

THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA ASHA KIRAN POLICY

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

SECTION I

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

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

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

SECTION II

1. Accidental Death
2. Loss of one limb and one eye or loss of both eyes or loss of both limbs
3. Loss of one limb or one eye

4. Permanent Total Disablement other than mentioned above.

2. DEFINITIONS

- 2.1 ACCIDENT** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 2.2 AGE** means age of the Insured person on last birthday as on date of commencement of the Policy.
- 2.3 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.
- 2.4 AYUSH TREATMENT** refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- 2.5 AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
- a. Central or State Government AYUSH Hospital or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
- 2.6 AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:
- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.7 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.

2.8 CASHLESS FACILITY means a facility extended by Us to You where the payments, of the costs of treatment undergone by You in accordance with the policy terms and conditions, are directly made to the Network provider by Us to the extent of pre-authorization approved.

2.9 CONDITION PRECEDENT means a Policy term or condition upon which Our liability under the Policy is conditional upon.

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

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

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

2.11 CO-PAYMENT means a cost sharing requirement under a Health Insurance policy that provides that the policyholder / Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

2.12 CRITICAL ILLNESS means the following Illnesses:

2.12.1 CANCER means

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

II. The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM

- Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- ix. All tumors in the presence of HIV infection.

2.12.2 MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIED SEVERITY)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
- i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
 - ii. New characteristic electrocardiogram changes
 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. **The following are excluded:**
- i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris.
 - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2.12.3 OPEN CHEST CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. **The following are excluded:**
- i. Angioplasty and/or any other intra-arterial procedures

2.12.4 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.

2.12.5 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.

2.12.6 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.

2.12.7 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 and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced
- II. **The following are excluded:**
 - i. Transient ischemic attacks (TIA)
 - ii. Traumatic injury of the brain
 - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2.12.8 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

2.12.9 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.

2.12.10 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.

2.12.11 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 and
 - ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months
- II. Other causes of neurological damage such as SLE and HIV are excluded.

2.13 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.

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

- Undertaken under General or Local Anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a Hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.15 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.

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

2.17 EMERGENCY CARE means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.

2.18 GRACE PERIOD means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

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

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

1	Adenoidectomy
2	Appendectomy
3	Anti-Rabies Vaccination
4	Coronary angiography
5	Coronary angioplasty
6	Dilatation & Curettage
7	ERCP (Endoscopic Retrograde Cholangiopancreatography)
8	ESWL (Extracorporeal Shock Wave Lithotripsy)
9	Excision of Cyst / granuloma / lump
10	FOLLOWING EYE SURGERIES:
A	Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
B	Corrective Surgery for blepharoptosis when not congenital / cosmetic
C	Corrective Surgery for entropion / ectropion
D	Dacryocystorhinostomy [DCR]
E	Excision involving one-fourth or more of lid margin, full-thickness
F	Excision of lacrimal sac and passage
G	Excision of major lesion of eyelid, full-thickness
H	Manipulation of lacrimal passage
I	Operations for pterygium
J	Operations of canthus and epicanthus when done for adhesions due to chronic Infections
K	Removal of a deeply embedded foreign body from the conjunctiva with incision
L	Removal of a deeply embedded foreign body from the cornea with incision
M	Removal of a foreign body from the lens of the eye
N	Removal of a foreign body from the posterior chamber of the eye
O	Repair of canaliculus and punctum
P	Repair of corneal laceration or wound with conjunctival flap
Q	Repair of post-operative wound dehiscence of cornea
R	Penetrating or Non-Penetrating Surgery for treatment of Glaucoma
11	Pacemaker insertion
12	Turbinectomy / turbinoplasty
13	Excision of pilonidal sinus
14	Therapeutic endoscopic surgeries
15	Conisation of the uterine cervix
16	Medically necessary Circumcision
17	Excision or other destruction of Bartholin's gland (cyst)
18	Nephrotomy

