THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA MEDICLAIM POLICY

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

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

This Policy states:-

What We Cover

Definitions

How much we will reimburse

What are 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.

1. 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, through the Third Party Administrator, in the manner stated herein.

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

2. DEFINITIONS

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

2.2 ANY ONE ILLNESS means continuous period of Illness and includes relapse within forty five days from the date of last consultation with the Hospital where treatment was taken.

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

2.4 CLAIM FREE YEAR means coverage under the New India 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 Insured Person.

2.5 CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

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

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

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

2.8 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.

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

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

- Undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than twenty four hours because of technological advancement, and
- Which would have otherwise required a Hospitalization of more than twenty four hours.

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

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

- has qualified nursing staff under its employment;
- has qualified Medical Practitioner/s in charge;
- Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

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

2.12 DEDUCTIBLE is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.13 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

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

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 twenty four consecutive hours.

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

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

2.19 INPATIENT CARE means treatment for which the insured person has to stay in a Hospital for more than twenty four hours for a covered event.

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

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

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

2.23 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.

2.24 MATERNITY EXPENSES means:

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.

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

2.26 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident 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 Medical Practitioner in the same locality would have charged for the same medical treatment.

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

- is required for the medical management of the Illness or Injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;

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

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

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

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

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

2.31 **NEW BORN BABY** means a baby born during the Period of Insurance to a female Insured Person, who has twenty four months of Continuous Coverage.

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

2.33 **PRE-EXISTING CONDITION/DISEASE** means any condition, ailment or Injury or related condition(s) for which You had signs or symptoms, and/or were diagnosed, and/or for which You received medical advice / treatment within forty eight months prior to the first policy issued by Us (as mentioned in the Schedule) and renewed continuously thereafter.

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

2.35 **PRE-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during thirty days preceding the Hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.36 **POST-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during sixty days immediately after the Insured Person is discharged from the Hospital provided that:

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

Hospitalisation was required, and

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

2.37 PORTABILITY means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another of the same insurer.

2.38 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.

2.39 REASONABLE AND CUSTOMARY CHARGESmean 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 .

2.40 RENAL FAILURE is a condition in which the kidneys lose the ability to remove waste and balance fluids

2.38.1 ACUTE RENAL FAILURE (ARF) is the abrupt loss of kidney function, resulting in the retention of metabolic waste products and dysregulation of volume and electrolytes of body fluids. The medical term Acute Kidney Injury (AKI) has now largely replaced ARF in the medical communities (Injury not necessarily related to Accidents), reflecting the recognition that smaller decrements in kidney function that do not result in overt organ failure are of substantial clinical relevance and are associated with increased morbidity and mortality.

2.38.2 CHRONIC RENAL FAILURE: End stage kidney disease characterized by irreversible failure of both kidneys to function normally, as a result of which either regular dialysis (hemodialysis or peritoneal dialysis) is instituted or a renal transplantation becomes necessary. The diagnosis has to be confirmed by a specialist medical practitioner.

2.38.3 RENAL TRANSPLANTATION: Kidney transplantation is a surgical procedure to remove a healthy and functioning kidney from a living or brain-dead donor and implant it into a patient with non-functioning kidneys.

2.41 RENEWAL means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

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

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

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

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

2.47 WARD who are under the care or protection of the Legal Guardian or Custodian. The definition of Children shall be applicable for Ward.

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

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

3. HOW MUCH WE WILL REIMBURSE

3.1 Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus. Subject to this, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room Rent, boarding and nursing expenses as provided by the Hospital not exceeding 1.0 % of the Sum Insured (without Cumulative Bonus) per day
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2.0 % of the Sum Insured (without Cumulative Bonus) per day
3.1 (c)	Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.
3.1 (d)	Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during Surgery like pacemaker, Relevant Laboratory/Diagnostic test, X-Ray and other medical expenses related to the treatment.
3.1 (e)	Pre-Hospitalization Medical expenses
3.1 (f)	Post-Hospitalization Medical expenses

3.2 PROPORTIONATE DEDUCTION

Reimbursement/payment of Room Rent, boarding and nursing expenses incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such expenses shall not exceed 2% of the Sum Insured per day. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

3.3 LIMIT ON PAYMENT FOR CATARACT:

Our liability for payment of any claim relating to Cataract, for each eye, shall not exceed 20% of the Sum Insured subject to a maximum of Rs. 50,000.

