



THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

NEW INDIA SIXTY PLUS MEDICLAIM POLICY

1. PREAMBLE

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

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

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

If during the Period of Insurance, You or any Insured Person incurs Hospitalisation Expenses which are Reasonable and Customary, and Medically Necessary for treatment of any Illness or Injury, we will reimburse such expense incurred by You, through the Third Party Administrator, in the manner stated herein.

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

2. DEFINITIONS

STANDARD DEFINITIONS

- 2.1 ACCIDENT** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 2.2 ANY ONE ILLNESS** means continuous period of Illness and includes relapse within forty-five days from the date of last consultation with the Hospital where treatment was taken.
- 2.3 AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
- Central or State Government AYUSH Hospital or
 - Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
 - 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:
 - Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

2.5 BANK RATE means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.

2.6 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 insurer to the extent pre-authorization approved.

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

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

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

2.9 CO-PAYMENT is a cost-sharing requirement under a health insurance policy that provides that the Insured Person will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

2.10 DAY CARE TREATMENT refers to medical treatment, and/or Surgical Procedure which is:

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

2.11 DAY CARE CENTRE means any institution established for Day Care Treatment of Illness and/or Injury 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 record of patients and will make these accessible to the insurance company's authorized personnel.

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

2.14 DOMICILIARY HOSPITALISATION means medical treatment for an Illness/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- The patient takes treatment at home on account of non-availability of room in a Hospital.

2.15 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.

2.16 GRACE PERIOD means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage is not available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

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

- has 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.

2.18 HOSPITALISATION means admission in a Hospital for a minimum period of twenty-four consecutive hours of Inpatient Care except for specified procedures / treatments as mentioned in Annexure I, where such admission could be for a period of less than twenty four consecutive hours.

Note: Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than twenty four consecutive hours.

2.19 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of

normal physiological function and requires medical treatment.

- i. Acute Condition means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
- ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics
 - a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b. it needs ongoing or long-term control or relief of symptoms
 - c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
 - d. it continues indefinitely
 - e. it recurs or is likely to recur

2.20 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.

2.21 INPATIENT CARE means treatment for which the insured person has to stay in a Hospital for more than twenty-four hours for a covered event.

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

2.23 ICU CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

2.25 MEDICAL EXPENSES means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident 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 Medical Practitioner in the same locality would have charged for the same medical treatment.

2.26 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

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

2.27 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.

2.28 MENTAL HEALTH ESTABLISHMENT means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends;

2.29 MENTAL HEALTH PROFESSIONAL means

- i. A Psychiatrist means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Policy
- ii. a professional registered with the concerned State Authority; (or)
- iii. a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam

2.30 MIGRATION means a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

2.31 NETWORK PROVIDER means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The list is available with the insurer/TPA and subject to amendment from time to time.

2.32 NON-NETWORK PROVIDER means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

2.34 PRE-EXISTING CONDITION/DISEASE means any condition, ailment, Injury or Illness

- a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of policy issued by the insurer or

- b. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of policy

2.35 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during thirty days preceding the Hospitalisation of the Insured Person, 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.

2.36 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during sixty days immediately after the Insured Person is discharged from the Hospital provided that:

- i. Such Medical Expenses are 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.

2.37 PORTABILITY means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

2.38 QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.39 REASONABLE AND CUSTOMARY CHARGES mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

2.40 RENEWAL means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

2.41 ROOM RENT means the amount charged by a Hospital towards Room and Boarding expense and shall include associated medical expenses.

2.42 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 from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

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

SPECIFIC DEFINITIONS

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

2.45 ATTENDANT means a person who provides basic patient care under direction of nursing staff. Perform duties such as feed, bathe, dress, groom, or move patients, or change linens. May transfer or transport patients. Includes nursing care attendants and nursing aides.

