINISTRATIVE OR NON - MEDICAL CHARGES		
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable

114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	Payable under Post-Hospitalisation where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP – COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SP02 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Payable for surgery of lumbar spine.

151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason andat reasonable cost of approximately Rs 200/day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post-surgery patients of major abdominal surgery including TAH,LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE / HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	Not Payable
157	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES Post hospitalization nursing charges	Not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGESDIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants ofadmissible medicines are not excluded
160	CREAMS POWDERS LOTIONS	Payable when prescribed (Toiletries are not payable, onlyprescribed medical pharmaceuticals payable)
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	One set every second day is Payable.
163	GLOVES Sterilized	Gloves payable / unsterilized gloves not payable
164	HIV KIT	payable pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during Hospitalisation is Payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed

171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre Hospitalisation or post Hospitalisation / Reports and Charts required / Device notpayable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where Medically Necessary - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Payable for case like CABG etc.

ANNEXURE III: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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

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**
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