THE NEW INDIA ASSURANCE CO. LTD.

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

IRDAI Registration No: 190

NEW INDIA PREMIER MEDICLAIM POLICY

This is Your NEW INDIA PREMIER 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 of which this is a renewal.

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

What We Cover

Definitions

How much we will reimburse

What is excluded under this Policy

Conditions

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

SECTION I - WHAT WE COVER

If during the **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, We** will reimburse such expense incurred by **You**, in the manner stated herein.

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

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

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

SECTION II – DEFINITIONS

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

2.2 **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 representatives.

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

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

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

2.12 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.

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

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

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

1. OPD Treatments
2. Treatment for Infertility
3. HIV/AIDS
4. Obesity Treatments

2.14 CRITICAL ILLNESSES mean the following Illnesses:

2.14.2 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.

2.14.3 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.

2.14.4 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

2.14.5 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.

2.14.6 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.

2.14.7 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.

2.14.8 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 emobilisation 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.

2.14.9 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

2.14.10 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.

2.14.11 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.

2.14.12 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.

2.15 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.

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

- undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a Hospitalisation of more than 24 hours.

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

2.17 DENTAL TREATMENT is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and Surgery.

2.18 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.

2.19 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.

2.20 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.

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

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

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

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

2.23 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

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

2.25 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.

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

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

2.28 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.

2.29 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.

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

2.31 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.

2.32 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 You;
- 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.

2.33 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 the licence.

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

2.34 MATERNITY EXPENSES shall mean:

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

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

2.35 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.

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

2.37 NON-NETWORK PROVIDER means any hospital that is not part of the network.

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

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

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

2.41 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.

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

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

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

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

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

- **i.** Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- **ii.** The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.
- **iii.** Such Medical Expenses are incurred not later than ninety days after the date of discharge from the Hospital.

2.44 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.

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

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

2.47 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

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

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

2.50 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.

2.51 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.

2.52 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.

2.53 ROOM RENT means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

2.54 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

2.55 SUM INSURED means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

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

2.58 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.

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

2.60 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.

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

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

2.63 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.

2.64 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

SECTION III - HOW MUCH WE WILL REIMBURSE

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

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

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

MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:

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

MEDICAL EXPENSES FOR ORGAN TRANSPLANT:

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

3.1.2 TREATMENTS UNDER AYURVEDIC / HOMEOPATHIC / UNANI SYSTEMS

We will provide coverage for AYUSH treatments during the Period of Insurance upto 20% of Sum Insured provided the treatment has been undergone 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 centre for spas, massage and health rejuvenation procedures.

3.1.3 HOSPITAL CASH

We will pay Hospital Cash at the rate of Rs. 2,000 per day for Plan A and Rs. 4,000 per day for Plan B for each day of Hospitalisation admissible under the Policy. The payment under this

Clause for Any One Illness shall be made for maximum 10 days of Hospitalisation. The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty-four hours. Payment under this Clause will reduce the Sum Insured.

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

3.1.4 PAYMENT OF AMBULANCE CHARGES

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

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

3.1.5 TREATMENT FOR CONGENITAL DISEASES

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

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

3.1.6 COVERAGE FOR MATERNITY & CHILD CARE

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

Special conditions applicable to Maternity and Child Care Benefit:

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

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

3.1.7 NEW BORN BABY COVERAGE

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 covered only after 48 months Waiting Period.

Waiting Period for Congenital Internal Disease 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.

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.

Note: New Born Baby means a baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.

3.1.8 TREATMENT FOR INFERTILITY

We shall provide expenses necessarily incurred for treatment of Infertility (including OPD Treatment) subject to a limit of Rs. 1,00,000 for Plan A and Rs. 2,00,000 for Plan B. This limit shall be our maximum liability in respect of all Insured Persons. If any claim is payable to any Insured Person under this Clause in any particular Period of Insurance, the benefit under this Clause shall not be available for any subsequent Renewal for any Insured Person irrespective of the amount claimed in the expiring Policy.

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

3.1.9 CRITICAL CARE BENEFIT

If during the Period of Insurance any Insured Person suffers and diagnosed for the first time from a Critical Illness as defined under Clause 2.14, which results in a claim for Hospitalisation being admissible under this Policy, Rs. 2,00,000 for Plan A and Rs. 5,00,000 for Plan B would be paid as a lump sum Critical Care Benefit in addition to the admissible amount of **Hospitalisation Expenses**. Critical Care Benefit is payable only once in the life time of each Insured Person and shall not be payable if the Critical Illness is a Pre- Existing Condition / Disease. Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured. This will be paid only if the Hospitalisation is more than 24 hours.

