THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA TOP-UP MEDICLAIM

1. PREAMBLE

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

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

If during the **Policy Period, You** or any **Insured Person** undergo **Hospitalisation** for Illness or Injury and incur **Medical Expenses**, by reason of which the **Cumulative Hospitalisation Expenses** for the Insured Persons during such **Policy Period** exceeds the **Threshold** specified in the Schedule, **We** will reimburse subject to terms and conditions of this Policy, the portion of the **Medical Expenses** for such **Hospitalisation** or any **Hospitalisation** thereafter as exceeds the **Threshold**, to the extent specified under **How Much We Will Reimburse** section of this Policy.

Provided,

a) Claim shall be made only for the Hospitalisation during which the Cumulative Medical Expenses exceeds Threshold or for any subsequent Hospitalisation, but not for earlier Hospitalisation or treatment.

b) Claim shall be payable only if the treatment claimed is within the scope of the Policy subject to terms, conditions, exclusions and limitations.

c) The Insured Person shall not be entitled to claim under this Policy any amount of such Medical Expenses as has been received from any other person or entity, in which event the claim payable by Us would be reduced by such amount as may have been received.

d) We shall in no case be liable to pay more than the Sum Insured.

e) The above coverage is subject to Limits, Terms and Conditions contained in this Policy.

2. DEFINITIONS

STANDARD DEFINITIONS

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

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

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

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever

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

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 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 Person where the payments, of the costs of treatment undergone by the Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent of pre-authorization approved.

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

2.8 CONGENITAL ANOMALY refers to a condition 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 DAY CARE CENTRE means any institution established for Day Care Treatment of Illness or Injury, or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment;
- Has qualified Medical Practitioner in charge;
- Has a fully equipped operation theatre of its own where Surgery is carried out;
- Maintains daily record of patients and will make these accessible to the Insurance Company's authorized personnel.

2.10 DAY CARE TREATMENT refers to medical treatment or Surgery which:

- Is undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
- Would have otherwise required a Hospitalisation of more than 24 hours.

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

2.11 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.

2.12 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.

2.13 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.

2.14 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

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

- Has 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 in charge round the clock;
- Has a fully equipped operation theatre of its own where Surgery is carried out;
- Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

2.16 HOSPITALISATION means admission in a Hospital for a minimum period of twenty-four In-patient consecutive hours except for specified procedures / treatments listed 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 24 hours.

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

i. Acute Condition means a disease, Illness or Injury that is likely to respond quickly to

treatment which aims to return the person to his or her state of health immediately before suffering the disease / Illness / Injury which leads to full recovery.

ii. Chronic Condition means a disease, Illness, or Injury that has one or more of the following characteristics

a. it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests

b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

2.18 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.

2.19 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.

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

2.21 ICU (INTENSIVE CARE UNIT) CHARGES means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

2.23 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.

2.24 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.

2.25 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.

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

2.26 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.

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

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

2.29 PRE-EXISTING DISEASE (PED) means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the Policy or its reinstatement.

2.30 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period preceding Your Hospitalisation, provided that:

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

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

2.31 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during the period immediately after Your discharge from the Hospital provided that:

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

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

2.32 PORTABILITY means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer

2.33 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.

2.34 REASONABLE AND CUSTOMARY EXPENSES 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.

2.35 RENEWAL defines the terms on which the contract of Insurance can be renewed on mutual consent with a provision of renewing within 30 days from the date of expiry of the policy for treating the renewal continuous for the purpose of all waiting periods.

2.36 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.

2.37 SURGERY OR SURGICAL PROCEDURE means manual or operative procedure required for

treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or Day Care Centre by a Medical Practitioner.

SPECIFIC DEFINITIONS

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

2.39 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.

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

2.41 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.

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

2.43 CUMULATIVE HOSPITALISATION EXPENSES mean the aggregate of all Medical Expenses incurred towards Hospitalisation in respect of one or more Insured Persons for treatment of any Illness or Injury as reflected in the Hospital Inpatient Hospitalisation Bills, provided

- It shall not include other expenses including Pre-Hospitalisation or Post-Hospitalisation Expenses even if incurred in connection with such Illness or Injury.
- The admission in the Hospital shall have occurred during the Period of Insurance.