19	Oophorectomy
20	Urethrotomy
21	PCNL (percutaneous nephrolithotomy)
22	Reduction of dislocation under General Anaesthesia
23	Transcatherter Placement of Intravascular Shunts
24	Incision of the Breast, lump excision
25	Vitrectomy
26	Thyroidectomy
27	Vocal cord Surgery
28	Stapedotomy
29	Tympanoplasty& revision tympanoplasty
30	Arthroscopic Knee Aspiration if Proved Therapeutic
31	Perianal abscess Incision & Drainage
32	DJ stent insertion
33	FESS (Functional Endoscopic Sinus Surgery)
34	Fissurectomy / Fistulectomy
35	Fracture / dislocation excluding hairline fracture
36	Haemo dialysis
37	Hydrocelectomy
38	Hysterectomy
39	Inguinal / ventral / umbilical / femoral hernia repair
40	Laparoscopic Cholecystectomy
41	Lithotripsy
42	Liver aspiration
43	Mastoidectomy
44	Parenteral chemotherapy
45	Haemorrhoidectomy
46	Polypectomy
47	FOLLOWING PROSTATE SURGERIES
A	TUMT (Transurethral Microwave Thermotherapy)
B	TUNA (Transurethral Needle Ablation)
C	Laser Prostatectomy
D	TURP (Transurethral Resection of Prostate)
E	Transurethral Electro-Vaporization of the Prostate (TUEVAP)
48	Radiotherapy
49	Sclerotherapy
50	Septoplasty
51	Surgery for Sinusitis
52	Varicose Vein Ligation
53	Tonsillectomy
54	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
55	Retinal Surgeries
56	Ossiculoplasty
57	Ascitic / pleural therapeutic tapping
58	therapeutic Arthroscopy
59	Mastectomy
60	Surgery for Carpal Tunnel Syndrome
61	Cystoscopic removal of urinary stones / DJ stents
62	AV Malformations (Non cosmetic only)

63	Orchidectomy
64	Cystoscopic fulguration of tumour
65	Amputation of penis
66	Creation of Lumbar Subarachnoid Shunt
67	Radical Prostatectomy
68	Lasik Surgery (non-cosmetic)
69	Orchidopexy (non-congenital)
70	Nephrectomy
71	Palatal Surgery
72	Stapedectomy & revision of stapedectomy
73	Myringotomy
74	Or any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalization and for which prior approval from TPA is mandatory.

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.

2.21 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

2.22 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.

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

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

2.25 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.

2.26 ICU (INTENSIVE CARE UNIT) CHARGES means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

2.29 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.

2.30 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 NETWORK HOSPITAL means Hospitals enlisted by Us, TPA or jointly by Us and TPA to provide medical services to an insured by a cashless facility.

2.32 NON-NETWORK HOSPITAL means any hospital that is not part of the network.

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

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

- a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or
- b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

- 2.35 PERMANENT TOTAL DISABLEMENT** means such disablement of a permanent nature, as incapacities of Insured Person for all work which he/she was capable of performing at the time of the Accident resulting in such disablement.
- 2.36 PRE-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during the period preceding Your Hospitalisation, provided that:
- i. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and
 - ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us.
- 2.37 POST-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during the period immediately after Your discharge from the Hospital provided that:
- i. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and
 - ii. The In-patient Hospitalization claim for such Hospitalization is admissible by Us.
- 2.38 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.
- 2.39 POLICY PERIOD** means period of one policy year as mentioned in the schedule for which the Policy is issued.
- 2.40 POLICY SCHEDULE** means the Policy Schedule attached to and forming part of Policy.
- 2.41 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.
- 2.42 PREFERRED PROVIDER NETWORK (PPN)** means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for Our policyholders. The list of planned procedures is available with Us / 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.
- 2.43 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.
- 2.44 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.

- 2.45 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.
- 2.46 ROOM RENT** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- 2.47 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.
- 2.48 SUM INSURED** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of all Insured Persons during the Policy Year.
- 2.49 SURGERY OR SURGICAL PROCEDURE** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital or Day Care Centre by a medical practitioner.
- 2.50 THIRD PARTY ADMINISTRATORS (TPA)** means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
- 2.51 WAITING PERIOD** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
- 2.52 WE / OUR / US / COMPANY** means **The New India Assurance Co. Ltd.**
- 2.53 YOU / YOUR** means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one) in the Schedule.

3. HOW MUCH WE WILL REIMBURSE

SECTION I

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

3.1.1 (a)	Room Rent, including but not limited to boarding and nursing expenses, actually incurred or 1% of the Sum Insured per day, whichever is less.
3.1.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expense actually incurred or 2% of Sum Insured per day, whichever is less.

3.1.1 (c)	Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.
3.1.1 (d)	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.
Reimbursement/payment of Room Rent, including but not limited to 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 Rent /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 and implants, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day for Room Rent (including but not limited to boarding and nursing expenses)/ICU/ICCU charges.	
3.1.1 (e)	Pre-Hospitalization Medical Expenses, not exceeding thirty days
3.1.1 (f)	Post-Hospitalization Medical Expenses, not exceeding sixty 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 aggregate of the Sum Insured, if any, of the Insured Person receiving the organ.

3.1.2 CO-PAYMENT FOR CHANGE IN ZONE:

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

- a) 80% of the admissible claim amount, or
- b) Sum Insured.

Whichever is less.