- 2.46 ASSOCIATE MEDICAL EXPENSES** means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
- 2.47 AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA)** number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers.
- 2.48 AYUSH TREATMENT** refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- 2.49 BREAK IN POLICY** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or within 30 days thereof.
- 2.50 CLAIM FREE YEAR** means coverage under the New India Sixty Plus Mediclaim Policy for a period of one year during which no claim is paid or payable under the terms and conditions of the Policy in respect of Insured Person.
- 2.51 CONTINUOUS COVERAGE** means uninterrupted coverage of the Insured Person with Us or any other Insurer, from the time the coverage incepted under any of the Health Insurance policies till the date of commencement of Period of Insurance of this Policy.
- A break in insurance for a period not exceeding thirty days shall not be reckoned as an interruption in coverage for the purpose of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.
- 2.52 CUMULATIVE BONUS BUFFER** means Bonus, as stated in the Schedule, carried forwarded at commencement of this Policy. CUMULATIVE BONUS BUFFER shall not be treated as part of the Sum Insured for the purposes of reckoning any limit specified in the Policy.
- 2.53 INSURED PERSON** means You and each of the others who are covered under this Policy as shown in the Schedule.
- 2.54 PERIOD OF INSURANCE** means the period for which this Policy is taken as specified in the Schedule.
- 2.55 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 coverages, exclusions and terms & conditions on which the Policy is issued to The Insured Person.
- 2.56 POLICY PERIOD** means period of one policy year as mentioned in the schedule for which the Policy is issued.
- 2.57 POLICY SCHEDULE** means the Policy Schedule attached to and forming part of Policy.
- 2.58 POLICY YEAR** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

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

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

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

2.61 TPA (THIRD PARTY ADMINISTRATORS) means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulation, 2019 notified by the Authority, and is engaged, for a fee or remuneration by Us, for the purposes of providing Health Services defined in those Regulations.

2.62 WAITING PERIOD means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

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

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

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

3. BENEFITS COVERED UNDER THE POLICY

3.1 Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus Buffer, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus Buffer.

Subject to above, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible under the following heads.

Section	Hospitalisation Benefit	Limits
3.1.1	Room charges subject to 1% of sum insured per day and Intensive care unit (ICU) charges subject to 2% of sum insured per day (including nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges).	Maximum limit under Section 3.1.1 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury Please Note that basic Sum Insured will only be considered for reckoning of Per day roomrent eligibility.
3.1.2	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	Maximum limit under Section 3.1.2 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury
3.1.3	Anesthesia, Blood, Oxygen, OT charges, Surgical appliances (any disposable surgical consumables), Medicines, drugs,	Maximum limit under Section 3.1.3 will be 50% of the aggregate of Sum Insured and Cumulative Bonus Buffer

	Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, Artificial limbs and implants other than Orthopedic.	per illness / injury
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- 3.2** Claims in respect of the following Treatments/ Surgeries including all types of implants used in the surgery, will be subject to the following limits (including Pre & Post Hospitalization expenses). Co- Payment/voluntary co-payment and sub limits mentioned in section 3.1 are not applicable if a claim is admissible under the below mentioned specified Treatments/Surgeries.

Treatments/Surgeries	2 Lakhs	3 Lakhs	5 Lakhs
Angiography (CT Angiogram excluded)	14000	20000	25000
Cataract (each eye)	15000	20000	25000
Hydrocele Surgery	20000	30000	50000
Dialysis (With a cap of 1500 per sitting)	25000	35000	50000
Fissurectomy	27000	38000	45000
Fistulectomy	27000	38000	45000
Surgery of Hernia	30000	40000	60000
Appendectomy	30000	40000	60000
Transurethral resection of the prostate (TURP)/ BPH surgery	30000	40000	60000
Hysterectomy	30000	40000	60000
Cholecystectomy	30000	40000	60000
Arthroscopic Surgery	30000	40000	60000
Haemorrhoidectomy	30000	40000	60000
Renal stones related surgical procedures	38000	55000	70000
All major Surgical and Medical Treatment for Fractures and Dislocations	50000	70000	100000
PID-Discectomy	70000	80000	100000
PTCA (Angioplasty)	75000	120000	150000
Joint Replacement for Major Joints (Per Joint)	80000	100000	150000
Major Spinal Surgeries	100000	150000	200000
All Major Cancer Surgeries	140000	200000	275000
Major Organ Transplant (Including Donor Expenses)	150000	200000	300000
CABG (Coronary Artery Bypass Graft)	150000	200000	275000
Note: In case of multiple surgeries in one sitting, in same incident and on same site, highest grade surgery amongst them will be approved at 100%, second surgery at 50% and third surgery at 25% of the capped amount specified above in section 3.2.			