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

2.45 POLICY means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

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

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

2.48 POLICY YEAR means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

2.49 SUB-LIMIT means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit.

2.50 SUM INSURED means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of all Insured Persons during the Policy Year.

2.51 THRESHOLD is the amount of Cumulative Hospitalisation Expenses specified in the Schedule chosen by the Insured Person up to which no Medical Expenses can be claimed under this policy.

2.52 THIRD PARTY ADMINISTRATORS (TPA) means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

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

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

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

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

3. BENEFITS COVERED UNDER THE POLICY

3.1 Our liability for all claims admitted during the Policy Period in respect of all Insured Persons, including all payment related to clause 3.1(e) and 3.6, will be only up to Sum Insured as mentioned in the Schedule. Subject to this, We will reimburse the following Reasonable and Customary and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), actually incurred subject to a cap of Rs. 5,000 per day for Rs. 5,00,000 Threshold and Rs. 8,000 per day for Rs. 8,00,000 Threshold.
3.1(b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oximeters expenses, actually incurred subject to a cap of Rs. 10,000 per day for Rs. 5,00,000 Threshold and Rs. 16,000 per day for Rs. 8,00,000 Threshold.
3.1(c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
3.1(d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics. Proportionate Deduction Clause 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 Clause 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.
3.1(e)	**Get Well Benefit** of Rs. 5,000 for Rs. 5,00,000 Threshold and Rs. 8,000 for Rs. 8,00,000 Threshold, will be paid for Any One Illness. This benefit will be payable only for the first four admissible claims under the Policy. This benefit will reduce the Sum Insured.

3.2 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, after taking the Threshold into consideration. 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.

3.3 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 during the course of organ transplant to the Insured Person, provided Our liability towards expenses incurred on the donor and the Insured recipient shall not exceed the Sum Insured.

3.4 LIMIT ON PAYMENT FOR CATARACT

Our liability for payment of any claim within the Policy Period, relating to Cataract for each eye shall not exceed Rs. Fifty thousand.

3.5 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.

3.6 HOSPITAL CASH

Hospital cash will be paid at the rate of Rs. 500 per day for Rs. 5,00,000 Threshold and Rs. 800 per day for Rs. 8,00,000 Threshold; maximum for 10 days for Any One Illness. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty-four hours. This benefit will reduce the Sum Insured. Hospital cash will be paid for completion of every 24 hours as a day but not part thereof.

3.7 PAYMENT OF AMBULANCE CHARGES

Ambulance service expenses actually incurred subject to cap of Rs. 5,000 for Rs. 5,00,000 Threshold and Rs. 8,000 for Rs. 8,00,000 Threshold. These expenses are payable only if they are Reasonable, Customary and Medically Necessarily 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. Payment under this benefit will reduce the Sum Insured. Ambulance charges will be paid once for Any One Illness for each Insured.

3.8 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

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

3.9 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 up to 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. 75,000 per policy period.

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

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

g) **Treatment of mental illness,** stress or psychological disorders and neurodegenerative disorders: Our 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 36 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 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.

3.10 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)
3.10.1	Uterine Artery Embolization and HIFU (High intensity focusedultrasound)	Upto 20% of Sum Insured subjectto Maximum Rs. 2 Lakh
3.10.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subjectto Maximum Rs. 2 Lakh
3.10.3	Deep Brain stimulation.	Upto 50% of Sum Insured subjectto Maximum Rs. 5 Lakh
3.10.4	Oral chemotherapy.	Upto 10% of Sum Insured subjectto Maximum Rs. 1 Lakh
3.10.5	Immunotherapy- Monoclonal Antibody to be given asinjection.	Upto 25% of Sum Insured subjectto Maximum Rs 2 Lakh.
3.10.6	Intravitreal injections.	Upto 10% of Sum Insured subjectto Maximum Rs.75,000.
3.10.7	Robotic surgeries.	Upto 50% of Sum Insured subjectto Maximum Rs. 5 Lakh.
3.10.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subjectto Maximum Rs. 3 Lakh.
3.10.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subjectto Maximum Rs. 2.5 Lakh.
3.10.10	Vaporisation of the prostrate (Green laser treatment orholmium laser treatment).	Upto 50% of Sum Insured subjectto Maximum Rs. 2.5 Lakh.
3.10.11	IONM-(Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subjectto Maximum Rs. 50,000.
3.10.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subjectto Maximum Rs. 2.5 Lakh.

