THE NEW INDIA ASSURANCE CO. LTD

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

NEW INDIA FLEXI GROUP MEDICLAIM POLICY

PROSPECTUS

Salient features of the Policy

1.0 **COVERAGE:** The Policy covers reimbursement of Hospitalisation Expenses for Illness/ Injury sustained.

2.0 In event of any claim being admissible, following Reasonable and Customary expenses are reimbursable under the policy:

2.1 Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of Sum Insured per day.

2.2 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.

2.3 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.

2.4 Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

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

2.6 Post-hospitalization medical charges up to 60 days period.

NOTE: SUB-LIMIT CLAUSE

1. **Proportionate Deduction:** 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.

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.

(N.B: Company's Liability in respect of all claims admitted during the Policy Period shall not exceed the Sum Insured per person mentioned in the schedule.)

2.7 LIMIT ON PAYMENT FOR CATARACT: Company's liability for payment of any claim relating to Cataract shall be limited to Actual or maximum of Rs.24000 (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 accidental injuries, is taken in a Government hospital or in any institute recognized by Government and /or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures.

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 for an admissible claim. This amount shall be part of the Sum Insured.

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). Such expenses shall be payable if required in conjunction to an admissible claim and shall be within the Sum Insured.

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 per policy period.

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. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

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. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

g) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

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. 2 Lakh
2.12.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 2 Lakh
2.12.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh
2.12.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 1 Lakh.
2.12.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 2 Lakh.
2.12.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.75,000.
2.12.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh.
2.12.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
2.12.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
2.12.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
2.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
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. 2.5 Lakh.

2.13 Zones

EACH ZONE IS CLASSIFIED AS BELOW: (The Cities mentioned below would include their Urban Agglomeration)	
Zone- I	**Greater Mumbai**
Zone-II	**Delhi and Delhi NCR ,Bangalore, Chennai, Hyderabad and Secunderabad, Ahmedabad and Kolkatta, Vadodara**
Zone-III	**Rest of India (other than those areas specified in Zone I,II and IV)**
Zone-IV	**The States of Bihar, Orissa, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Jharkhand, Sikkim, Chhattisgarh, Uttarakhand, Jammu and Kashmir**

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.

3.49 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.

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 COMMUNICATION: Every notice or communication to be given or made under this policy shall be delivered in writing at the address as shown in the Schedule.

5.2 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. 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 condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.3 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 documents as listed in the claim form below 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.

a. Bill, Receipt and Discharge certificate / card from the Hospital.
b. Cash Memos from the Hospitals(s) / Chemists(s), supported by proper prescriptions.
c. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
d. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
e. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
f. 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. This waiver cannot be claimed as a matter of right.

5.4 PHYSICAL EXAMINATION: Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or Illness requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company.

5.5 The Company shall not be liable to make any payment under this policy in respect of any claim 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 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 policy may be renewed by mutual consent. The company shall not however be bound to give notice that it is due for renewal and 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 unexpired 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 upto 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 Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the 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 and admissible claims thereof shall be payable in Indian currency.

6.1 LOW CLAIM RATIO DISCOUNT (BONUS): Low Claim Ratio Discount at the following scale will be allowed on the Total premium at renewal only depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal. Where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claim ratio under the Group Policy	Discount (%)
Not Exceeding 60%	5%
Not Exceeding 50%	15%
Not Exceeding 40%	25%
Not Exceeding 30%	35%
Not Exceeding 25%	40%

6.2 HIGH CLAIM RATIO LOADING (MALUS): The Total Premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal Where the Group Mediclaim Policy has not been in force for the 3 completed years, such shorter periods of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claim Ratio under the Group Policy	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

Note: (1) Low Claim Ratio Discount (Bonus) or High Claim Ratio Loading Malus will be applicable to the Premium at renewal of the policy depending on the incurred Claim Ratio for the entire Group Insured.

(2) Incurred claim would mean claims paid plus claims outstanding at the end of the period minus O/S at the beginning of the period in respect of the entire group insured under the policy during the relevant period.