3.3 ATTENDANT BENEFIT:

We will pay a benefit of up to Rs. 5000/-, Rs. 7000/- and Rs, 10,000/- per hospitalization for the Sum Insured of Two, Three and Five Lakhs respectively subject to the limit of Maximum Rs. 800 per day or actuals, whichever is less, and after submitting relevant supporting documents. This amount will reduce the Sum Insured.

3.4 OPTIONAL COVER: VOLUNTARY CO-PAY

If You opt for a voluntary co-pay of an extra 10% i.e. for a total co-pay of 20%, a discounted Premium given in the table shall be charged.

3.5 CO-PAYMENT:

You shall bear a Co-Payment of 10% of the final claim admissible amount and Our liability shall be restricted to the payment of the balance amount subject to the available Sum Insured and Cumulative Bonus Buffer i.e., In the Claims admitted, the Company's liability will be:

- a) Sum Insured and Cumulative Bonus Buffer **(or)**
- b) 90% of the admissible claim amount

Whichever is less.

If You opt for a voluntary co-pay of extra 10% i.e. for a total co-payment of 20% then the Claims admitted, the Company's liability will be:

- a) Sum Insured and Cumulative Bonus Buffer (or)
- b) 80% of the admissible claim amount Whichever is less.

Co-Payment is not applicable if a Claim is admissible under section 3.2.

3.6 HOSPITAL CASH:

We will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalization admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty-four consecutive hours. Payment under this clause shall reduce the Sum Insured.

Hospital Cash will be payable for completion of every twenty-four hours and not part thereof.

3.7 LIMIT ON PAYMENT FOR CATARACT:

Our liability for payment of any claim relating to Cataract, for each eye shall not exceed the limit mentioned in the section 3.2

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

3.8 PAYMENT OF AMBULANCE CHARGES:

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

3.9 PRE & POST HOSPITALIZATION EXPENSES: We will pay You the Pre & Post Hospitalization expenses of 30 days, 60 days respectively, subject to the maximum limit of 10% of the Sum Insured, if the Claim has been accepted under section 3.1

3.10 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

No payment shall be made for any Hospitalisation expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anaesthetist directly and not included in the Hospital Bill shall be paid provided a numbered Bill is produced in support

thereof, for an amount not exceeding Rs. Ten thousand, where such payment is made in cash and for an amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

3.11 MEDICAL EXPENSES FOR ORGAN TRANSPLANT:

If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ) incurred on the donor, provided Our liability towards expenses incurred on the donor and the insured recipient will be limited to amount stated in section 3.2

3.12 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.

3.13 SPECIFIC COVERAGES:

- a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period subject to it arising during treatment of covered illness.
- b) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).
- c) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.
- d) **Age Related Macular Degeneration (ARMD)** is covered after 36 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. 50,000 per policy period.
- e) **Behavioural and Neuro developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.
- f) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 36 months waiting periods.

Note: For the coverages defined in 3.13 (a) to (f), waiting periods, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020.

Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

- g) Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders** The Company shall indemnify the Hospital or the Insured the Medical Expenses related to following and they are covered after a waiting period of 36 months with a sub-limit up to 25% of Sum Insured per policy period.

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

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

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

Condition

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

Exclusions

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

Note: For the coverages defined in 3.13 (g), waiting period shall be applicable for both New and Existing Policyholders w.e.f 16th August 2018 or date of inception of first policy, whichever is later. This Coverage shall only be available after completion of the said waiting period.

