THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI 400001

NEW INDIA MEDICLAIM POLICY

This is Your NEW INDIA 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.

This Policy states:-

What We Cover

Definitions

How much we will reimburse

What are Excluded under this Policy

Conditions

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.

1. WHAT WE COVER

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

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

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

2.3 **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.

2.4 **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.

2.5 **AYUSH TREATMENT** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.6 **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.

2.7 **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.

2.8 **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

2.9 **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.

2.10 CLAIM FREE YEAR means coverage under the New India 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.

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

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

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

2.13 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.

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

2.15 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 Surgery is carried out;
- Maintains daily record of patients and will make these accessible to the insurance company's authorized personnel.

2.16 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.

2.17 DEDUCTIBLE is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

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

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

2.20 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.

2.21 EMERGENCY CARE: 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.

2.22 GRACE PERIOD means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

2.23 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.

2.24 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.

2.25 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

2.26 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.

2.27 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.

2.28 INSURED PERSON means You and each of the others who are covered under this Policy as shown in the Schedule.

2.29 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.

2.30 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.

2.31 LEGAL GUARDIAN OR CUSTODIAN is a person who has taken the responsibility of taking care of or protecting the children of deceased parents. This definition is to be used for the sole purpose of taking a Health Insurance Policy. This person shall not be eligible for claiming tax rebate under section 80D of the IT act.

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

2.33 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.

2.34 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.

2.35 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.

2.36 MIGRATION means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

2.37 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.

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

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

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

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

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

2.42 PREFERRED PROVIDER NETWORK (PPN) means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

2.43 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.

2.44 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.

2.45 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 PORTABILITY means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another of the same insurer.

2.50 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.

2.51 REASONABLE AND CUSTOMARY CHARGESmean 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 .

2.52 RENAL FAILURE is a condition in which the kidneys lose the ability to remove waste and balance fluids

- **ACUTE RENAL FAILURE (ARF)** is the abrupt loss of kidney function, resulting in the retention of metabolic waste products and dysregulation of volume and electrolytes of body fluids. The medical term Acute Kidney Injury (AKI) has now largely replaced ARF in the medical communities (Injury not necessarily related to Accidents), reflecting the recognition that smaller decrements in kidney function that do not result in overt organ failure are of substantial clinical relevance and are associated with increased morbidity and mortality.
- **CHRONIC RENAL FAILURE:** End stage kidney disease characterized by irreversible failure of both kidneys to function normally, as a result of which either regular dialysis (hemodialysis or peritoneal dialysis) is instituted or a renal transplantation becomes necessary. The diagnosis has to be confirmed by a specialist medical practitioner.
- **RENAL TRANSPLANTATION:** Kidney transplantation is a surgical procedure to remove a healthy and functioning kidney from a living or brain-dead donor and implant it into a patient with non-functioning kidneys.

2.53 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.

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

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

2.56 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.

2.57 SURGERY 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.

2.58 TPA (THIRD PARTY ADMINISTRATORS) means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulation, 2016 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.

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

2.60 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.

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

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

2.63 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. HOW MUCH WE WILL REIMBURSE

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, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus. 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), not exceeding 1% of the Sum Insured per day
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses not exceeding 2% of the Sum Insured per day.
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
3.1 (d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
3.1 (e)	Pre-Hospitalization Medical expenses
3.1 (f)	Post-Hospitalization Medical expenses

3.2 PROPORTIONATE DEDUCTION

Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on

1. Cost of Pharmacy and Consumables
2. Cost of Implants and Medical Devices
3. Cost of Diagnostics.

Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

3.3 LIMIT ON PAYMENT FOR CATARACT:

Our liability for payment of any claim relating to Cataract, for each eye, shall not exceed 20% of the Sum Insured subject to a maximum of Rs. 50,000.

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.

3.4 TREATMENTS UNDER AYURVEDIC / HOMEOPATHIC / UNANI SYSTEMS

Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 25% of the Sum Insured provided the treatment for Illness or Injury, is taken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures.

3.5 HOSPITAL CASH

For those Insured Persons, whose Sum Insured is more than or equal to Rs. three lakhs, we will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalisation 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.

3.6 ADDITIONAL BENEFIT - HEALTH CHECK-UP

The Insured Person shall be entitled for reimbursement of the cost of Medical check-up at the end of a block of every three Claim Free Years. Such payment shall be restricted to Rs. 5,000 or 1% of the average Sum Insured of the Insured Person in the preceding three years, whichever is less. This benefit is available only once in three years.

Any payment made under this clause shall not be considered as a claim for the purpose of Clauses 5.11 of this Policy.

3.7 PAYMENT OF AMBULANCE CHARGES

We will pay You the charges for Ambulance services not exceeding 1% of the Sum Insured, 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 Hospitalfor better medical facilities.

3.8 PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

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

amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

3.9 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 liabilitytowards expenses incurred on the donor and the insured recipient shall not exceed the aggregate of the Sum Insured and Cumulative Bonus, if any, of the Insured Person receiving the organ.