4. EXCLUSIONS

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

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

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

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

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

d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of 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. Puberty and Menopause related Disorders
19. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia
20. Internal Congenital Diseases

(iii) 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. 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 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.

4.5 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.

4.6 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

4.7 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.

4.8 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.

4.9 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.

4.10 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.

4.11 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.

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

4.13 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)**

4.14 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)**

4.15 REFRACTIVE ERROR (Code- Excl15)

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

4.16 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.

4.17 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

4.18 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

4.19 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.

4.20 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.

4.21 Pre-Hospitalisation Medical Expenses and Post Hospitalisation Medical Expenses.

4.22 Expenses incurred for acupressure, acupuncture, magnetic and such other therapies.

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

4.24 Vaccination or inoculation.

4.25 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.

4.26 Dental treatment or Surgery of any kind unless necessitated by Accident and requiring Hospitalisation.

4.27 Convalescence, general debility, Venereal disease and intentional self-injury.

4.28 Bodily Injury or sickness due to wilful 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.

4.29 Stem cell implantation / Surgery for other than those treatments mentioned in clause 3.10.12.

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

4.31 Domiciliary Hospitalisation.

4.32 Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.

4.33 Any kind of Service charges, Surcharges, Admission Fees/Registration Charges levied by the Hospital.

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

4.35 Treatment or Investigation taken outside India.

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 FRAUD, MISREPRESENTATION, CONCEALMENT:

The policy shall be null and void without any refund and no benefits shall be payable in the event of

- Misrepresentation, mis-description or nondisclosure of any material fact/particular in your proposal for this Policy.
- The claim made under this Policy being 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:

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the 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 the chosen policy.

ii. Insured person 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 the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

Note: The Insured Person must disclose such other insurance at the time of making a claim under this Policy. None of the provisions of this Clause shall apply for payments under Section II, Clause 3.1 (e) and 3.6 of the Policy.

5.3 RENEWAL CLAUSE:

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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. refunds 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

Notwithstanding 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.

lf 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 PAYMENT OF CLAIM:

i. We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.

ii. While efforts will be made by Us to not call for any document not listed in Clause 5.15, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.

iii. All necessary claim documents pertaining to Hospitalisation should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within seven days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.

   a. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

   b. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

   c. The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

   If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

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

All admissible claims shall be payable in Indian Currency.

5.7 GRIEVANCE REDRESSAL:

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

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

5.8 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 45 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.

5.9 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.

5.10 NOMINATION:

The policyholder is required at the inception of the policy to make a nomination. In the event of death of the policyholder, the claim proceeds will be paid to the nominee. Nomination can be changed at any time during the term of the policy. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made and in case there is no subsisting nominee, the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

SPECIFIC TERMS AND CLAUSES

5.11 BASIS OF INSURANCE:

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

5.12 PREMIUM:

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

5.13 PLACE OF TREATMENT AND PAYMENT:

This Policy covers only Medical/Surgical treatment taken in India. Any kind of expense incurred outside India is not covered in this Policy.

Admissible claims shall be payable only in Indian Rupees.

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

shall be submitted to the TPA after payment of Hospital bills by You.

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 all Hospitalisation falling within Period of Insurance, 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.

5.14 COMMUNICATION:

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

5.15 NOTICE OF HOSPITALISATION:

You must send details of all Hospitalisations, in respect of all Insured Persons, where the date of admission at the Hospital falls within the Period of Insurance, within fifteen days of discharge from the Hospital, as per Annexure III, to the TPA at the address shown in the Schedule.

5.16 NOTICE OF CLAIM:

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

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

b. In case of Hospitalisation due to medical emergency, intimate TPA within forty-eight hours from the time of Hospitalisation.

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

   i. Original 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.

   vi. Certificate from attending Medical Practitioner/Surgeon that the patient is fully cured.

   vii. Originals of Hospital bills, Hospital receipts and discharge summary relating to the previous Hospitalisations occurring during the Period of Insurance.

   In case any of these documents are not available due to the reason that they have

been submitted to any other Insurer or the employer or to any other entity, copies of these documents certified by the Insurer or the employer or the entity, to whom the originals have been submitted, needs to be furnished.

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

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 that it was not possible for You or any other person to comply with the prescribed time-limit.

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

5.18 Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person, at our cost, if we deem it necessary in connection with any claim.