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

S No	Treatment or Procedure	Limit (Per Policy Period)
3.14.1	Uterine Artery Embolization and HIFU (High intensity focusedultrasound)	Upto 20% of Sum Insured subject toa Maximum upto Rs. 1 Lakh
3.14.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject toa Maximum upto Rs. 1 Lakh
3.14.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject toa maximum upto Rs. 2.5 Lakh
3.14.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 50,000.
3.14.5	Immunotherapy- Monoclonal Antibody to be given asinjection.	Upto 25% of Sum Insured subject toa Maximum of Rs 1 Lakh.
3.14.6	Intravitreal injections.	Upto 10% of Sum Insured subject toa Maximum of Rs.50,000.
3.14.7	Robotic surgeries.	Upto 50% of Sum Insured subject toMaximum of Rs. 2.5 Lakh.
3.14.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject toMaximum Rs. 2.5 Lakh.
3.14.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject toMaximum of Rs. 2.5 Lakh.
3.14.10	Vaporisation of the prostate (Green laser treatment orholmium laser treatment).	Upto 50% of Sum Insured subject toMaximum of Rs. 2.5 Lakh.
3.14.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject toMaximum of Rs. 50,000.
3.14.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject toMaximum of Rs. 2.5 Lakh.

3.15 TREATMENT FOR CONGENITAL DISEASES

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

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

3.16 COVERAGE UNDER AYUSH TREATMENT

Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule.

4. WHAT ARE EXCLUDED UNDER THIS POLICY

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

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

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

- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

- a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 24 / 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

(i) 90 Days Waiting Period

- 1. Diabetes Mellitus
- 2. Hypertension
- 3. Cardiac Conditions

(ii) 24 Months waiting period

- 1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- 2. Benign ear, nose, throat disorders
- 3. Benign prostate hypertrophy
- 4. Cataract and age related eye ailments
- 5. Gastric/ Duodenal Ulcer
- 6. Gout and Rheumatism
- 7. Hernia of all types
- 8. Hydrocele
- 9. Non Infective Arthritis
- 10. Piles, Fissures and Fistula in anus
- 11. Pilonidal sinus, Sinusitis and related disorders
- 12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident

13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Renal Failure
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
 - a. Disorders of adult personality
 - b. Disorders of speech and language including stammering, dyslexia
21. Internal Congenital Diseases

(iii) 36 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. Congenital External Diseases

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

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

4.4 EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

- a. Expenses related to any admission primarily for diagnostics and evaluation purposes.
- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

However, Treatment for any symptoms, illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

4.4.2 REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

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

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

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

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

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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

4.4.7 BREACH OF LAW (Code- Excl10)

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

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

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

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

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

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

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

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

4.4.15 MATERNITY EXPENSES (Code - Excl18)

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

SPECIFIC EXCLUSIONS

4.4.16 Acupressure, acupuncture, magnetic therapies.

- 4.4.17** Any expenses incurred on Domiciliary Hospitalization.
- 4.4.18** Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.
- 4.4.19** Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.
However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.
- 4.4.20** Circumcision unless Medically Necessary for treatment of an Illness not excluded here under or as may be necessitated due to an Accident.
- 4.4.21** Convalescence, General debility and Venereal disease.
- 4.4.22** Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.
- 4.4.23** Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation.
- 4.4.24** External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and similar related items etc., and also any medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.
- 4.4.25** 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.
- 4.4.26** Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.14.12
- 4.4.27** Treatment for Sleep Apnoea Syndrome, treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and CPAD (Continuous Peritoneal Ambulatory Dialysis).
- 4.4.28** Treatment taken outside the geographical limits of India

4.4.29 Vaccination and/or inoculation

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

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 FRAUD, MISREPRESENTATION, CONCEALMENT:

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

5.2 MULTIPLE POLICIES:

Claims in respect of multiple Policies held by policyholders:

1. Indemnity Policies:

- a) If a policyholder has more than one health insurance policy from different insurers he/she can file for claim settlement as per his/her choice under any policy.
- b) The Insurer of that chosen policy shall be treated as the primary Insurer.
- c) In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder, his/her choice of the other insurer(s) and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

2. Benefit based Policies: On occurrence of the insured event the policyholder, can claim from all Insurers under all policies.

Note: The Insured Person must disclose such other Insurance at the time of making a claim under this Policy.

None of the provisions of this Clause shall apply for payments under Clause 3.7 of the Policy and if the expenses for illness/treatments listed under section 3.2 of the policy clause barring cataract are exceeding the amount capped thereunder, the balance admissible expenses can be claimed from other policies of New India, if any.

