THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

The New India Assurance Co. LTD,

AJAY ENGINEERING COMPOUND, , ADALAT ROAD, AURANGABAD
, ,
Tel. No. : 02402333572
Email : nia.160400@newindia.co.in

NEW INDIA FLOATER MEDICLAIM POLICY

Policy Number : 160400342128000000360

Period of Insurance

From	: 18-Jan-2022 12:00:01 AM	To	: 17-Jan-2023 11:59:59 PM

Policy Holder's Details

Name of Insured	: GUNVANTIBHAI PRAVINBHAI PATEL		
Address	: 8, SHUBHLAXMI SOC., AMBALISAN STATION,,		
City	: AMBALIAYASAN,	Pincode	: 382732
Tel./Mobile No.	: XXXXXX9898		
E-mail Id	: pancholi.tejas@gmail.com,		

For Insurance Renewals

Please contact:

Issuing Office	: 02402333572
Agency Name	: JAINUINE INSURANCE BROKERS PVT. LTD.
Tel. No.	: 02402350377
Email	: kailash@jainuineinsurance.co.in

For Claims contact TPA

TPA Name	: MDINDIA HEALTH INSURANCE TPA PVT. LIMITED
Toll Free	: 18002097800
Tel. No.	: 18002097777
Email	: customercare@mdindia.com

Tax Invoice No : 16040021P0016930

IRDA Registration Number: 190

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

New India Floater Mediclaim Policy

UIN : NIAHLIP21278V042021

Policy Schedule

Current Policy No	16040034212800000360	**Current Policy Period**	From:18/01/2022 12:00:01 AM To:17/01/2023 11:59:59 PM
Previous Policy No	16040034202800000540	**Previous Policy Period**	18-JAN-21 to 17-JAN-22

Policyholder's Details

Policyholder Name	GUNVANTIBHAI PRAVINBHAI PATEL	**Customer ID**	PO37549750
		PAN Card No	
		Mobile No/Phone No	XXXXXX9898
Policyholder's address	8, SHUBHLAXMI SOC., AMBALISAN STATION, DIST- MEHSANA AMBALIAYASAN ,GUJARAT, 382732	**Email id**	pancholi.tejas@gmail.com,
		Name of the Nominee	REKHABEN G PATEL
		Relation with the Policy holder	Spouse
		GSTIN	NA

Policy Issuing Office and Intermediary Details

Office Name and Code	AURANGABAD DO-160400 (160400)	**Office Contact No**	02402333572 / 02402333361
Office Email Id	nia.160400@newindia.co.in	**Development Officer**	JAINUINE INSURANCE BROKERS PVT. LTD. (DA3388757) JAINUINE INSURANCE BROKERS PVT.LTD. (SI00028623) JAINUINE INSURANCE BROKERS PVT.LTD. (SI00028623) JAINUINE INSURANCE BROKERS PVT.LTD. (SI00028623)
		Name of the Agent/Intermediary	JAINUINE INSURANCE BROKERS PVT. LTD. (DA3388757)
Office Address	AJAY ENGINEERING COMPOUND, ADALAT ROAD, AURANGABAD ,431005	**Contact No. of Agent/Intermediary**	02402350377, 9850049400 / NA
		E-mail id of Intermediary	kailash@jainuineinsurance.co.in,
Regional Office	NAGPUR R.O. (160000)	**GSTIN**	27AAACN4165C3ZP
Regional Contact No	07122555031/07122555032	**SAC**	997133 (Accident and health insurance services)

Details Of TPA (Notice or Communication to be given in respect of claim)

Name of the TPA	MDINDIA HEALTH INSURANCE TPA PVT. LIMITED		
Email-id of the TPA	customercare@mdindia.com	**Address of the TPA**	S. NO. 46/1, E-SPACE, A-2 BUILDING, 3RD FLOOR, PUNE-NAGAR ROAD, VADGAONSHERI, PUNE-411014,,
Toll Free / Contact No of the TPA	18002097800 18002097777 /		
Fax of TPA	02025300003		

Highlights of New India Floater Mediclaim Policy*

* Day one baby cover.	* Ayurvedic / Homoeopathic / Unani treatments are covered up to 25% of the Sum Insured.
* Critical Care Benefit 10% of the Sum Insured.	* Optional Cover I: No Proportionate Deduction.
* Room rent and ICU Charges at 1% and 2% of Sum Insured per day respectively.	* Optional Cover II: Maternity Expenses Benefit for Sum Insured 5 Lakhs and Above.
* Hospital Cash up to 1% of Sum Insured.	* Optional Cover III: Revision in Limit of Cataract (For 8 Lakhs & above Sum Insured).