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

3.4 TREATMENTS UNDER AYURVEDIC / HOMEOPATHIC / UNANI SYSTEMS

Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 25% of the Sum Insured provided the treatment for Illness or Injury, is taken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures.

3.5 HOSPITAL CASH

For those Insured Persons, whose Sum Insured is more than or equal to Rs. three lakhs, we will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty four consecutive hours. Payment under this clause shall reduce the Sum Insured.

Hospital Cash will be payable for completion of every twenty four hours and not part thereof.

3.6 ADDITIONAL BENEFIT - HEALTH CHECK-UP

The Insured Person shall be entitled for reimbursement of the cost of Medical check-up at the end of a block of every three Claim Free Years. Such payment shall be restricted to Rs. 5,000 or 1% of the average Sum Insured of the Insured Person in the preceding three years, whichever is less. This benefit is available only once in three years.

Any payment made under this clause shall not be considered as a claim for the purpose of Clauses 5.11 of this Policy.

3.7 PAYMENT OF AMBULANCE CHARGES

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

medical facilities.

3.8 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

No payment shall be made for any Hospitalisation expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anaesthetist directly and not included in the Hospital Bill shall be paid provided a numbered Bill is produced in support thereof, for an amount not exceeding Rs. Ten thousand, where such payment is made in cash and for an amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

3.9 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 liabilitytowards expenses incurred on the donor and the insured recipient shall not exceed the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ.

3.10 REINSTATEMENT OF SUM INSURED

If the Sum Insured is exhausted due to a claim admissible under the Policy, then the Sum Insured shall be reinstated to the Sum Insured stated in the Schedule, provided our liability under the Reinstated Sum Insured shall be subject to the following conditions:

1. Such Reinstatement of Sum Insured shall be effected only where the Sum Insured is Rs. Five Lakhs or more.
2. Such Reinstatement shall take effect only after the Date of Discharge from the Hospital for that claim which resulted in exhaustion of the Sum Insured
3. No Illness or Injury, for a Hospitalisation occurring during the Period of Insurance till the Date of Reinstatement, for which a Claim is paid or admissible, shall be considered under the Reinstated Sum Insured.
4. Such Reinstatement shall be available only once for each Insured Person during a Period of Insurance.

3.11 DAY ONE 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. Any expense incurred towards post natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered. Congenital External Anomaly of the New Born Baby is also not covered under the policy.

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

3.12 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.

3.13 OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 3.2 stands deleted for the members covered in the Policy as stated in the Schedule.

You shall continue to bear the differential between actual and eligible Room Rent.

3.14 OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

On the payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 4.4.13 stands deleted for the members as mentioned in the Schedule. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

Special conditions applicable to Maternity Expenses Benefit:

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

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

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

3.15 OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This optional cover, if opted, will be in addition to limit specified in Clause 3.3

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

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

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

3.16 OPTIONAL COVER IV: VOLUNTARY CO-PAY

If the Insured person opts for voluntary co-pay of 20%, a discount of 15% shall be of given on the premium payable for the Insured Person.

3.17 CUMULATIVE BONUS

The Sum Insured under Policy shall be increased by 25% at each renewal in respect of each claim free year of insurance, subject to maximum of 50%. If a claim is made in any particular year; the cumulative bonus accrued may be reduced at the same rate at which it is accrued.