3.10 REINSTATEMENT OF SUM INSURED

If the Sum Insured is exhausted due to a claim admissible under the Policy, then the Sum Insured shall be reinstated to the Sum Insured stated in the Schedule, provided our liability under the Reinstated Sum Insured shall be subject to the following conditions:

1. Such Reinstatement of Sum Insured shall be effected only where the Sum Insured is Rs. Five Lakhs or more.
2. Such Reinstatement shall take effect only after the Date of Discharge from the Hospital for that claim which resulted in exhaustion of the Sum Insured
3. No Illness or Injury, for a Hospitalisation occurring during the Period of Insurance till the Date of Reinstatement, for which a Claim is paid or admissible, shall be considered under the Reinstated Sum Insured.
4. Such Reinstatement shall be available only once for each Insured Person during a Period of Insurance.

3.11 DAY ONE BABY COVER

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy. Any expense incurred towards post natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered.

Congenital External Anomaly of the New Born Baby is covered only after 36 months Waiting Period. Waiting Period for Congenital Internal Disease would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

Any Illness or Disease will be covered within the Sum Insured of the mother till the expiry of the Policy and No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for insurance and covered as an Insured Person.

Note: New Born Baby means a baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.

3.12 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 OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 3.2 stands deleted for the members covered in the Policy as stated in the Schedule.

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

3.14 OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

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

Special conditions applicable to Maternity Expenses Benefit:

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

Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there.

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

3.15 OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This optional cover, if opted, will be in addition to limit specified in Clause 3.3

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

Sum Insured	Additional Cataract limit
Rs. 8,00,000	Rs. 80,000
Rs. 10,00,000	Rs. 1,00,000

Rs. 12,00,000	Rs. 1,20,000
Rs. 15,00,000	Rs. 1,50,000

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

3.16 OPTIONAL COVER IV: VOLUNTARY CO-PAY

If the Insured person opts for voluntary co-pay of 20%, a discount of 15% shall be of given on the premium payable for the Insured Person.

3.17 CUMULATIVE BONUS

The Sum Insured under Policy shall be increased by 25% at each renewal in respect of each claim free year of insurance, subject to maximum of 50%. If a claim is made in any particular year; the cumulative bonus accrued may be reduced at the same rate at which it is accrued.

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

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

Note:

i. Cumulative Bonus shall be applicable for persons having Sum Insured of 2 Lakh & above.
ii. The Cumulative Bonus Buffer under the expiring policy, if any, shall be converted to Cumulative Bonus.
iii. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person who has not claimed under the expiring policy.
iv. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported under the policy.
v. CB shall be available only if the Policy is renewed within the Grace Period.
vi. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.
vii. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies, the same CB of the expiring policy shall be apportioned to each Individual of such Renewed Policies.
viii. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.
ix. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

x. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

3.18 SPECIFIC COVERAGES:

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

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

c) Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders The Company shall indemnify the Hospital or the Insured the Medical Expenses related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured per policy period.

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

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

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

Condition

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

Exclusions

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

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

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

f) Behavioural and Neuro Developmental Disorders: *Disorders of adult personality and Disorders of speech and language including stammering, dyslexia;* are covered as Inpatient

procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.

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

Note: For the coverages defined in 3.18, waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f 1st October 2020. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

3.19 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)
3.19.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3.19.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3.19.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to a maximum upto Rs. 5 Lakh
3.19.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 1 Lakh
3.19.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to a Maximum of Rs 2 Lakh.
3.19.6	Intravitreal injections.	Upto 10% of Sum Insured subject to a Maximum of Rs.75,000.
3.19.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum of Rs. 5 Lakh.
3.19.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
3.19.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.19.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
3.19.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum of Rs. 50,000.
3.19.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.

3.20 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 four years.**

4. WHAT ARE EXCLUDED UNDER THIS POLICY

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

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.

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

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

d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 24 / 48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

(i) 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

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

12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. 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) 48 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

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

4.4 EXCLUSIONS

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

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

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

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

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses

or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or

2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

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

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

4.4.7 BREACH OF LAW (Code- Excl10)

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

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

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

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

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

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

4.4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

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

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

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

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

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 Naturopathy and Siddha Treatments.

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

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

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

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

4.4.27 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.19.12

4.4.28 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).

4.4.29 Treatment taken outside the geographical limits of India

4.4.30 Vaccination and/or inoculation

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

5. CONDITIONS

5.1 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.

5.2 PREMIUM:

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

5.3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 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.

5.8 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.

5.9 MULTIPLE POLICIES:

If two or more policies are taken by You during a period from Us or other Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of Your policies.

1. In all such cases Insurer who has issued the chosen Policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of chosen

policy.

2. Policyholder having multiple policies shall also have the right to prefer claims from other Policy/policies for the amounts disallowed under the earlier chosen Policy/Policies, even if the Sum Insured is not exhausted. The Claim shall be settled subject to the terms and conditions of the other Policy/Policies so chosen.
3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, You shall have the right to choose Insurers from whom You want to claim the balance amount.
4. You shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen Policy.