3.1.10 OPD COVER:

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

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

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

3.1.11 COVER FOR HIV- AIDS

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

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

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

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

3.1.12 LIMIT ON PAYMENT OF CATARACT:

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

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

3.1.13 SECOND OPINION FOR MAJOR SURGERIES

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

3.1.14 COVERAGE FOR HAZARDOUS SPORTS

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

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

Our liability under this Clause shall not exceed 10% of Sum Insured. However, if Injury or Illness is related to particular line of employment or occupation (not for recreational purpose), it will

be covered upto Sum Insured.

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

3.1.15 CONCIERGE SERVICES

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

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

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

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

3.1.16 SPECIFIC COVERAGES:

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

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

c) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured.

d) **Age Related Macular Degeneration (ARMD)** is covered after 36 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of Rs. 1,00,000 per policy period.

e) **Behavioural and Neuro developmental Disorders**: *Disorders of adult personality and Disorders of speech and language including stammering, dyslexia;* are covered as Inpatient

procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured.

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

Note: For the coverages defined in 3.1.16, waiting period's, 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.

3.1.17 COVERAGE FOR MODERN TREATMENTS OR PROCEDURES: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
3.1.17.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto Rs. 2 Lakh
3.1.17.2	Balloon Sinuplasty	Upto Rs. 2 Lakh
3.1.17.3	Deep Brain stimulation	Upto Rs. 5 Lakh
3.1.17.4	Oral chemotherapy	Upto Rs. 1 Lakh
3.1.17.5	Immunotherapy- Monoclonal Antibody to be given as injection	Upto Rs 2 Lakh
3.1.17.6	Intravitreal injections	Upto Rs. 75,000
3.1.17.7	Robotic surgeries	Upto Rs. 5 Lakh
3.1.17.8	Stereotactic radio surgeries	Upto Rs. 3 Lakh
3.1.17.9	Bronchial Thermoplasty	Upto Rs. 2.5 Lakh
3.1.17.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Upto Rs. 2.5 Lakh
3.1.17.11	IONM - (Intra Operative Neuro Monitoring)	Upto Rs. 50,000
3.1.17.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	Upto Rs. 2.5 Lakh

PART II: (COVER AVAILABLE ONLY FOR PLAN B)

3.2.1 COVER FOR PSYCHIATRIC AND PSYCHOSOMATIC DISORDERS

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

3.2.2 TREATMENT FOR OBESITY

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

1. Respiratory: Obstructive sleep apnea, Pickwickian syndrome (obesity hypoventilation syndrome)
2. Cardiovascular: Coronary artery disease, left ventricular hypertrophy, coronary pulmonale,

obesity-associated cardiomyopathy, accelerated atherosclerosis, and pulmonary hypertension of obesity

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

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

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

3.2.3 DIETICIAN COUNSELING

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

SECTION IV - WHAT IS EXCLUDED UNDER THIS POLICY

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

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by 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 24 / 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

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

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

(i) 90 Days Waiting Period

1. Diabetes Mellitus

2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele
9. Non Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Renal Disorders
14. Skin Disorders
15. Stone in Gall Bladder and Bile duct, excluding malignancy
16. Stones in Urinary system
17. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
18. Varicose Veins and Varicose Ulcers
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia
21. Internal Congenital Diseases

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

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

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

4.4.4 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.5 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 except as provided under **3.1.14.**

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.

4.4.6 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.

4.4.7 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.

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

4.4.9 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).**

4.4.10 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)**

4.4.11 REFRACTIVE ERROR (Code- Excl15)

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

4.4.12 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.

4.4.13 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.

4.4.14 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.

4.4.15 Any expenses incurred on Domiciliary Hospitalization.

4.4.16 Treatment taken outside the geographical limits of India.

4.4.17 Vaccination and/or inoculation.

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

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

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

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

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

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

4.4.23 Acupressure, acupuncture, magnetic therapies.

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

4.4.25 Convalescence, General debility and Venereal disease.

4.4.26 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.

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

4.4.28 Naturopathy Treatment.

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

SECTION V - CONDITIONS

5.1 BASIS OF INSURANCE:

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

5.2 PREMIUM:

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

5.3 PLACE OF TREATMENT AND PAYMENT:

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

Admissible claims shall be payable only in Indian Rupees.

