GROUP MEDICLAIM POLICY
ISSUED TO

M/S. NEW INDIA ASSURANCE COMPANY LIMITED

POLICY NO. 0210002825P101212969

PERIOD OF INSURANCE
FROM 00:00 Hrs of 01/04/2025
To MIDNIGHT of 31/03/2026

ISSUED BY

UNITED INDIA INSURANCE COMPANY LIMITED

DIVISIONAL OFFICE NO – 10
VULCAN INSURANCE BUILDING, GROUND FLOOR, VEER
NARIMAN ROAD, MUMBAI – 400020
Tel. No. (022) 2204 9948/49 FAX (022) 2282 0583

UNITED INDIA INSURANCE COMPANY LIMITED

DIVISIONAL OFFICE 10, STADIUM HOUSE,
VEER NARIMAN ROAD, CHURCHGATE, MUMBAI – 400020

GROUP MEDICLAIM POLICY FOR NEW INDIA EMPLOYEES

POLICY SCHEDULE

Policy No.	0210002825P101212969
Insured	M/S. NEW INDIA ASSURANCE CO. LTD.
Address	87, M.G. ROAD FORT, MUMBAI – 400001
Period of Insurance	FROM 00:00 Hrs. of 01/04/2025 to Midnight of 31/03/2026

Risk Covered : New Mediclaim Scheme covering Employees of New India Assurance Co. Ltd. Policy Conditions and Annexure 1 attached.

Sum Insured : As per records of the Insured.

Total Sum Insured in Words: As per records of the Insured

Premium Details:

Premium:	₹	1,375,702,847.00
CGST(9%):	₹	123,813,256.00
SGST(9%):	₹	123,813,256.00
Stamp Duty:	₹	1.00
Total:	₹	1,623,329,359.00
Receipt Number :		10102100025101612588
Receipt Date:		21/04/2025
Development Officer Code/ Agent Code:		

For United India Insurance Co. Ltd.

Authorised Signatory

UNITED INDIA INSURANCE COMPANY LIMITED

DIVISIONAL OFFICE 10, STADIUM HOUSE,
VEER NARIMAN ROAD, CHURCHGATE, MUMBAI – 400020

ATTACHED TO AND FORMING PART OF POLICY NO 0210002825P101212969

The following exclusions (details available in the policy) stand deleted from the policy:

1. Exclusion 4.1 relating to Pre-existing health conditions

2. Exclusion 4.2 relating to first 30 day exclusions

3. Exclusion 4.3 relating to time bound exclusions

4. Exclusion 4.4 relating to war and war like operations

5. Exclusion 4.13 relating to pregnancy and childbirth.

In addition, it is also agreed that the policy is governed as per Staff Mediclaim formulated for all Public Sector General Insurance Employees and related letters, communications, clarifications, circulars, etc. issued from time to time.

For United India Insurance Co. Ltd.

Authorised Signatory

ATTACHED TO AND FORMING PART OF POLICY NO. 0210002825P101212969

MEDICLAIM INSURANCE POLICY (GROUP – TAILORMADE)

1.1 Whereas the insured named in the schedule hereto has by proposal and declaration dated 31/03/2017 as stated in the proposal (which shall be the basis of this contract and is deemed to be incorporated herein) has applied to United India Insurance Co.Ltd.,(hereinafter called the company) for the insurance hereinafter set forth in respect of person(s) named in the schedule hereto (hereinafter called INSURED PERSON(S) and has paid premium to the company as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called TPA) or the company as the case may be.

NOW THIS POLICY WITNESSES that subject to terms, conditins, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the company undertakes that, if during the period stated in the schedule any insured person(s) shall contract or suffer from any diseases/illness/ailment (hereinafter called disease) or sustain any bodily injury through accident (hereinafter called injury).

AND

If such disease or bodily injury shall require any such insured person(s) upon the address of duly qualified Physician/Medical Specialist /Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur (a) hospitalization expenses for medical /surgical treatment at any Nursing Home / Hospital in India as herein defined (hereinafter called 'HOSPITAL') as an inpatient OR (b) domiciliary treatment in India under Domiciliary Hospitalization Benefits as hereinafter defined, the TPA / Company shall reimburse to the hospitals (only if treatment is taken at Network Hospitals) with prior written approval of TPA/Company) or to the insured person(s) (If payment to the hospitals is not agreed to or to the insured person(s) upto the limit of liability specified in the policy and or schedule of the policy but not exceeding the Sum Insured in any one period of insurance for one or all the family member(s) stated in the schedule hereto.