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

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

Note:

i. Cumulative Bonus shall be applicable for persons having Sum Insured of 2 Lakh & above.
ii. The Cumulative Bonus Buffer under the expiring policy, if any, shall be converted to Cumulative Bonus.
iii. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person who has not claimed under the expiring policy.
iv. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported under the policy.
v. CB shall be available only if the Policy is renewed within the Grace Period.
vi. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.
vii. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies, the same CB of the expiring policy shall be apportioned to each Individual of such Renewed Policies.

viii. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.

ix. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

x. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

4. WHAT ARE EXCLUDED UNDER THIS POLICY

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

4.1 Treatment of any Pre-Existing Condition/Disease, until forty eight months of Continuous Coverage of such Insured Person has elapsed from the Date of inception of his/her first Policy with Us as mentioned in the Schedule.

4.2 Any Illness contracted by the Insured person during the first thirty days of the commencement date of this Policy. This exclusion shall not apply if the Insured person has Continuous Coverage for more than twelve months.

4.3.1 Unless the Insured Person has Continuous Coverage in excess of twenty four months with Us, expenses on treatment of the following Illnesses are not payable:

1. All internal and external benign tumors, 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. Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from Accident
13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Renal Failure

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 forty eight months of Continuous Coverage have elapsed since inception of the first Policy with the Company.

4.3.2 Unless the Insured Person has Continuous Coverage in excess of forty eight months with Us, the expenses related to treatment of

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis

are not payable.

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

4.4.2 **a.** Circumcision unless Medically Necessary for treatment of an Illness not excluded here under or as may be necessitated due to an Accident

b. Change of life/sex change or cosmetic or aesthetic treatment (except for burns/Injury) of any description such as correction of eyesight, etc.

c. Plastic Surgery other than as may be necessitated due to an Accident or as a part of any Illness.

4.4.3 Vaccination and/or inoculation.

4.4.4 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.

4.4.5 Dental treatment or Surgery of any kind unless necessitated by Accident and requiring Hospitalisation**.**

4.4.6 Convalescence, general debility, 'Run-down' condition or rest cure, any treatment relating to Obesity or complications of obesity, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, Venereal disease, intentional self-Injury and Illness or Injury caused by the use of intoxicating drugs/alcohol.

4.4.7 Congenital Internal and External Disease or Defects or anomalies.

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

The exclusion for Congenital **External** Disease or Defects or anomalies shall not apply after **thirty six** months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to **10% of theaverage Sum Insured of the Insured Person in the preceding four years.**

4.4.8 Bodily Injury due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide, Illness arising out of non-adherence to medical advice.

4.4.9 Treatment of any Bodily Injury or Illness sustained whilst or as a result of active participation in any hazardous sports of any kind.

4.4.10 Treatment of any Injury or Illness sustained whilst or as a result of participating in any criminal act.

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

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

4.4.13 Maternity Expenses, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certification by Gynaecologist that it is life threatening one if left untreated.

4.4.14 Naturopathy and Siddha Treatments.

4.4.15 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and similar related items etc., and also any medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

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

4.4.17 Genetic disorders and stem cell implantation/Surgery.

4.4.18 Domiciliary Hospitalisation.

4.4.19 Acupressure, acupuncture, magnetic therapies

4.4.20 Experimental or unproven treatments/ therapies.

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

4.4.22 Treatment for Age Related Macular Degeneration (ARMD) , Treatment for Sleep Apnoea Syndrome, treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and CPAD (Continuous Peritoneal Ambulatory Dialysis).

5. 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 any misrepresentation or non-disclosure We will be entitled to treat the Policy as void.

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 medical/surgical treatment and/or services rendered only in India.

Admissible claims shall be payable only in Indian Rupees.

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

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

5.4 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 to 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.** Intimate within twenty four hours from the time of Hospitalisation in case of Hospitalisation due to medical emergency.
- **c.** Submit following supporting documents TPA relating to the claim within seven days

from the date of discharge from the Hospital:

- **i.** Bill, Receipt and Discharge certificate / card from the Hospital.
- **ii.** Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
- **iii.** Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
- **iv.** Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
- **v.** Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.