* Midterm inclusion of newly married spouse.	* For Pre Existing Diseases Waiting period is 48 Months as per clause 4.1 of the policy document.
* Cataract claims, up to 10% of Sum Insured or ₹ 50,000 whichever less, for each eye.	* For specified diseases waiting period is 24 months as per clause 4.3.1 of the policy document.
	*** Please refer to policy document for detailed terms and conditions.**

Important

*1.Date of Inception of first policy is the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break subject to portability guidelines.

2.Enhanced Sum Insured under the policy will be subject to policy clauses 4.1,4.2 and 4.3

3. PED and specified diseases waiting periods for each of the merged policy shall be reckoned as per its date of inception of first policy.

* Please visit https://www.newindia.co.in for the list of network hospitals providing cashless facility. If network hospital is not available in your city/location, please contact the concerned TPA." You are also requested to share your policy details when you visit the network hospital.

Insured Persons details

S. No	Name of the insued (Member ID)	Date of birth(Age)	Sex	Relation	*Date of inception of first policy	Pre Existing Disease
1	GUNVANTIBHAI PRAVINBHAI PATEL(PO37549750)	13/02/1989(32)	M	SELF	18/01/2018	NA
2	REKHABEN G PATEL(ME04661374)	26/05/1988(33)	M	SPOUSE	18/01/2018	NA
3	BRISA G PATEL(ME04661388)	19/08/2014(7)	F	CHILD	18/01/2018	NA
4	VINI G PATEL(ME08257312)	17/10/2017(4)	F	CHILD	25/05/2018	NA

Floater Sum Insured	200000	Floater Cumulative Bonus	100000

Cumulative Bonus Details

S. No	Sum Insured	SI Effective Date	CB percentage	CB Amount
1	200000	17-DEC-21	50	100000

Optional Cover Table

Policy Level - Optional Cover - 1 (No Proportionate Deduction)	Not Opted		
Member Level - Optional Cover - II (Maternity Benefit)	Not Opted	Member Level - Optional Cover - III (Revision in Cataract Limit)	Not Opted

S No	Name of the Insured	Basic Premium	Premium for Optional Cover - I	Premium for Optional Cover - II	Premium for Optional Cover - III	Discount	Gross Premium
1	GUNVANTIBHAI PRAVINBHAI PATEL	2636	0	0	0	396	2240
2	REKHABEN G PATEL	2636	0	0	0	396	2240
3	BRISA G PATEL	1380	0	0	0	207	1173
4	VINI G PATEL	1380	0	0	0	207	1173

Previous Year Policy Details									
Sl. No.	Name of Insured	Company	Previous Policy No	From Date	To Date	SI	PED in Previous Policy	Claim No	Claim Amount
1	GUNVANTIBHAI PRAVINBHAI PATEL	NIA	160400341728000009 20	18/01/2018	17/01/2019	200000	N	NA	0
2	REKHABEN G PATEL	NIA	160400341728000009 20	18/01/2018	17/01/2019	0	N	NA	0
3	BRISA G PATEL	NIA	160400341728000009 20	18/01/2018	17/01/2019	0	N	NA	0
4	VINI G PATEL	NIA	160400341728000009 20	18/01/2018	17/01/2019	0	N	NA	0
5	GUNVANTIBHAI PRAVINBHAI PATEL	NIA	160400341828000007 67	18/01/2019	17/01/2020	200000	N	NA	0
6	REKHABEN G PATEL	NIA	160400341828000007 67	18/01/2019	17/01/2020	0	N	NA	0
7	BRISA G PATEL	NIA	160400341828000007 67	18/01/2019	17/01/2020	0	N	NA	0
8	VINI G PATEL	NIA	160400341828000007 67	18/01/2019	17/01/2020	0	N	NA	0
9	REKHABEN G PATEL	NIA	160400341928000007 51	18/01/2020	17/01/2021	0	N	NA	0
10	BRISA G PATEL	NIA	160400341928000007 51	18/01/2020	17/01/2021	0	N	NA	0
11	VINI G PATEL	NIA	160400341928000007 51	18/01/2020	17/01/2021	0	N	NA	0
12	REKHABEN G PATEL	NIA	160400342028000005 40	18/01/2021	17/01/2022	0	N	NA	0
13	BRISA G PATEL	NIA	160400342028000005 40	18/01/2021	17/01/2022	0	N	NA	0
14	VINI G PATEL	NIA	160400342028000005 40	18/01/2021	17/01/2022	0	N	NA	0

	Total Gross Premium(Without GST)	6826
	CGST(@9%)	0
	SGST(@9%)	0
Net Premium in Words(RUPEES EIGHT THOUSAND FIFTY-FIVE ONLY)	IGST	1229
	Total GST	1229
	Net Premium(With GST)	8055

*This Policy is subject to terms and conditions of New India Floater Mediclaim.