5.19 ENHANCEMENT OF SUM INSURED OR THRESHOLD:

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

Sum Insured can be enhanced only to the next Sum Insured band.

Enhancement of Sum Insured will not be considered for:

1) Insured Persons over 65 years of age.
2) Insured Person who had undergone Hospitalization in the preceding two years.
3) Insured Persons suffering from one or more of the following Illnesses/Conditions:
   a) Diabetes
   b) Hypertension
   c) Any chronic Illness / ailment
   d) Any recurring Illness / ailment
   e) Any Critical Illness

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

5.20 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.

5.21 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.22 REPUDIATION OF CLAIMS:

A claim, which is not covered under the Policy conditions, can be rejected. With Our prior approval, Communication of repudiation shall be sent to You, by Our TPA, explicitly mentioning the grounds for repudiation.

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

5.23 SINGLE POLICY:

You are allowed to take only Single Policy of New India Top-Up Mediclaim Policy.

5.24 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 1 OF DAY CARE PROCEDURES

S. No.	ITEM
1	Adenoidectomy
2	Appendectomy
3	Anti-Rabies Vaccination
4	Coronary angiography
5	Coronary angioplasty
6	Dilatation & Curettage
7	ERCP (Endoscopic Retrograde Cholangiopancreatography)
8	ESWL (Extracorporeal Shock Wave Lithotripsy)
9	Excision of Cyst/granuloma/lump
10	**FOLLOWING EYE SURGERIES:**
A	Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
B	Corrective Surgery for blepharoptosis when not congenital/cosmetic
C	Corrective Surgery for entropion / ectropion
D	Dacryocystorhinostomy [DCR]
E	Excision involving one-fourth or more of lid margin, full-thickness
F	Excision of lacrimal sac and passage
G	Excision of major lesion of eyelid, full-thickness
H	Manipulation of lacrimal passage
I	Operations for pterygium
J	Operations of canthus and epicanthus when done for adhesions due to chronic Infections
K	Removal of a deeply embedded foreign body from the conjunctiva with incision
L	Removal of a deeply embedded foreign body from the cornea with incision
M	Removal of a foreign body from the lens of the eye
N	Removal of a foreign body from the posterior chamber of the eye
O	Repair of canaliculus and punctum
P	Repair of corneal laceration or wound with conjunctival flap
Q	Repair of post-operative wound dehiscence of cornea
R	Penetrating or Non-Penetrating Surgery for treatment of Glaucoma
11	Pacemaker insertion
12	Turbinectomy/turbinoplasty
13	Excision of pilonidal sinus
14	Therapeutic endoscopic surgeries
15	Conisation of the uterine cervix
16	Medically necessary Circumcision
17	Excision or other destruction of Bartholin's gland (cyst)

18	Nephrotomy
19	Oopherectomy
20	Urethrotomy
21	PCNL (percutaneous nephrolithotomy)
22	Reduction of dislocation under General Anaesthesia
23	Transcatherter Placement of Intravascular Shunts
24	Incision Of The Breast, lump excision
25	Vitrectomy
26	Thyriodectomy
27	Vocal cord Surgery
28	Stapedotomy
29	Tympanoplasty& revision tympanoplasty
30	Arthroscopic Knee Aspiration if Proved Therapeutic
31	Perianal abscess Incision & Drainage
32	DJ stent insertion
33	FESS (Functional Endoscopic Sinus Surgery)
34	Fissurectomy / Fistulectomy
35	Fracture/dislocation excluding hairline fracture
36	Haemo dialysis
37	Hydrocelectomy
38	Hysterectomy
39	Inguinal/ventral/ umbilical/femoral hernia repair
40	Laparoscopic Cholecystectomy
41	Lithotripsy
42	Liver aspiration
43	Mastoidectomy
44	Parenteral chemotherapy
45	Haemorrhoidectomy
46	Polypectomy
47	**FOLLOWING PROSTATE SURGERIES**
A	TUMT (Transurethral Microwave Thermotherapy)
B	TUNA (Transurethral Needle Ablation)
C	Laser Prostatectomy
D	TURP (Transurethral Resection of Prostate)
E	Transurethral Electro-Vaporization of the Prostate (TUEVAP)
48	Radiotherapy
49	Sclerotherapy
50	Septoplasty