7.1 MATERNITY EXPENSES BENEFIT EXTENSION (OPTIONAL COVER): This is an optional cover which can be obtained on payment of 10% of the total basic premium for all the Insured Persons under the Policy Total basic premium means the total premium computed before applying Group Discount and / or High Claim Ratio Loading, Low Claim Discount and special discount in lieu of agency commission.

7.2 Option for maternity Benefits 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 currency of the policy.

7.3 The maximum benefit allowable under this clause will be upto Rs.50,000/- or the Sum Insured opted by the member of the group whichever is lower.

7.4 Special conditions applicable to Maternity Expenses Benefit Extension:

1. These Benefits are admissible only if the expenses are incurred in Hospital as inpatients in India.
2. A waiting period of 9 months is applicable 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 delivery 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. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
4. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12weeks from the date of conception are not covered.

5. Pre-natal and post-natal expenses are not covered unless admitted in Hospital 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 CASHLESS SERVICE THROUGH TPAS: Claims in respect of Cashless access services will be through the agreed list of network of hospital 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 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 Medical Practitioners medical advice and later on submit the full claim papers to the TPA for reimbursement.

9.0 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/particulars 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.

10.1 AGE LIMIT:

This Insurance is available to persons between the ages of 18 years to 65 years. Children between ages of 3 months to 18 years can be covered only if the parents are also covered under the policy. Insured may renew his Policy beyond the age of 65 years provided there is no break in Insurance.

10.2 FAMILY:

A family comprising the Insured and any one or more of the following can take this Policy:

i. Spouse
ii. Dependent Children
iii. Dependent Parents

10.3 RENEWAL CLAUSE: The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to any 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.

11.0 MEDICAL EXPENSES FOLLOWING 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 in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

12.0 REPUDIATION OF CLAIM: 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 IRDAI (Protection of Policyholders' Interest) Regulation, 2017.

14.0 GRIEVANCE REDRESSAL: In the event of Insured has any grievance relating to the insurance, Insured Personmay 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.

15.0 PAYMENT OF CLAIM: The insurer shall settle the claim, including rejection, within thirty days of the receipt of the last necessary document.

On receipt of the duly completed documents either from the insured or Hospital the claim shall be processed as per the conditions of the policy. Upon acceptance of claim by the insured for settlement, the insurer or their representative (TPA) shall transfer the funds within seven working days. In case of any extra ordinary delay, such claims shall be paid by the insurer or their representative (TPA) with a penal interest at a rate which is 2% above the bank rate at the beginning of the financial year in which the claim is reviewed

All admissible claims shall be payable in Indian Currency only.

16.0 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.

10.0 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 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.

19.0 SPECIAL CONDITIONS: The Policy is subject to deviations from the standard wordings as mentioned in the schedule of the policy.

The conditions are as under:

19.1 OPD COVERAGE: It is hereby declared and agreed at the request of the Insured that Expenses related to Outpatient treatment covered. The limits will be as mentioned in the Schedule.

19.2 REASONABLE AND CUSTOMARY CHARGES: It is hereby declared and agreed at the request of the Insured that "Reasonable and Customary Expenses" mentioned in Clause 2.0 stands waived.

19.3 ROOM RENT / ICU / ICCU: It is hereby declared and agreed at the request of the Insured

that limits as stated in clause 2.1 & 2.2 stands modified. The limits will be as mentioned in the schedule.

19.4 WAIVER OF PROPORTIONATE DEDUCTION: It is hereby declared and agreed at the request of the Insured that Sub-limit clause 1 applicable to Clause 2.3 stands deleted.

19.5 SPECIALIST/OUTSIDE MEDICAL PRACTITIONER: It is hereby declared and agreed at the request of the Insured that Sub-limit clause 3 applicable to Clause 2.3 stands modified. The limits will be as mentioned in the schedule.

19.6 PRE & POST HOSPITALISATION MEDICAL EXPENSES: It is hereby declared and agreed at the request of the Insured that limits as stated in Clause 2.5 & 2.6 stands modified. The limits will be as mentioned in the schedule.