3.1.3 LIMIT ON PAYMENT FOR CATARACT

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

3.1.4 TREATMENTS UNDER AYURVEDIC / HOMEOPATHIC / UNANI SYSTEMS

Our liability for expenses incurred for Ayurvedic / Homeopathic / Unani treatments shall not exceed 25% of the Sum Insured in respect of all such treatments admitted during the Policy Period, provided the treatment for Illness or Injury, is taken in any AYUSH Hospital.

3.1.6 HOSPITAL CASH

We will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation,

admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty four hours.

3.1.7 CRITICAL CARE BENEFIT

If during the Policy Period any Insured Person diagnosed to be suffering from any Critical Illness as defined under 2.12, which results in a claim admissible under this Policy, 10% of the Sum Insured would be paid as Critical Care Benefit along with the admissible claim amount. Critical Care Benefit is payable only once in the life time of each Insured Person and is not applicable to any Insured Persons for whom it is a Pre-Existing Disease. Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

3.1.8 PAYMENT OF AMBULANCE CHARGES

We will pay You the charges for Ambulance services not exceeding 1% of the Sum Insured, Reasonably, Customary 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.

3.1.9 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.

3.1.10 TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Anomaly shall be covered after **twenty four** months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage.

Congenital External Anomaly shall be covered after **forty eight** months of Continuous Coverage, but such cover shall be limited to 10% of **the average Sum Insured in the preceding four years**.

3.1.11 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, maximum upto Rs. 25,000 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) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** We shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured.

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

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

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

Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

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

- d) **Puberty and Menopause related Disorders:** Treatment for any symptoms, illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.
- e) **Age Related Macular Degeneration (ARMD)** is covered after 48 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 75,000 per policy period.
- f) **Behavioural and Neuro developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.
- g) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

Note: For the coverages defined in 3.1.11, waiting periods, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020. Coverage for such illness or procedures shall only be available after completion of the said waiting periods.

3.1.12 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)
3.1.12.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
3.1.12.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
3.1.12.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh
3.1.12.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
3.1.12.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 1 Lakh.
3.1.12.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.30,000.
3.1.12.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 2 Lakh.
3.1.12.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.1.12.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.1.12.10	Vaporisation of the prostate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
3.1.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 25,000.
3.1.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.

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

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

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

	Coverage		Compensation
3.2.1	Death of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.2.2	Permanent Total Disablement of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.2.3	Loss of both eyes / Loss of both limbs / Loss of one limb and one eye of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3.2.4	Loss of one limb / one eye of	Proposer or Spouse	50% of Sum Insured
		Proposer and Spouse	100% of Sum Insured

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

Note: The Company shall not be liable under this Policy for Compensation under more than one of the sub-clauses 3.2.1, 3.2.2, 3.2.3 or 3.2.4 in respect of same Injury or disablement.

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

4. WHAT ARE 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 48 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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

- a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 24 / 48 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. Skin Disorders
 14. Stone in Gall Bladder and Bile duct, excluding malignancy
 15. Stones in Urinary system
 16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
 17. Varicose Veins and Varicose Ulcers
 18. Puberty and Menopause related Disorders
 19. Behavioural and Neuro-Developmental Disorders:
 - a. Disorders of adult personality
 - b. Disorders of speech and language including stammering, dyslexia
 20. Internal Congenital Diseases

(iii) 48 Months waiting period

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

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

- a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

- a. Surgery to be conducted is upon the advice of the Doctor
- b. The surgery/Procedure conducted should be supported by clinical protocols
- c. The member has to be 18 years of age or older and
- d. Body Mass Index (BMI);
 - 1. greater than or equal to 40 or
 - 2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

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

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

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in

hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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

4.4.7 BREACH OF LAW (Code- Excl10)

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

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

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

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

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

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

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

- a. Any type of contraception, sterilization
- b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- c. Gestational Surrogacy
- d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.4.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

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

- a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
- b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
- c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

4.4.18 Vaccination and/or inoculation

4.4.19 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.

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

4.4.21 Convalescence, general debility, Venereal disease.

4.4.22 Bodily Injury or Illness or Death or Disability 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.

4.4.23 Treatment of any Injury or Illness or Disablement or Death, sustained whilst or as a result of participating in any criminal act.

4.4.24 Naturopathy Treatment.

4.4.25 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, Elasto crepe 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.

4.4.26 Stem cell implantation / Surgery for other than those treatments mentioned in clause 3.1.12.12.

4.4.27 Domiciliary Hospitalisation

4.4.28 Acupressure, acupuncture, magnetic therapies

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

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

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

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

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

Admissible claims shall be payable only in Indian Rupees.