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

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

5.4 COMMUNICATION:

You must send all communications and papers regarding a claim to the TPA at the address shown in the Schedule. For all other matters relating to the policy, communication must be sent our Policy issuing office. Communications you wish to rely upon must be in writing.

5.5 NOTICE OF CLAIM:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.9 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 III, Clause 3.1.3 and Clause 3.1.10 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 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 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
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 or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

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

5.12 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

period of Insurance will be refunded on pro rata 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

In case of death of any of the member the refund will be pro rata basis, provided there is no claim on that member in the policy period.

5.13 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.

5.14 ENHANCEMENT OF SUM INSURED:

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

Enhancement of Sum Insured will not be considered for:

1) Any Insured Person over 65 years of age.

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

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

- **a)** Diabetes
- **b)** Hypertension
- **c)** Any chronic Illness
- **d)** Any recurring Illness
- **e)** Any Critical Illness

Note:

i. In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to the additional Sum Insured from such date.
ii. Migration from Plan A to Plan B will only be considered up to 60 years of age
iii. On migration from Plan A to Plan B the covers available under Plan B will trigger only after competition of respective waiting periods.
iv. On migration from Plan A to Plan B the enhanced limits available under Plan B will be applicable only on completion of the waiting periods mentioned therein.

5.15 ARBITRATION:

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

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

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

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

5.16 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 India 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 IRDAI (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.

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

5.20 GRIEVANCE REDRESSAL:

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

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

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-II. 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-II respectively.

ANNEXURE I: LIST OF DAY CARE PROCEDURES:

1	Abdominal Exploration in Cryptorchidism	2	Amputation of the Penis
3	Arthroscopic Knee Aspiration	4	Bilateral Orchidectomy
5	Chemosurgery to Skin	6	Closed Reduction on Fracture, Luxation or Epiphyseolysis With Osteosynthesis
7	Conisation of Uterine Cervix	8	Coronary Angiography
9	Corrective Surgery for Blepharoptosis	10	Corrective Surgery for Entropion and Ectropion
11	Culdotomy	12	Cystoscopical Removal of Stones
13	Destruction of Diseased Tissue in Skin and Subcutaneous Tissues	14	Dilatation of The Cervical Canal
15	Division of The Anal Sphincter (Sphincterotomy)	16	Epididymectomy
17	Excision and Destruction of a Lingual Tonsil	18	Excision and Destruction of Diseased Hard and Soft Palate
19	Excision and Destruction of Diseased Scrotal Tissue	20	Excision and Destruction of Diseased Tissue of Eyelid
21	Excision and Destruction of Diseased Tissue of Nose	22	Excision and Destruction of Diseased Tissue of Testes
23	Excision in The Area of Epididymis	24	Excision of Diseased Tissue of a Salivary Gland and a Salivary Duct
25	External Incision and Drainage in the Region of Mouth, Jaw and Face	26	Fenestration of Inner Ear
27	Free Skin Transplantation, Donor Site	28	Free Skin Transplantation, Recipient Site
29	Glossectomy	30	Haemodialysis
31	Implantation, Exchange and Removal of a Testicular Prosthesis	32	Incision (Opening) and Destruction (Elimination) of Inner Ear
33	Incision and Excision of Periprostatic Tissue	34	Incision and Excision of Tissue in Perianal Region
35	Incision and Lancing of a Salivary Gland and a Salivary Duct	36	Incision of a Pilonidal Sinus
37	Incision of Diseased Eyelids	38	Incision of Tear Glands
39	Incision of Breast	40	Incision of Cornea
41	Incision of Hard and Soft Palate	42	Incision of Mastoid Process and Middle Ear
43	Incision of Ovary	44	Incision of Prostate
45	Incision of Scrotum and Tunica Vaginalis Testis	46	Incision of Testes
47	Incision of Uterus (Hysterotomy)	48	Incision of Vagina
49	Incision of Vulva	50	Incision on Bone, Septic and Aseptic
51	Incision, Excision and Destruction in The Mouth	52	Incision, Excision and Destruction of Diseased Tissue of Tongue
53	Insufflation of Fallopian Tubes	54	Lithotripsy
55	Local Excision and Destruction of Diseased Tissue of Penis	56	Local Excision and Destruction of Diseased Tissue of Vagina and Pouch Of Douglas
57	Local Excision of Diseased Tissue of Skin and Subcutaneous Tissues	58	Mastoidectomy
59	Myringoplasty (Type -I Tympanoplasty)	60	Myringotomy
61	Nasal Sinus Aspiration	62	Open Surgical Excision and Destruction of Prostate Tissue
63	Operation of Cataract	64	Operation on a Testicular Hydrocele
65	Operations for Pterygium	66	Operations on Bartholin's Glands (Cyst)
67	Operations on The Canthus and Epicanthus	68	Operations on The Foreskin
69	Operations on The Nipple	70	Operations on The Seminal Vesicles
71	Operations on The Turbinates (Nasal Concha)	72	Orchidopexy
73	Other Excision and Destruction Of Prostate Tissue	74	Other Excisions of Middle and Inner Ear
75	Other Excisions of Skin and Subcutaneous Tissues	76	Other Incisions of Skin and Subcutaneous Tissues