5.3 RENEWAL CLAUSE:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The company shall provide notice for renewal 30 days in advance from the due date.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
- v. No loading shall apply on renewals based on individual claims experience.
- vi. There shall be no fresh underwriting unless there is increase in sum insured.

5.4 CANCELLATION CLAUSE:

The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

- a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
- b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

Not with standing anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non- disclosure of material facts or fraud

5.5 FREE LOOK PERIOD:

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies of less than a year, renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

5.6 PORTABILITY AND MIGRATION:

Migration:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the

policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then you can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy.

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 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy.

5.7 GRIEVANCE REDRESSAL:

In the event of Your having any grievance relating to the insurance or any claim thereunder, You may contact any of the Customer Care 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 detail of the office of the Insurance Ombudsman is provided in the Annexure III. Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

5.8 MORATORIUM PERIOD: After completion of sixty continuous months of coverage(including portability and migration in health insurance policy), no policy and claim shall be contestable by the insurer on grounds of non-disclosure, mis-representation except on grounds of established fraud . This period of sixty continuous months is called as Moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limit.

SPECIFIC TERMS AND CLAUSES

5.9 BASIS OF INSURANCE:

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

5.10 PREMIUM:

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

5.11 PLACE OF TREATMENT AND PAYMENT:

This Policy covers medical/surgical treatment and/or services rendered only in India. Admissible claims shall be payable only in Indian Rupees.

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

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. If we/TPA have doubts regarding admissibility of a claim at the initial stage, which cannot be decided without further verification of treatment records, request for Cashless

facility may be declined. Such decision by TPA or Us shall be final. Denial of Cashless facility would not imply denial of claim. If Cashless facility is denied, You may submit the papers on completion of treatment and admissibility of the claim would be subject to the terms, conditions and exceptions of the Policy.

5.12 COMMUNICATION:

You must send all communications and papers regarding a claim to the TPA at the address shown in the Policy Schedule.

For all other matters relating to the policy, communication must be sent to our Policy issuing office.

Communications you wish to rely upon must be in writing.

5.13 NOTICE OF CLAIM:

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

- a. Intimate TPA in writing on detection of any Illness/Injury being suffered immediately or forty-eight hours before Hospitalisation.
- b. Intimate within twenty-four hours from the time of Hospitalisation in case of Hospitalisation due to medical emergency.
- c. Submit following supporting documents TPA relating to the claim within seven days from the date of discharge from the Hospital:
 - i. Bill, Receipt and Discharge certificate / card from the Hospital.
 - ii. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
 - iii. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
 - iv. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
 - v. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
- d. In case of Post-Hospitalisation treatment (limited to sixty days), submit all claim documents within 7 days after completion of such treatment.
- e. Provide TPA with authorization to obtain medical and other records from any Hospital, Laboratory or other agency.

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

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

- 5.14** The Insured person shall submit to the TPA all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/Us such additional information and assistance as the TPA / We may require.

5.15 Any Medical Practitioner authorised by the TPA/Us shall be allowed to examine the Insured Person, at our cost, if We deem Medically Necessary in connection with any claim.

5.16 ENHANCEMENT OF SUM INSURED:

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

Up to 65 Years	Up to Sum Insured of 5 lakhs without Medical Examination.
Age 66 - 70 Years	By one slab with Medical Examination.

Enhancement of Sum Insured will not be considered for:

- 1) Any Insured Person over 70 years of age.
- 2) Any Insured Person who had undergone more than one Hospitalization in the preceding two years.
- 3) Any Insured Person suffering from one or more of the following Illnesses/Conditions:
 - a) Any chronic Illness
 - b) Any recurring Illness
 - c) Any Critical Illness

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

5.17 CUMULATIVE BONUS BUFFER:

Cumulative Bonus Buffer could be carried over to the next year only if the renewal is effected before, or within thirty days of, expiry of the Policy.

The Cumulative Bonus buffer will be carried forward unless and until it is completely utilized.

The Cumulative Bonus Buffer accrued under any of our policies, on migration to New India Sixty Plus Mediclaim Policy is protected. However, no fresh accrual will be allowed.