In WITNESS WHEREOF,the undersigned being duly authorized by the Insurers and on behalf of the Insurers has(have) hereunder set his/her(their) hand(s) on this 18th day of January 2022.

at _____ this _____ day of _____ 20

Date of Issue: 17/01/2022

(MRS. MADHURI DHONDGE)
[DIVISIONAL MANAGER]

FOR AND ON BEHALF OF
THE NEW INDIA ASSURANCE COMPANY LIMITED
DULY CONSTITUTED ATTORNEY(S)

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Insurer Office Code	:	AURANGABAD DO-160400 (160400)
Address	:	AJAY ENGINEERING COMPOUND, ADALAT ROAD, AURANGABAD ,431005
Telephone	:	02402333572 / 02402333361
Fax	:	02402331226

New India Floater Mediclaim

PREMIUM CERTIFICATE FOR THE PURPOSE OF DEDUCTION UNDER SECTION 80 D OF INCOME TAX (AMENDMENT) ACT 1986

This is to certify that Mr./Mrs. GUNVANTIBHAI PRAVINBHAI PATEL has paid ₹ 8055 towards premium for New India Floater Mediclaim for the period 18/01/2022 12:00:01 AM to 17/01/2023 11:59:59 PM

Policy no.	:	16040034212800000360
Receipt no. & date	:	10000089210100377305 17/01/2022

Date of Issue: 17/01/2022

(MRS. MADHURI DHONDGE)
[DIVISIONAL MANAGER]

Authorized Signatory For and on behalf of The New India Assurance Company Limited

(Note: This certificate must be surrendered to the Insurance Company for issuance of fresh certificate in case of cancellation of the policy or any alteration in the Insurance affecting the premium)

IMPORTANT

This policy is subject to the terms and conditions contained in the policy document (Clauses).

This policy is governed by Health Insurance Regulations 2016 issued by Insurance Regulatory Development Authority of India on 12.07.2016.

This policy is also governed by IRDAI (Protection of Policyholders' Interest) Regulations, 2017.

This Schedule comes attached with the policy document (Clauses). If not attached, please ask for the same.

Health Insurance Regulation 2016 and IRDAI (Protection of Policyholders' Interest) Regulations, 2017 are available on the website of IRDAI.

Beware of spurious calls offering alluring benefits. Never share any policy details with unknown callers. Call 1800-209-1415 for any enquiry or contact the nearest operating office of New India Assurance Co Ltd.

Tax Invoice No : 16040021P0016930

IRDA Registration Number: 190

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

COLLECTION RECEIPT CUM ADJUSTMENT VOUCHER

Issuing Office	:	AURANGABAD DO-160400 (160400)
Address	:	AJAY ENGINEERING COMPOUND, ADALAT ROAD, AURANGABAD ,431005 KRANTI CHOWK (AUANGABAD)
Phone	:	02402333572
Email	:	nia.160400@newindia.co.in
Fax	:	02402331226
Collection Number	:	10000089210100377305
Collection Date	:	17/01/2022
Business Source Code	:	DA3388757
PAN No of Payer	:	

Received with thanks from GUNVANTIBHAI PRAVINBHAI PATEL.

The amount received/Adjusted is towards -

Policy No.	A/C Description	Amount₹	A/C Code	Sub A/C Code
16040034212800000360	Bank-100000	8055.00	9100.100000	BA00013647-100000-9100

Total = ₹ 8055.00

Your Payment/Adjustment Details are as under -

Mode	Amount ₹	Cheque No.	Cheque Date	Drawee Bank	Drawee Branch	Reference No.	Scroll/BG/A PD Balance
EPG Credit Advice	8055.00	WAX608 4943 8782	N.A.	N.A.	N.A.	1604002110073367	N.A.