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

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

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

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

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

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

5.8 <u>FRAUD, MISREPRESENTATION, CONCEALMENT:</u>

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 <u>MULTIPLE POLICIES:</u>

If two or more policies are taken by You during a period from Us or other Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of Your policies.

1. In all such cases Insurer who has issued the chosen Policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of chosen policy.
2. Policyholder having multiple policies shall also have the right to prefer claims from other Policy/policies for the amounts disallowed under the earlier chosen Policy/Policies, even

if the Sum Insured is not exhausted. The Claim shall be settled subject to the terms and conditions of the other Policy/Policies so chosen.

3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, You shall have the right to choose Insurers from whom You want to claim the balance amount.
4. You shall only be indemnified the Hospitalisation 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 Clause 3.5 of the Policy.

5.10 RENEWAL CLAUSE:

We shall renew this Policy if You shall remit the requisite Premium to Us prior to expiry of the Period of Insurance stated in the Schedule. The Renewal is subject to the rates & terms prevalent at the time of Renewal.

We shall be entitled to decline Renewal if

1. We have withdrawn the Policy, in which event You shall have the option for Renewal under any similar Policy being issued by Us, provided however, benefits payable shall be subject to the terms contained in such other Policy; or
2. Any fraud, misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining Insurance or subsequently in relation thereto, or non-cooperation of the Insured Person; or
3. You fail to remit Premium for Renewal before expiry of the Period of Insurance. We will accept Renewal of the Policy if it is effected within thirty days of the expiry of the Period of Insurance. On such acceptance of Renewal, We however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalisation commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.

Note: In case of revision including the premium, modification, or withdrawal of the Policy a notice, by suitable mode of communication, will be provided to You 90 days before such revision, modification or withdrawal. You will have the option to migrate to similar Health Insurance Policy with Us at the time of renewal with all the accrued continuity benefits such as waiver of waiting period etc. Provided the policy has been maintained without a break as per portability guidelines prescribed by IRDAI.

There will be no loading on renewals on Individual claims experience basis .

5.11 ENHANCEMENT OF SUM INSURED:

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

Age <= 50 years	Up to Sum Insured of 15 lakhs without Medical Examination.
Age 51-60 Years	By two slabs without Medical Examination
Age 61 – 65 Years	By one slab with Medical Examination

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

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

5.12 CUMLATIVE BONUS:

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

5.13 CANCELLATION CLAUSE:

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by you by sending fifteen days' notice in writing by Registered A/D to you at the address stated in the Policy. Even if there are several insured persons, notice will be sent to you.

On such cancellation, premium corresponding to the unexpired period of Insurance will be refunded, if no claim has been made or paid under the Policy

You may at any time cancel this Policy and in such event We shall allow refund of premium, if no claim has been made or paid under the Policy, at Our short period rate table given below:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

5.14 FREE LOOK PERIOD:

The free look period shall be applicable at the inception of the first New India Mediclaim Policy.

You will be allowed a period of fifteen days from the date of receipt of the Policy to review the terms and conditions of the Policy and to return the same if not acceptable.

If You have not made any claim during the free look period, You shall be entitled to:

1. A refund of the premium paid less any expenses incurred by Us on medical examination and the stamp duty charges or;
2. where the risk has already commenced and the option of return of the policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or;
3. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

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

5.16 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interests) Regulation, 2017.

5.17 SETTLEMENT/REJECTION OF CLAIM:

- **i.** We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.
- **ii.** While efforts will be made by Us to not call for any document not listed in Clause 5.5, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.
- **iii.** All necessary claim documents pertaining to Hospitalization should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within seven days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.
  - **a.** In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.
  - **b.** In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.
  - **c.** The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.
    If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.
- **iv.** In the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- **v.** However, where the circumstances of a claim warrant an investigation in the opinion of the Insurer, We shall initiate and complete such investigation at the earliest, in any case not

later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document.