5.18 ARBITRATION:

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

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

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

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

5.19 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024..

5.20 SETTLEMENT/REJECTION OF CLAIM:

- i. Settlement of claims (other than cashless) shall be settled within fifteen days from submission of claim.
- ii. While efforts will be made by Us to not call for any document not listed in Clause 5.13, 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 Hospitalization should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within seven days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.
 - a. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.
 - b. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each. The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.
- iv. In the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

5.21 SINGLE POLICY:

You are allowed to take only Single Policy of New India Sixty Plus Mediclaim Policy.

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

ANNEXURE I: LIST OF DAY CARE PROCEDURES:

1	Stapedotomy	2	Excision And Destruction Of A Lingual Tonsil
3	Stapedectomy	4	Other Operations On The Tonsils And Adenoids
5	Revision Of A Stapedectomy	6	Incision On Bone, Septic And Aseptic
7	Other Operations On The Auditory Ossicles	8	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
9	Myringoplasty (Type -I Tympanoplasty)	10	Suture And Other Operations On Tendons And Tendon Sheath
11	Tympanoplasty (Closure Of An Eardrum Perforation/Reconstruction Of The Auditory Ossicles)	12	Reduction Of Dislocation Under Ga
13	Revision Of A Tympanoplasty	14	Arthroscopic Knee Aspiration
15	Other Microsurgical Operations On The Middle Ear	16	Incision Of The Breast
17	Myringotomy	18	Operations On The Nipple
19	Removal Of A Tympanic Drain	20	Incision And Excision Of Tissue In The Perianal Region
21	Incision Of The Mastoid Process And Middle Ear	22	Surgical Treatment Of Anal Fistulas
23	Mastoidectomy	24	Surgical Treatment Of Haemorrhoids
25	Reconstruction Of The Middle Ear	26	Division Of The Anal Sphincter (Sphincterotomy)
27	Other Excisions Of The Middle And Inner Ear	28	Other Operations On The Anus
29	Fenestration Of The Inner Ear	30	Ultrasound Guided Aspirations
31	Revision Of A Fenestration Of The Inner Ear	32	Sclerotherapy Etc
33	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	34	Incision Of The Ovary
35	Other Operations On The Middle And Inner Ear	36	Insufflation Of The Fallopian Tubes
37	Excision And Destruction Of Diseased Tissue Of The Nose	38	Other Operations On The Fallopian Tube
39	Operations On The Turbinates (Nasal Concha)	40	Dilatation Of The Cervical Canal
41	Other Operations On The Nose	42	Conisation Of The Uterine Cervix
43	Nasal Sinus Aspiration	44	Other Operations On The Uterine Cervix
45	Incision Of Tear Glands	46	Incision Of The Uterus (Hysterotomy)
47	Other Operations On The Tear Ducts	48	Therapeutic Curettage
49	Incision Of Diseased Eyelids	50	Culdotomy
51	Excision And Destruction Of Diseased TissueOf The Eyelid	52	Incision Of The Vagina

53	Operations On The Canthus And Epicanthus	54	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
55	Corrective Surgery For Entropion And Ectropion	56	Incision Of The Vulva
57	Corrective Surgery For Blepharoptosis	58	Operations On Bartholin'S Glands (Cyst)
59	Removal Of A Foreign Body From The Conjunctiva	60	Incision Of The Prostate
61	Removal Of A Foreign Body From The Cornea	62	Transurethral Excision And Destruction Of Prostate Tissue
63	Incision Of The Cornea	64	Transurethral And Percutaneous Destruction Of Prostate Tissue
65	Operations For Pterygium	66	Open Surgical Excision And Destruction Of Prostate Tissue
67	Other Operations On The Cornea	68	Radical Prostatovesiculectomy
69	Removal Of A Foreign Body From The Lens Of The Eye	70	Other Excision And Destruction Of Prostate Tissue
71	Removal Of A Foreign Body From The Posterior Chamber Of The Eye	72	Operations On The Seminal Vesicles
73	Removal Of A Foreign Body From The Orbit And Eyeball	74	Incision And Excision Of Periprostatic Tissue
75	Operation Of Cataract	76	Other Operations On The Prostate
77	Incision Of A Pilonidal Sinus	78	Incision Of The Scrotum And Tunica Vaginalis Testis
79	Other Incisions Of The Skin And Subcutaneous Tissues	80	Operation On A Testicular Hydrocele
81	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues	82	Excision And Destruction Of Diseased Scrotal Tissue
83	Other Excisions Of The Skin And Subcutaneous Tissues	84	Plastic Reconstruction Of The Scrotum And Tunica Vaginalis Testis
85	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues	86	Other Operations On The Scrotum And Tunica Vaginalis Testis
87	Free Skin Transplantation, Donor Site	88	Incision Of The Testes
89	Free Skin Transplantation, Recipient Site	90	Excision And Destruction Of Diseased Tissue Of The Testes
91	Revision Of Skin Plasty	92	Unilateral Orchiectomy
93	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	94	Bilateral Orchiectomy
95	Chemosurgery To The Skin	96	Orchidopexy
97	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	98	Abdominal Exploration In Cryptorchidism
99	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	100	Surgical Repositioning Of An Abdominal Testis
101	Partial Glossectomy	102	Reconstruction Of The Testis