Total = ₹ 8055.00

Utilization details of the Collected Amount :

Premium	GST	Stamp Duty	Excess Amount
6826.00	1229.00	0.00	0

Sl no.	Agency Code	Agency Name	Department Code
1	NA	JAINUINE INSURANCE BROKERS PVT. LTD.	34

For The New India Assurance Company Limited

Revenue Stamp

Date of Issue: 17/01/2022

(MRS. MADHURI DHONDGE)
[DIVISIONAL MANAGER]

Cashier's Initial

Authorized Signatory

Note -

1.Please note the Policy Number, Collection Number and date in all future correspondence. .

2.NIA shall not be liable for any claim arising out of sales made during the period between the due date and date of payment of the installment if the premium paid has been exhausted by turnover declarations/if there is insufficient premium balance.

THE NEW INDIA ASSURANCE CO. LTD.
(Government of India Undertaking)

Tax Invoice No : 16040021P0016930

IRDA Registration Number: 190

NEW INDIA FLOATER MEDICLAIM POLICY

1. PREAMBLE

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

The terms set out in this Policy will be the basis for any claim or benefit under this Policy.

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

If during the **Period of Insurance, You** or any **Insured Person** incurs **Hospitalisation** Expenses which are **Reasonable and Customary** and **Medically Necessary** for treatment of any **Illness** or **Injury** 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 Policy 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.

2. DEFINITIONS

STANDARD DEFINITIONS

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

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

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

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable,

and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 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.

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

2.7 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.

2.8 CRITICAL ILLNESSES means the following Illnesses:

2.8.1 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.

2.8.2 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.

2.8.3 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

2.8.4 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.

2.8.5 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.

2.8.6 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.

2.8.7 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 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.

2.8.8 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

2.8.9 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.

2.8.10 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.

2.8.11 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.

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

2.10 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.

2.11 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.

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

2.13 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.

2.14 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.

2.15 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.

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

- Has qualified nursing staff under its employment round the clock;
- Has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 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 surgical procedures are carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

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

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
d. it continues indefinitely
e. it recurs or is likely to recur

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

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

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

2.22 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(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.23 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.

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

2.25 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.

2.26 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.

2.27 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.

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

2.29 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.

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

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

2.32 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.

2.33 PRE-HOSPITALISATION MEDICAL EXPENSES means Medical Expenses incurred during the period of 30 days preceding Your Hospitalisation, provided that:

a. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and

b. The Inpatient Hospitalization claim for such Hospitalization is admissible by Us.

2.34 POST-HOSPITALISATION MEDICAL EXPENSES means Medical Expenses incurred during the period of 60 days immediately after Your discharge from the Hospital provided that:

a. Such Medical Expenses are incurred for the same condition for which Your Hospitalisation was required, and

b. The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

2.35 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.

2.36 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.

2.37 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.

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

2.39 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.

SPECIFIC DEFINITIONS

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

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

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

2.43 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.

2.44 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.

2.45 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.

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

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

2.48 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

2.49 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.

2.50 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

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

Note: Sum Insured means pre-defined limit as shown in the schedule excluding Cumulative Bonus.

2.52 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.

2.53 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.

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

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

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

3. BENEFITS COVERED UNDER THE POLICY

3.1 Our liability for all claims admitted during the Period of Insurance in respect of all Insured Persons shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus. 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 (a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of the Sum Insured per day.
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the Sum Insured per day.
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

3.1 (d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
3.1 (e)	Pre-Hospitalization Medical Expenses, not exceeding thirty days
3.1 (f)	Post-Hospitalization Medical Expenses, not exceeding sixty days
3.1 (g)	Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on **1.** Cost of Pharmacy and Consumables **2.** Cost of Implants and Medical Devices **3.** Cost of Diagnostics. Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

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.

3.2 LIMIT ON PAYMENT FOR CATARACT

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

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

3.3 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.

3.4 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 Period of Insurance, provided the treatment for Illness or Injury, is taken in any AYUSH Hospital.

3.5 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.

3.6 CRITICAL CARE BENEFIT

If during the Period of Insurance any Insured Person discovers that he or she is suffering from any Critical Illness as defined under 2.8, 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 Condition/Disease. Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

3.7 PAYMENT OF AMBULANCE CHARGES

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

3.8 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

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

3.9 TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies shall be covered after **twenty-four** months of Continuous Coverage.