19.7 CATARACT: It is hereby declared and agreed at the request of the Insured that Clause 2.7 stands modified. The limits will be as mentioned in the schedule.

19.8 AYUSH COVERAGE: It is hereby declared and agreed at the request of the Insured that Clause 2.8 stands modified. The limits will be as mentioned in the schedule.

19.9 AMBULANCE SERVICES: It is hereby declared and agreed at the request of the Insured that Clause 2.9 stands modified. The limits will be as mentioned in the schedule.

19.10 DONOR SUM INSURED: It is hereby declared and agreed at the request of the Insured that Clause 2.10 stands modified. The limits will be as mentioned in the schedule.

19.11 SPECIFIC COVERAGES: It is hereby declared and agreed at the request of the Insured that Clause 2.11 stands modified. The limits will be as mentioned in the schedule.

19.12 COVERAGE FOR MODERN TREATMENTS OR PROCEDURES: It is hereby declared and agreed at the request of the Insured that Clause 2.12 stands modified. The limits will be as mentioned in the schedule.

19.13 PRE-EXISTING DISEASE/CONDITION: It is hereby declared and agreed at the request of the Insured that Exclusion 4.1 for "Pre-Existing Diseases (Code- Excl01)" stands deleted.

19.14 2/4 YEARS WAITING PERIOD: It is hereby declared and agreed at the request of the Insured that Exclusion 4.2 for "Specific Waiting Period (Code- Excl02)" stands deleted.

19.15 30 DAYS WAITING PERIOD: It is hereby declared and agreed at the request of the Insured that Exclusion 4.3 for "First Thirty Days Waiting Period (Code- Excl03)" stands deleted.

19.16 VACCINATION: It is hereby declared and agreed at the request of the Insured that exclusion 4.4.19 stands modified. The coverage and limits will be as listed in the schedule.

19.17 ADDITIONAL ITEMS COVERAGE: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.20 stands modified. The coverage will be as listed in the schedule.

19.18 DENTAL TREATMENT: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.21 stands modified. The coverage and limits will be as listed in the schedule.

19.19 INFERTILITY AND STERILITY: It is hereby declared and agreed at the request of the Insured that one of the permanent exclusion that is "Infertility and Sterility" stated in Clause 4.4.14 stands deleted. The coverage and limits will be as mentioned in the schedule.

19.20 HAZARDOUS SPORT: It is hereby declared and agreed at the request of the Insured that Clause 4.4.6 stands deleted. The limits will be as mentioned in the schedule.

19.21 INVESTIGATION & EVALUATION: It is hereby declared and agreed at the request of the Insured that Clause 4.4.1 stands deleted. The limits will be as mentioned in the schedule.

19.22 MATERNITY EXPENSES: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.15 stands deleted & Clause 7.1 stands modified. The coverage and limits will be as listed in the schedule.

19.23 NEWBORN BABY: It is hereby declared and agreed at the request of the Insured that "Newborn Baby" stands covered from day one. The limits will be as mentioned in the schedule.

19.24 STEM CELL TREATMENT: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.27 stands modified. The coverage and limits will be as listed in the schedule.

19.25 DOMICILIARY HOSPITALISATION: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.28 stands deleted. The limits will be as mentioned in the schedule.

19.26 OVERSEAS COVERAGE: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.29 stands deleted. The limits will be as mentioned in the schedule.

19.27 SERVICE CHARGES: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.31 stands deleted. The limits will be as mentioned in the schedule.

19.28 RFQMR/ECP/EECP: It is hereby declared and agreed at the request of the Insured that Exclusion 4.4.32 stands deleted. The limits will be as mentioned in the schedule.

19.29 NOTICE OF CLAIM: It is hereby declared and agreed at the request of the Insured that Clause 5.3 stands modified. The limits will be as mentioned in the schedule.

19.30 SUBMISSION OF CLAIM DOCUMENTS: It is hereby declared and agreed at the request of the Insured that Clause 5.3 stands modified. The limits will be as mentioned in the schedule.