77	Other Microsurgical Operations on Middle Ear	78	Other Operations in Mouth
79	Other Operations on Anus	80	Other Operations on Auditory Ossicles
81	Other Operations on Cornea	82	Other Operations on Fallopian Tube
83	Other Operations on Middle and Inner Ear	84	Other Operations on Nose
85	Other Operations on Penis	86	Other Operations on Prostate
87	Other Operations on Salivary Glands and Salivary Ducts	88	Other Operations on Scrotum and Tunica Vaginalis Testis
89	Other Operations on Spermatic Cord, Epididymis and Ductus Deferens	90	Other Operations on Tear Ducts
91	Other Operations on Testis	92	Other Operations on Tongue
93	Other Operations on Tonsils and Adenoids	94	Other Operations on Uterine Cervix
95	Other Restoration and Reconstruction of Skin And Subcutaneous Tissues	96	Palatoplasty
97	Parenteral Chemotherapy	98	Partial Glossectomy
99	Plastic Reconstruction of Penis	100	Plastic Reconstruction of Scrotum and Tunica Vaginalis Testis
101	Plastic Surgery to the Floor of Mouth	102	Radical Prostatovesiculectomy
103	Radiotherapy for Cancer	104	Reconstruction of a Salivary Gland and a Salivary Duct
105	Reconstruction of Ductus Deferens and Epididymis	106	Reconstruction of Middle Ear
107	Reconstruction of Spermatic Cord	108	Reconstruction of Testis
109	Reconstruction of Tongue	110	Reduction of Dislocation Under GA
111	Removal of a Foreign Body from the Conjunctiva	112	Removal of a Foreign Body from the Cornea
113	Removal of a Foreign Body From the Lens of the Eye	114	Removal of a Foreign Body from the Orbit And Eyeball
115	Removal of a Foreign Body from the Posterior Chamber of Eye	116	Removal of a Tympanic Drain
117	Resection of a Salivary Gland	118	Revision of a Fenestration of Inner Ear
119	Revision of a Stapedectomy	120	Revision of a Tympanoplasty
121	Revision of Skin Plasty	122	Sclerotherapy etc
123	Simple Restoration of Surface Continuity of Skin and Subcutaneous Tissues	124	Stapedectomy
125	Stapedotomy	126	Surgical Repositioning of an Abdominal Testis
127	Surgical Treatment of a Varicocele and a Hydrocele of Spermatic Cord	128	Surgical Treatment of Anal Fistulas
129	Surgical Treatment of Haemorrhoids	130	Suture and Other Operations on Tendons and Tendon Sheath
131	Therapeutic Curettage	132	Tonsillectomy with Adenoidectomy
133	Tonsillectomy Without Adenoidectomy	134	Transoral Incision and Drainage of a Pharyngeal Abscess
135	Transurethral and Percutaneous Destruction of Prostate Tissue	136	Transurethral Excision and Destruction of Prostate Tissue
137	Tympanoplasty (Closure of an Eardrum Perforation / Reconstruction of the Auditory Ossicles)	138	Ultrasound Guided Aspirations
139	Unilateral Orchidectomy		

ANNEXURE II:

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

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

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

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

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

35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

ANNEXURE III: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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**	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**
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**	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**
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**	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**
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**	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**
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**	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**
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**	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**
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**	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**
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, Ist Phase, Bengaluru – 560 078.** **Tel.: 080 - 26652048 / 26652049** **Email: bimalokpal.bengaluru@ecoi.co.in**	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**
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**	