103	Glossectomy	104	Implantation, Exchange And Removal Of A Testicular Prosthesis
105	Reconstruction Of The Tongue	106	Other Operations On The Testis
107	Other Operations On The Tongue	108	Surgical Treatment Of A Varicocele And A Hydrocele Of The Spermatic Cord
109	Incision And Lancing Of A Salivary Gland And A Salivary Duct	110	Excision In The Area Of The Epididymis
111	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct	112	Epididymectomy
113	Resection Of A Salivary Gland	114	Reconstruction Of The Spermatic Cord
115	Reconstruction Of A Salivary Gland And A Salivary Duct	116	Reconstruction Of The Ductus Deferens And Epididymis
117	Other Operations On The Salivary Glands And Salivary Ducts	118	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
119	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	120	Operations On The Foreskin
121	Incision Of The Hard And Soft Palate	122	Local Excision And Destruction Of Diseased Tissue Of The Penis
123	Excision And Destruction Of Diseased Hard And Soft Palate	124	Amputation Of The Penis
125	Incision, Excision And Destruction In The Mouth	126	Plastic Reconstruction Of The Penis
127	Plastic Surgery To The Floor Of The Mouth	128	Other Operations On The Penis
129	Palatoplasty	130	Cystoscopic Removal Of Stones
131	Other Operations In The Mouth	132	Lithotripsy
133	Transoral Incision And Drainage Of A Pharyngeal Abscess	134	Coronary Angiography
135	Tonsillectomy Without Adenoidectomy	136	Haemodialysis
137	Tonsillectomy With Adenoidectomy	138	Radiotherapy For Cancer
139	Parenteral Chemotherapy		

ANNEXURE II:**LIST I – ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY**

S. No.	ITEM
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

S. No.	ITEM
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSE OXYMETER 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 NATALBOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

ANNEXURE III : CONTACT DETAILS OF INSURANCE OMBUDSMEN

The updated details of Insurance Ombudsman are available on <https://www.cioins.co.in/Ombudsman>

AHMEDABAD – 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@cioins.co.in Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu.	BHOPAL - Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in Jurisdiction : Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR – Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in Jurisdiction : Odisha	CHANDIGARH – 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@cioins.co.in Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI – 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@cioins.co.in Jurisdiction : Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	DELHI - 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@cioins.co.in Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
GUWAHATI – 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@cioins.co.in Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	HYDERABAD – 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@cioins.co.in Jurisdiction : Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

ERNAKULAM – 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@cioins.co.in Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	KOLKATA - 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@cioins.co.in Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in Jurisdiction : Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	MUMBAI – Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in Jurisdiction : List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
JAIPUR – Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in Jurisdiction : Rajasthan	PUNE - 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@cioins.co.in Jurisdiction : State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
BENGALURU – 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@cioins.co.in Jurisdiction :Karnataka.	NOIDA – 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@cioins.co.in Jurisdiction : State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi,

	Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in Jurisdiction : Bihar, Jharkhand.	THANE – Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasant Rao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.thane@cioins.co.in Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

