THE NEW INDIA ASSURANCE CO. LTD.

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

GROUP MEDICLAIM POLICY (2007)

WHEREAS THE Insured designated in the Schedule hereto has by a Proposal and declaration, dated as stated in the Schedule, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE COMPANY LTD., (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the INSURED PERSON) and has paid premium as consideration for such insurance,

1.0 **COVERAGE:** NOW THIS POLICY WITNESSES that, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any Illness (herein defined)or sustain any Injury (herein defined)and if such Illness or Injury shall require any such Insured Person, upon the advice of a duly qualified Medical Practitioner/ Medical Surgeon to incur Hospitalization Expenses (herein defined) for Medical / Surgical treatment at a Hospital / Day Care Centre in India as (herein defined) as an Inpatient, the Company will pay to the Hospital or reimburse the Insured person, through the Third Party Administrator, amount of such expenses as would fall under different heads mentioned below and are Reasonably and Customarily, and Medically Necessary incurred in respect thereof by or on behalf of such Insured Person.

2.0 Following Reasonable &Customary expenses are reimbursable under the policy:

2.1 Room, boarding and nursing expenses as provided by the Hospital not exceeding 1.0 % of the sum Insured per day or actual, whichever is less.

2.2 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2.0 % of the sum insured per day, or actual, whichever is less.

2.3 Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.

2.4 Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray and other medical expenses related to the treatment.

2.5 Pre-hospitalization medical expenses up to 30 days period.

2.6 Post hospitalization medical expenses up to 60 days period.

NOTE:

1. The amounts payable under 2.3 and 2.4 shall be at the rate applicable to the entitled room category. In case of admission to a room / ICU / ICCU at rates exceeding the limits as mentioned under 2.1 and 2.2, the reimbursement / payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of room rent / ICU / ICCU charges.

2. No payment shall be made under 2.3 other than as part of the hospitalization bill.

3. However, the bills raised by Surgeon, Anesthetist directly and not included in the hospitalization bill may be reimbursed in the following manner:

   a. The Reasonable, Customary and Medically Necessary Surgeon fee and Anesthetist fee would be reimbursed, limited to the maximum of 25% of Sum Insured. The payment shall be reimbursed provided the insured pays such fee(s) through cheque and the Surgeon / Anesthetist provides a numbered bill. Bills given on letter-head of the Surgeon, Anesthetist would not be entertained.

   b. Fees paid in cash will be reimbursed up to a limit of Rs. 10,000/- only, provided the Surgeon / Anesthetist provides a numbered bill.

2.7 LIMIT ON PAYMENT FOR CATARACT

Company's liability for payment of any claim relating to Cataract shall be limited to Actual, upto Rs.24,000 (inclusive of all charges, excluding service tax), for each eye, whichever is less.

2.8 AYUSH Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 25% of the sum insured provided the treatment for Illness and Injury, is taken in AYUSH Hospital.

2.9 Ambulances services – 1.0 % of the sum insured or actual, whichever is less, subject to maximum of Rs. 2,500/- in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

2.10 Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Company's liability towards expenses incurred on the donor and the insured recipient shall not exceed the sum insured of the insured person receiving the organ.

2.11 SPECIFIC COVERAGES:

a) Impairment of Persons' intellectual faculties by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period, subject to it arising during treatment of covered illness.

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

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

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

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.

3. Schizophrenia - esp. Psychotic episodes.
4. Bipolar disorder - manic phase.

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

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

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

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

e) **Age Related Macular Degeneration (ARMD)** is covered after 48 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 75,000 per policy period.

f) **Behavioural and Neuro developmental Disorders**: Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.

g) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

Note: For the coverages defined in 2.11, waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

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

S No	Treatment or Procedure	Limit (Per Policy Period)
2.12.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
2.12.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
2.12.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh
2.12.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
2.12.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 1 Lakh.
2.12.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.30,000.
2.12.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 2 Lakh.
2.12.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
2.12.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
2.12.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
2.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 25,000.
2.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.

2.13 Persons paying Zone I premium can avail treatment in any Zone. There will not be any zone deduction in such cases.

Persons paying Zone II premium can avail treatment in Zone II, Zone III and Zone IV. There will not be any zone deduction in such cases.

Persons paying Zone II premium but availing treatment in Zone I will have to bear 10% as Co-Pay for each admissible claim.

Persons paying Zone III premium can avail treatment in Zone III and Zone IV. There will not be any zone deduction in such cases.

Persons paying Zone III premium but availing treatment in Zone II will have to bear 10% as Co-Pay for each admissible claim.

Persons paying Zone III premium but availing treatment in Zone I will have to bear 20% as Co-Pay for each admissible claim.

Person paying Zone IV premium can avail treatment in Zone III and Zone IV. There will not be any zone deduction in such cases.

Person paying Zone IV premium but availing treatment in Zone II, will have to bear 10% as Co-Pay for each admissible claim.

Person paying Zone IV premium but availing treatment in Zone I, will have to bear 20% as Co-Pay for each admissible claim.