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

None of the provisions of this Clause shall apply for payments under Clause 3.5 of the Policy.

5.10 RENEWAL CLAUSE:

We shall renew this Policy if You shall remit the requisite Premium to Us prior to expiry of the Period of Insurance stated in the Schedule. The Renewal is subject to the rates & terms prevalent at the time of Renewal.

We shall be entitled to decline Renewal if

1. We have withdrawn the Policy, in which event You shall have the option for Renewal under any similar Policy being issued by Us, provided however, benefits payable shall be subject to the terms contained in such other Policy; or
2. Any fraud, misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining Insurance or subsequently in relation thereto, or non-cooperation of the Insured Person; or
3. You fail to remit Premium for Renewal before expiry of the Period of Insurance. We will accept Renewal of the Policy if it is effected within thirty days of the expiry of the Period of Insurance. On such acceptance of Renewal, We however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalisation commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.

Note: In case of revision including the premium, modification, or withdrawal of the Policy a notice, by suitable mode of communication, will be provided to You 90 days before such revision, modification or withdrawal. You will have the option to migrate to similar Health Insurance Policy with Us at the time of renewal with all the accrued continuity benefits such as waiver of waiting period etc. Provided the policy has been maintained without a break as per portability guidelines prescribed by IRDAI.

There will be no loading on renewals on Individual claims experience basis .

5.11 ENHANCEMENT OF SUM INSURED:

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

of the Medical Practitioner and subject to limits as stated below:

Age <= 50 years	Up to Sum Insured of 15 lakhs without Medical Examination.
Age 51-60 Years	By two slabs without Medical Examination
Age 61 – 65 Years	By one slab with Medical Examination

Enhancement of Sum Insured will not be considered for:

1) Any Insured Person over 65 years of age.
2) Any Insured Person who had undergone more than one Hospitalisation 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.

5.12 CUMLATIVE BONUS:

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

5.13 CANCELLATION CLAUSE:

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by you by sending fifteen days' notice in writing by Registered A/D to you at the address stated in the Policy. Even if there are several insured persons, notice will be sent to you.

On such cancellation, premium corresponding to the unexpired period of Insurance will be refunded, if no claim has been made or paid under the Policy

You may at any time cancel this Policy and in such event We shall allow refund of premium, if no claim has been made or paid under the Policy, at Our short period rate table given below:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

5.14 FREE LOOK PERIOD:

The free look period shall be applicable at the inception of the first New India Mediclaim Policy.

You will be allowed a period of fifteen days from the date of receipt of the Policy to review the terms and conditions of the Policy and to return the same if not acceptable.

If You have not made any claim during the free look period, You shall be entitled to:

1. A refund of the premium paid less any expenses incurred by Us on medical examination and the stamp duty charges or;

2. where the risk has already commenced and the option of return of the policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or;
3. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

5.15 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.

5.16 PROTECTION OF POLICY HOLDERS' INTEREST:

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

5.17 SETTLEMENT/REJECTION 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 5.5, 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.
- **c.** The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

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

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

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

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

5.1 PORTABILITY AND MIGRATION:

Migration:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then You will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

Portability:

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

5.18 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

5.19 MORATORIUM PERIOD: After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

5.20 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	SclerotherapyEtc
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 Tissue Of 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 Orchidectomy
93	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	**94**	Bilateral Orchidectomy
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**	Cystoscopical 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	PULSEOXYMETER CHARGES

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

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

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

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

ANNEXURE III: CONTACT DETAILS OF INSURANCE OMBUDSMEN

AHMEDABAD - **Shri Kuldip Singh** **Office of the Insurance Ombudsman,** **Jeevan Prakash Building, 6th floor,** **Tilak Marg, Relief Road, Ahmedabad – 380 001.** **Tel.: 079 - 25501201/02/05/06** **Email: bimalokpal.ahmedabad@ecoi.co.in**	BHOPAL - **Shri Guru Saran Shrivastava** **Office of the Insurance Ombudsman,** **Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar,** **Opp. Airtel Office, Near New Market, Bhopal – 462 003.** **Tel.: 0755 - 2769201 / 2769202** **Fax: 0755 - 2769203** **Email: bimalokpal.bhopal@ecoi.co.in**
BHUBANESHWAR - **Shri Suresh Chandra Panda** **Office of the Insurance Ombudsman,** **62, Forest park, Bhubneshwar – 751 009.** **Tel.: 0674 - 2596461 /2596455** **Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@ecoi.co.in**	CHANDIGARH - **Dr. Dinesh Kumar Verma** **Office of the Insurance Ombudsman,** **S.C.O. No. 101, 102 & 103, 2nd Floor,** **Batra Building, Sector 17 – D, Chandigarh – 160 017.** **Tel.: 0172 - 2706196 / 2706468** **Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@ecoi.co.in**
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