Congenital External Disease or Defects or anomalies shall be covered after **forty-eight** 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 the preceding four years.**

3.10 CUMULATIVE BONUS

Cumulative Bonus shall be increased by 25% at each renewal in respect of each claim free year of insurance, subject to maximum of 50%. If a claim is made in any particular year; the Cumulative Bonus accrued shall be reduced at the same rate at which it is accrued.

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

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

Note:

i. Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported under the policy.
ii. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.
iii. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies / individual policies, the same Cumulative Bonus of the expiring policy shall be apportioned to each Individual of such Renewed Policies.
iv. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

3.11 OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 3.1(g) stands deleted for the members covered in the Policy as stated in the Schedule.

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

3.12 OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

On the payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 4.4.15 stands deleted for Insured Person as mentioned in the Schedule. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

Special conditions applicable to Maternity Expenses Benefit:

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

Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there. The maternity limit mentioned above shall be applicable per event for all the Policies of Our Company including Group Policies. Even if two or more Policies of New India are invoked, sublimit of the Policy chosen by Insured shall prevail and our liability is restricted to stated sublimit.

3.13 OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This optional cover, if opted, will be in addition to limit specified in Clause 3.2.

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

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

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

3.14 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) **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.

d) **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.

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 per policy period.

f) **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 3.14 (a) to (f), waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f 1st October 2020 or date of inception of first policy, whichever is later. Coverage for such illness or procedures shall only be available after completion of the said waiting periods.

g) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders** The Company shall indemnify the Hospital or the Insured the Medical 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 per policy period.

The below covers are subject to the patient exhibiting any of 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 exhibiting 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.

Note: For the coverages defined in 3.14 (g), waiting period shall be applicable for both New and Existing Policyholders w.e.f 16th August 2018 or date of inception of first policy, whichever is later. This Coverage shall only be available after completion of the said waiting period.

3.15 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)
3.15.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3.15.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3.15.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to a maximum upto Rs. 5 Lakh
3.15.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 1 Lakh.
3.15.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to a Maximum of Rs 2 Lakh.
3.15.6	Intravitreal injections.	Upto 10% of Sum Insured subject to a Maximum of Rs.75,000.
3.15.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum of Rs. 5 Lakh.
3.15.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
3.15.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.15.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.15.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum of Rs. 50,000.
3.15.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.

4. EXCLUSIONS

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 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 dioptres.

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

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

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

SPECIFIC EXCLUSIONS

4.4.16 Acupressure, acupuncture, magnetic therapies.

4.4.17 Any expenses incurred on Domiciliary Hospitalization.

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

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

4.4.21 Convalescence, General debility and Venereal disease.

4.4.22 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.

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

4.4.24 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.

4.4.25 Naturopathy Treatment.

4.4.26 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.

4.4.27 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.15.12

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

4.4.29 Treatment taken outside the geographical limits of India

4.4.30 Vaccination and/or inoculation

4.4.31 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.

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 FRAUD, MISREPRESENTATION, CONCEALMENT:

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

5.2 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 Clause 3.5 and Clause 3.6 of the Policy.

5.3 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. 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 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 Hospitalization 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.

5.4 CANCELLATION CLAUSE:

The policy shall be null and void, and no benefits shall be payable in case of Fraud, misrepresentation, misdescription or nondisclosure of any material fact / particular. Premium paid shall also stand forfeited.

We may at any time cancel the Policy on 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. We shall allow refund of premium, if no claim has been made or paid under the Policy, at short period rate which is tabulated below.

You may also at any time cancel this Policy. We shall allow refund of premium, if no claim has been made or paid under the Policy, at short period rate which is tabulated 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

5.5 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.

5.6 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

5.7 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 5.14, 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 the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

v. However, where the circumstances of a claim warrant an investigation in the opinion of the Insurer, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document.

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

5.8 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 III.

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

5.9 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.

SPECIFIC TERMS AND CLAUSES

5.10 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.

5.11 PREMIUM:

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

5.12 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.

5.13 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.

5.14 NOTICE OF CLAIM:

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.

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.

5.15 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.

5.16 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.

5.17 ENHANCEMENT OF SUM INSURED:

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

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=50 years	Enhancement up to Sum Insured of 15 lakhs without Medical Examination
Age 51-60 Years	Enhancement by two slabs without Medical Examination
Age 61-65 Years	Enhancement by one slab with Medical Examination

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.

5.18 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.

5.19 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.20 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. Communication of repudiation shall be sent to You by Us, explicitly mentioning the grounds for repudiation.

5.21 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**	