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

5.18 PORTABILITY:

This policy is subject to portability guidelines issued by IRDAI and as amended from time to time.

5.19 GRIEVANCE REDRESSAL:

In the event of Your having any grievance relating to the insurance or any claim thereunder, You may contact any of the Customer Care Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact detail of the office of the Insurance Ombudsman is 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	SclerotherapyEtc

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 Diseased Tissue 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	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues	82	Excision And Destruction Of Diseased Scrotal Tissue
83	Other Excisions Of The Skin And Subcutaneous Tissues	84	Plastic Reconstruction Of The Scrotum And Tunica Vaginalis Testis

85	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues	86	Other Operations On The Scrotum And Tunica Vaginalis Testis
87	Free Skin Transplantation, Donor Site	88	Incision Of The Testes
89	Free Skin Transplantation, Recipient Site	90	Excision And Destruction Of Diseased Tissue Of The Testes
91	Revision Of Skin Plasty	92	Unilateral Orchidectomy
93	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	94	Bilateral Orchidectomy
95	Chemosurgery To The Skin	96	Orchidopexy
97	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	98	Abdominal Exploration In Cryptorchidism
99	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	100	Surgical Repositioning Of An Abdominal Testis
101	Partial Glossectomy	102	Reconstruction Of The Testis
103	Glossectomy	104	Implantation, Exchange And Removal Of A Testicular Prosthesis
105	Reconstruction Of The Tongue	106	Other Operations On The Testis
107	Other Operations On The Tongue	108	Surgical Treatment Of A Varicocele And A Hydrocele Of The Spermatic Cord
109	Incision And Lancing Of A Salivary Gland And A Salivary Duct	110	Excision In The Area Of The Epididymis
111	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct	112	Epididymectomy
113	Resection Of A Salivary Gland	114	Reconstruction Of The Spermatic Cord
115	Reconstruction Of A Salivary Gland And A Salivary Duct	116	Reconstruction Of The Ductus Deferens And Epididymis
117	Other Operations On The Salivary Glands And Salivary Ducts	118	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
119	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	120	Operations On The Foreskin
121	Incision Of The Hard And Soft Palate	122	Local Excision And Destruction Of Diseased Tissue Of The Penis
123	Excision And Destruction Of Diseased Hard And Soft Palate	124	Amputation Of The Penis
125	Incision, Excision And Destruction In The Mouth	126	Plastic Reconstruction Of The Penis
127	Plastic Surgery To The Floor Of The Mouth	128	Other Operations On The Penis
129	Palatoplasty	130	Cystoscopical Removal Of Stones
131	Other Operations In The Mouth	132	Lithotripsy
133	Transoral Incision And Drainage Of A Pharyngeal Abscess	134	Coronary Angiography
135	Tonsillectomy Without Adenoidectomy	136	Haemodialysis

137	Tonsillectomy With Adenoidectomy	138	Radiotherapy For Cancer
139	Parenteral chemotherapy		

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

SNO	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 varicose vein surgery and should be considered for these conditions where 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 is specifically 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 in case 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	ANTISEPTIC OR DISINFECTANT 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 government is 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 and at 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 of admissible medicines are not excluded
160	CREAMS POWDERS LOTIONS	Payable when prescribed (Toiletries are not payable, only prescribed 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 not payable
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

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD - Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078 Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL - Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR - Shri. B. N. Mishra Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009 Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
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@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh

CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018 Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI - Smt. Sandhya Baliga Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002 Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004 Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR - Shri. Ashok K. Jain Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005 Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in	Rajasthan
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@gbic.co.in	Kerala, Lakshadweep, Mahe - a part of Pondicherry

KOLKATA - Shri. K. B. Saha 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@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW - Shri. N. P. Bhagat 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@gbic.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054 Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA - Shri. Ajesh Kumar Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301 Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA - Shri. Sadasiv Mishra Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006 Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand
PUNE - Shri. A. K. Sahoo 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@gbic.co.in	Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region