19.31 CORPORATE BUFFER: It is hereby declared and agreed at the request of the Insured that "Corporate Buffer" stands included in the policy. Corporate Buffer means additional Sum Insured available for the whole group. The limits will be as mentioned in the schedule.

19.32 AILMENT CAPPING: It is hereby declared and agreed at the request of the Insured that capping for specific ailments stands modified. The limits will be as listed in the schedule.

19.33 LASIK SURGERY: It is hereby declared and agreed at the request of the Insured that "Lasik surgery" stands covered in the policy. The limits will be as mentioned in the

schedule.

19.34 TOP-UP COVER: It is hereby declared and agreed at the request of the Insured that "Top-up cover" stands included in the policy. Top-up means additional Sum Insured available for individual Insured/family, which can be utilized once the basic Sum Insured is exhausted. The limits will be as mentioned in the schedule.

19.35 VOLUNTARY DEDUCTIBLE/CO-PAY: It is hereby declared and agreed at the request of the Insured that "Voluntary deductible/co-pay" will be applicable in each and every claim. The limits will be as listed in the schedule.

19.36 DAY CARE TREATMENT: It is hereby declared and agreed at the request of the Insured that "Day Care Treatment" listed in Clause 3.18 stands modified. The coverage and limits will be as listed in the schedule.

19.37 EYE CARE: It is hereby declared and agreed at the request of the Insured that "Eye Care treatments" stands covered the policy. The coverage and limits will be as listed in the schedule.

19.38 TERRORISM: It is hereby declared and agreed at the request of the Insured that "Injury arising out of terrorism" stands covered the policy. The coverage and limits will be as listed in the schedule.

19.39 HEALTH CHECKUP: It is hereby declared and agreed at the request of the Insured that cost of Health checkup will be payable under the policy. The limits will be as mentioned in the schedule.

19.40 TRAUMA CARE: It is hereby declared and agreed at the request of the Insured that treatment of Trauma will be payable under the policy. The limits will be as mentioned in the schedule.

19.41 CYBER KNIFE SURGERY: It is hereby declared and agreed at the request of the Insured that Cyber Knife surgery will be covered in the policy. The limits will be as mentioned in the schedule.

19.42 ORAL CHEMOTHERAPY: It is hereby declared and agreed at the request of the Insured that cost of oral chemotherapy will be payable under the policy. The limits will be as mentioned in the schedule.

19.43 ANIMAL BITE: It is hereby declared and agreed at the request of the Insured that treatment of Animal bite will be payable under the policy. The coverage and limits will be as mentioned in the schedule.

19.44 HOSPITAL CASH: It is hereby declared and agreed at the request of the Insured that Hospital Cash will be payable under the policy. The limits will be as mentioned in the schedule.

19.45 STOP LOSS: It is hereby declared and agreed at the request of the Insured that "Stop Loss" Clause will be applicable in the policy. Stop Loss means if ICR reaches a pre-specified limit, the payment of claims will be stopped until additional Premium is paid for the coverage. The limits will be as mentioned in the schedule.

19.46 ANY OTHER COVERAGE: It is hereby declared and agreed at the request of the Insured

that Additional coverage as specified in the schedule will be payable under the policy.

20.0 CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/public.asp. You may also call our Call Centre at the Toll free number **1800-209-1415**, which is available 24x7.

You also have the right to represent your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

21.0 HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfills the conditions of definition of Hospital in the Policy. Within twenty four hours of Hospitalisation the TPA should be intimated. The following documents in original should be submitted to the TPA within seven days from the date of Discharge from the Hospital:

- Claim Form duly filled and signed by the claimant
- Discharge Certificate from the hospital
- All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history
- Bills, Receipts, Cash Memos from hospital supported by proper prescription
- Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
- Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt
- Attending doctor's / consultant's / specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis
- Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

22.0 CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

23.0 WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to You for providing Cashless facility for all hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

24.0 WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization expenses at the time of discharge from hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid, and You would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Network Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx The list of Network Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Network Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a Hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.