3.0 DEFINITIONS:

3.1 ACCIDENT is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

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

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

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

- **a.** Central or State Government AYUSH Hospital or
- **b.** Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
- **c.** AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
  - **i.** Having at least 5 in-patient beds;
  - **ii.** Having qualified AYUSH Medical Practitioner in charge round the clock;
  - **iii.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  - **iv.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

3.7 BREAK IN POLICY means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

3.8 CASHLESS FACILITY means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the policy

terms and conditions, are directly made to the network provider by the Company to the extent pre-authorization approved.

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

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

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

3.11 DAY CARE CENTRE: A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment;
- Has qualified medical practitioner/s in charge;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

- Undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a hospitalization of more than 24 hours.

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

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

3.14 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.

3.15 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.

3.16 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.

3.17 HOSPITAL means any institution established for Inpatient Care and Day Care treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the

enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

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

The term 'Hospital' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

3.18 HOSPITALISATION means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

3.19 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.

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

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

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

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

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

3.24 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.

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

3.26 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

3.27 MEDICALLY NECESSARY treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Illness or Injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

3.29 NETWORK HOSPITAL means Hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a cashless facility.

3.30 NON-NETWORK HOSPITAL means any Hospital that is not part of the network.

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

3.32 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.

3.33 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period preceding the Insured Person is Hospitalised, provided that:

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

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

3.34 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period immediately after the Insured Person is discharged from the hospital provided that:

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

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

3.35 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.

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

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

3.38 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.

3.39 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.

3.40 QUALIFIED NURSE Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.41 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.

3.42 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 all waiting periods.

3.43 ROOM RENT means the amount charged by a Hospital for the occupancy of a bed per day (24 hours) basis and shall include associated medical expenses.

3.44 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.

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

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

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

3.48 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.

4.0 EXCLUSIONS: The Company shall not be liable to make any payment under this policy in respect of:

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. Any Skin disorders
2. All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps
3. Benign Ear, Nose, Throat disorders
4. Benign Prostate Hypertrophy
5. Cataract & age-related eye ailments
6. Gastric/ Duodenal Ulcer
7. Gout & Rheumatism
8. Hernia of all types
9. Hydrocele
10. Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of uterus
11. Non-Infective Arthritis
12. Piles, Fissure and Fistula in Anus
13. Pilonidal Sinus, Sinusitis and related disorders
14. Prolapse Inter Vertebral Disc unless arising from Accident
15. Stone in Gall Bladder & Bile duct
16. Stones in Urinary Systems
17. Unknown Congenital Internal Anomaly
18. Varicose Veins and Varicose Ulcers
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia

(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 PERMANENT EXCLUSIONS: Any medical expenses incurred for or arising out 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.

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

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

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.4.18 Circumcision unless required to treat Injury or Illness.

4.4.19 Vaccination & Inoculation.

4.4.20 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.

4.4.21 All types of Dental treatments except arising out of an accident.

4.4.22 Convalescence, general debility.

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

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

4.4.24 Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act.

4.4.25 Naturopathy Treatment.

4.4.26 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.27 Stem cell implantation / surgery for other than those treatments mentioned in clause 2.12.12.

4.4.28 Domiciliary Hospitalization.

4.4.29 Treatment taken outside India.

4.4.30 Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.

4.4.31 Service charges or any other charges levied by hospital, except registration/admission charges.

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

5.0 CONDITIONS:

5.1 CONTRACT: The proposal form, declaration, Health Certificate, and policy issued shall constitute the complete contract of insurance.

5.2 COMMUNICATION: Every notice or communication to be given or made under this Policy other than that relating to claim shall be delivered in writing at the address of the policy issuing office as shown in the schedule. The claim shall be referred to the TPA appointed for providing claim service as per the procedure mentioned in the guidelines circulated by the T.P.A. to the policyholders. In case TPA services are not availed then claim shall be reported to the policy issuing office.

5.3 PREMIUM PAYMENT: The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under the Policy. No waiver of any terms, provision, conditions and endorsement of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

5.4 PHYSICAL EXAMINATION: Any Medical Practitioner authorized by the TPA /Company shall be allowed to examine the Insured Person in case of any alleged disease/illness/injury requiring Hospitalization. Non-co-operation by the Insured Person will result into rejection of his/her claim.

5.5 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.

5.6 MULTIPLE POLICIES:

1. In case of multiple policies taken by Insured Person during a period from the Company or one or more Insurers to indemnify treatment costs, Insured Person shall have the right to require a settlement of Insured Person's claim in terms of any of his/her policies. In all such cases the Company, if chosen by Insured Person, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of 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, Insured Person 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.

5.7 CANCELLATION CLAUSE:

The Company may at any time cancel this Policy by sending the Insured 30 days' notice by registered letter at the Insured's last known address and in such event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. The company shall however, remain liable for any claim, which arose prior to the date of cancellation. The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

PERIOD OF RISK	RATE OF PREMIUM TO BE CHARGED
Up to one month	1/4th of the annual rate
Up to three months	½ of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

5.8 DISCLAIMER OF CLAIM: If The TPA / Company shall disclaim liability to the Insured for any claim hereunder and if the insured shall not, within 12 calendar months from the date or receipt of the notice of such disclaimer notify the TPA / Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.9 All medical / surgical treatment under this policy shall have to be taken in India.