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

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

5.4 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:

FOR PERSONAL ACCIDENT:

In case of death claim:

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

In case of Injury claim:

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

FOR MEDICLAIM:

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

- a. Intimate TPA in writing on detection of any Disease/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/Policy issuing office (as the case may be) 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.
 - vi. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.
- 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** Proof satisfactory to the Company shall be furnished of all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured Person on the occasion of any alleged Injury or complement when and so often as the same may reasonably be required on behalf of the Company and in the event of death, to make a post-mortem examination of the body of the insured and such evidence as the Company may from time to time require (including a post-mortem examination, if necessary) shall be furnished within the space of fourteen days after demand in writing.
- 5.7** 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 / Company such additional information and assistance as the TPA / Company may require.
- 5.8** 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.
- 5.9** **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.

5.10 MULTIPLE POLICIES:

1. In case of multiple policies taken by You during a period from Us or one or more Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of his/her policies. In all such cases We, if chosen by You, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
2. Insured 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 We shall independently settle the claim subject to the terms and conditions of this Policy.
3. If the amount to be claimed exceeds the Sum Insured under a single policy after, You shall have the right to choose Insurers from whom You wants to claim the balance amount.
4. Where an Insured has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured 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 Section II, Clause 3.1.6 and 3.1.7 of the Policy.

5.11 RENEWAL CLAUSE:

We shall renew this Policy if You shall remit the requisite Premium to Us prior to expiry of the Policy Period stated in the Schedule. We shall be entitled to decline renewal if:

1. 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
2. We have discontinued issue of the Policy, in which event You shall however 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
3. You fail to remit Premium for renewal before expiry of the Policy Period. We will accept renewal of the Policy if it is effected within thirty days of the expiry of the Policy Period. On such acceptance of renewal, We, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.
4. In the event of dissociation of the dependent daughter(s) due to any reason including death, benefits under Section II ceases automatically.
5. The Company shall offer an option to migrate to suitable Health Insurance policy once the Daughter/s become financially independent or there is a deviation from the definition of the family.

5.12 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 (50% of Medical examination cost will be reimbursed to the Insured Person). Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

Sum Insured can be enhanced to the next Sum Insured band only.

Enhancement of Sum Insured will not be considered for:

- 1) Insured Persons over 65 years of age.
- 2) Insured Person who had undergone Hospitalization in the preceding two years.
- 3) Insured Persons suffering from one or more of the following Illnesses/Conditions:
 - a) Diabetes
 - b) Hypertension
 - c) Any chronic Illness / ailment
 - d) Any recurring Illness / ailment
 - e) Any Critical Illness

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

5.13 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, other than on grounds of fraud, premium corresponding to the unexpired Policy Period will be refunded on prorata basis, 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 policy.

You will be allowed a period of 15 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 of the Insured Person(s) 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.

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 PORTABILITY AND MIGRATION:

MIGRATION:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then You will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

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 such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

5.17 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2017.

5.18 PAYMENT 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 Hospitalisation 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 case of any delay, such claims shall be paid by Us with a penal interest as per Regulation 9(6) of IRDA (Protection of Policyholders' Interests) Regulations, 2017 as modified from time to time.

All admissible claims shall be payable in Indian Currency.

5.19 REPUDIATION OF CLAIMS:

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

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

5.20 GRIEVANCE REDRESSAL:

In the event of Your having any grievance relating to the insurance, You may contact any of the Grievance 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 details of the office of the Insurance Ombudsman are provided in the Annexure II.

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

5.21 MORATORIUM PERIOD: After completion of eight continuous years under this policy no look back would be applied. This period of eight **years** is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums

Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

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



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

S No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT

51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES

33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

ANNEXURE II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

<p>AHMEDABAD - Shri Kuldip Singh 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</p>	<p>BHOPAL - Shri Guru Saran Shrivastava 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@ecoi.co.in</p>
<p>BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in</p>	<p>CHANDIGARH - Dr. Dinesh Kumar Verma 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</p>
<p>CHENNAI - Shri M. Vasantha Krishna 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</p>	<p>DELHI - Shri Sudhir Krishna 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</p>
<p>GUWAHATI - Shri Kiriti .B. Saha 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</p>	<p>HYDERABAD - Shri I. Suresh Babu 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</p>
<p>ERNAKULAM - Ms. Poonam Bodra 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</p>	<p>KOLKATA - Shri P. K. Rath 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</p>
<p>LUCKNOW -Shri Justice Anil Kumar Srivastava 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</p>	<p>MUMBAI - Shri Milind A. Kharat 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</p>
<p>JAIPUR - Smt. Sandhya Baliga 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</p>	<p>PUNE - Shri Vinay Sah 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</p>
<p>BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in</p>	<p>NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>
<p>PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in</p>	