51	Surgery for Sinusitis
52	Varicose Vein Ligation
53	Tonsillectomy
54	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
55	Retinal Surgeries
56	Ossiculoplasty
57	Ascitic/pleural therapeutic tapping
58	therapeutic Arthroscopy
59	Mastectomy
60	Surgery for Carpal Tunnel Syndrome
61	Cystoscopic removal of urinary stones / DJ stents
62	AV Malformations (Non cosmetic only)
63	Orchidectomy
64	Cystoscopic fulguration of tumour
65	Amputation of penis
66	Creation of Lumbar Subarachnoid Shunt
67	Radical Prostatectomy
68	Lasik Surgery (non-cosmetic)
69	Orchidopexy (non-congenital)
70	Nephrectomy
71	Palatal Surgery
72	Stapedectomy & revision of stapedectomy
73	Myringotomy
74	Or any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalization and for which prior approval from TPA is mandatory.

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 pharmaceuticalspayable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

S. No.	ITEM
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

ANNEXURE III: NOTICE OF HOSPITALISATION

THE NEW INDIA ASSURANCE CO. LTD.

Registered & Head Office : 87, M.G. Road, Fort, Mumbai - 400 001.

Please give the following information correctly and completely.

All dates to be entered as Date / Month / Year

1. Name of the Insured : _
2. Name of the Claimant : _
3. Policy Number : _
4. Date of Admission : _
5. Date of Discharge : _
6. Nature of Illness : _
7. Amount Paid to the Hospital : _

DECLARATION

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment of any fact, my right to claim reimbursement shall be forfeited.

Date: **Signature of the Claimant**

ANNEXURE IV: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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@ecoi.co.in**	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@ecoi.co.in**
BHUBANESHWAR – **Office of the Insurance Ombudsman,** **62, Forest park, Bhubneshwar – 751 009.** **Tel.: 0674 - 2596461 /2596455** **Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@ecoi.co.in**	CHANDIGARH – **Office of the Insurance Ombudsman,** **S.C.O. No. 101, 102 & 103, 2nd Floor,** **Batra Building, Sector 17 – D, Chandigarh – 160 017.Tel.: 0172 - 2706196 / 2706468** **Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@ecoi.co.in**
CHENNAI – **Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,** **Anna Salai, Teynampet, CHENNAI – 600 018.** **Tel.: 044 - 24333668 / 24335284** **Fax: 044 - 24333664** **Email: bimalokpal.chennai@ecoi.co.in**	DELHI - **Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building,** **Asaf Ali Road, New Delhi – 110 002.Tel.: 011 - 23232481/23213504** **Email: bimalokpal.delhi@ecoi.co.in**
GUWAHATI – **Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,** **Nr. Panbazar over bridge, S.S. Road, Guwahati –781001(ASSAM).** **Tel.: 0361 - 2632204 / 2602205** **Email: bimalokpal.guwahati@ecoi.co.in**	HYDERABAD – **Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court",** **Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.** **Tel.: 040 - 67504123 / 23312122** **Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@ecoi.co.in**
ERNAKULAM – **Office of the Insurance Ombudsman,** **2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.** **Tel.: 0484 - 2358759 / 2359338** **Fax: 0484 - 2359336** **Email: bimalokpal.ernakulam@ecoi.co.in**	KOLKATA - **Office of the Insurance Ombudsman, Hindustan Bldg.Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.** **Tel.: 033 - 22124339 / 22124340** **Fax : 033 - 22124341** **Email: bimalokpal.kolkata@ecoi.co.in**
LUCKNOW – **Office of the Insurance Ombudsman,** **6th Floor, Jeevan Bhawan, Phase-II,** **Nawal Kishore Road, Hazratganj, Lucknow - 226 001.Tel.: 0522 - 2231330 / 2231331** **Fax: 0522 - 2231310** **Email: bimalokpal.lucknow@ecoi.co.in**	MUMBAI – **Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,** **S. V. Road, Santacruz (W), Mumbai - 400 054.** **Tel.: 022 - 26106552 / 26106960** **Fax: 022 - 26106052** **Email: bimalokpal.mumbai@ecoi.co.in**

JAIPUR –	PUNE -
Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg,Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	**Office of the Insurance Ombudsman,Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune –411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in**
BENGALURU – **Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19,24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in**	NOIDA – **Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in**
PATNA - **Office of the Insurance Ombudsman,1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in**	