6.0 RENEWAL OF POLICY:

The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to deficiency of service.

The Company shall not be responsible or liable for non-renewal of the policy due to non-receipt /delayed receipt of renewal notice or due to any other reason whatsoever.

We shall be entitled to decline renewal if:

a. Any fraud, moral hazard/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

b. 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

c. You fail to remit Premium for renewal before expiry of the Period of Insurance. We may accept renewal of the Policy if it is effected within thirty days (grace period) 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

LOW CLAIM DISCOUNT: A low claim discount at the following rates will be allowed on the renewal premium, if the incurred claims of the group in the preceding three completed years, excluding the year immediately preceding the renewal is as below:

Incurred Claim Ratio	Discount %
Not Exceeding 60%	5
Not Exceeding 50%	15
Not Exceeding 40%	25
Not Exceeding 30%	35
Not Exceeding 25%	40

If the policy has been in force for a period less than 3 completed years, such shorter period, excluding the year immediately preceding the renewal will be considered.

HIGH CLAIM LOADING: if the incurred claim ratio of the group for three years (or for lesser period, if the cover has not been in force for three years), excluding the year immediately preceding the date of renewal exceeds 70%, premium for renewal of the policy will be loaded as per scale below:

Incurred Claim Ratio	Loading %
Between 70% and 100%	25
Between 101% and 125%	55
Between 126% and 150%	90
Between 151% and 175%	120
Between 176% and 200%	150
Over 200%	Cover to be reviewed

7.0 MATERNITY EXPENSES BENEFIT EXTENSION (OPTIONAL COVER): This is an optional cover, which can be obtained on payment of 20% of the total basic premium for all the insured person under the policy. Total basic premium means the total premium computed before applying Group discount and or High claim ratio loading, Low claim discount.

Option of maternity benefit has to be exercised at the inception of the policy period and no refund is allowable in case of insured's cancellation of this option during the currency of the policy.

The maximum benefit allowable under this clause will be 10% of Sum Insured for normal delivery subject to maximum of Rs 25,000. Under Caesarean section, benefit will be 20% of sum insured subject to maximum of Rs. 50,000/-

Special conditions applicable to Maternity Benefit:

1. These benefits are admissible only if the expenses are incurred in Hospital as in patient in India.
2. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by Accident or other medical emergency.
3. Claim in respect of delivery for only first two children and for operation associated there with will be considered in respect of any one insured person covered under the policy or any renewal thereof. Those Insured Persons who are already having two or more living children would not be eligible for this benefit.
4. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.
5. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing home and treatment is taken there.

NOTE: When Group Policy is extended to include maternity expenses benefit, the exclusion 4.4.15 of the policy stands deleted.

8.0 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.

9.0 COMPANY'S LIABILITY:

The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured including Cumulative Bonus.

10.0 NOTICE OF CLAIM:

Preliminary notice of claim with particulars relating to Policy Number, name of insured person in respect of whom claim is to be made, nature of illness/injury and Name and Address of the attending Medical Practitioner/Hospital/Nursing Home should be given to the Company/TPA within 7 days from the date of hospitalization in respect of reimbursement claims.

Final claim along with hospital receipted original Bills / Cash memos**, claim form and list of documents as listed below etc. should be submitted** to the Policy issuing Office / TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

1. Bill, Receipt and Discharge certificate / card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
4. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
6. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Waiver: Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the Company / TPA that under the Circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

11.0 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICE:

Claims in respect of Cashless access services will be through the agreed list of network of hospital / nursing home and is subject to pre-admission authorization. The TPA shall, upon getting the related medical information from the insured person /network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital /nursing home mentioning the sum guaranteed as payable also the ailment for which the person is seeking to be admitted as a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his

/her treating doctors' advice and later on submit the full claim papers to the TPA for reimbursement.

12.0 REPUDIATION OF CLAIMS

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

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

13.0 PROTECTION OF POLICY HOLDERS' INTEREST: This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2017.

14.0 GRIEVANCE REDRESSAL: In the event of Insured has any grievance relating to the insurance, You may contact any of the Grievance Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact details of the office of the Insurance Ombudsman are provided in the Annexure II.

15.0 PAYMENT OF CLAIM

i. The Company 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 the Company to not call for any document not listed in Clause 10.0, 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 thirty 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.

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

All admissible claims shall be payable in Indian Currency.

16.0 PORTABILITY AND MIGRATION:

MIGRATION:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has

been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then You will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

PORTABILITY:

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

17.0 PERIOD OF POLICY: This insurance policy is issued for a period of one year.

18.0 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.

19.0 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.

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

ANNEXURE I:

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

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

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

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

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

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

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

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

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

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

ANNEXURE II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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**	