1.2 COVERAGE UNDER THE POLICY

The following reasonable and necessary expenses (subject to limits) are payable under the policy for various benefits:

A.	HOSPITALIZATION BENEFITS	
	BENEFITS	LIMIT OF REIMSBURSEMENT
a.	Room, Boarding and Nursing Expenses as provided by the Hospital / Nursing Home	Not exceeding 1% of the Sum Insured upto Rs.10 lakhs plus 0.5% of Sum Insured for Sum Insured beyond Rs.10 lakhs Per day for treatment in Hospitals /Nursing Homes located in cities/places categorized under Serial no.1 of PSGIC's CCA circular. Not exceeding the Sum of 0.75% of the Sum insured for Sum insured upto Rs.10 lakhs plus 0.5% of the Sum Insured for the Sum Insured beyond Rs.10 lakhs for treatment in hospitals / Nursing Homes located in any other place. WITH CAPPING OF RS.15,000/- IN CLASS 'A' CITIES AND RS.12,500/- IN OTHER CITIES.
b.	Intensive Care(IC) Unit exper provided by the Hospital / Nursing	Maximum reimbursement limit per day for stay in IC/CCU/ICCU/Critical Care Centre shall be double that of

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	Home	room rent entitlement.
	No.of days stay under a & b above should not exceed total number of days admission in the hospital. All related charges shall also be as per entitled category vis-à-vis room rent except Pharmacy/Medicines Bills and body implants.	
c.	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists' Fees	As per the limits of the Sum Insured
d.	Anaesthesia, Blood, Oxygen, Operation theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial limbs and similar expenses.	As per the limits of the Sum Insured
e.	Ambulance services charges as defined hereinafter under 2.5	Rs.5,000/- per hospitalization
f.	Maternity benefit	Maternity benefit under the policy shall be for hospitalization of a female employee / spouse of a male employee for the limits as under: Normal Delivery: 'A' Class City: Rs.50,000/-; Other cities: Rs.40,000/- Caeserean Delivery: 'A'Class City: Rs.1,00,000/- ; Other Cities: Rs.65,000/- Maternity Benefit shall also be extended to an independent child or a family member of the dependent / independent child provided such child or the family member has been covered in the policy at least for the last three years as on the date of hospitalization under Maternity Cover.
g.	Cover to Infant from Day 1	Eligible new born baby of the employee stands covered from day 1 as a separate unit. Premium for eligible new born baby shall be charged from the 1st of the month in which baby completes 90 days of the age, on pro rata basis. Monthly premium for eligible new born baby shall be collected from the month in which the baby completes 90 days of age.
h.	Medical Check Up facility	Any of the insured person of a family is entitled for this benefit as under: - 1% of Average family Sum Insured OR - For maximum of Rs.5,000/- whichever is less. The First Block of 4 claim free years of policy commences from the date on which the GMC policy on revised terms come into effect, subject to the following conditions: - This benefit is available to the insured / insured family members after 4 claim free years, till the expiry of 5th year of policy or any claim paid / reported under the policy, whichever shall first

WAIVED

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		occur in the 5th year. - If the bevefit is not claimed in 5th year of policy, then in future at the time of insured claiming this benefit, last 4 claim free years preceding to the year in which benefit is claimed shall be taken into consideration. - The total amount payable under this benefit is subject to a Maximum limit of upto Rs.5,000/- either availed by one / more insured family members.
i.	Pre / Post Hospitalization	Medical expenses insured 30 days prior to hospitalization and 60 days post hospitalization are covered.
j.	Exclusion no. 4.1,4.2,4.3	Exclusion no. 4.1,4.2,4.3 stand waived.
B.	DOMICILIARY HOSPITALIZATION (AS DEFINED HEREINAFTER)	
a.	Surgeon, Medical practitioner , Consultants, Specialists' Fees, Blood. Oxygen, Surgical Appliances. Medicines & drugs, Diagnostic material and Peritoneal Dialysis, Oral Chemotherapy and Nursing Expenses	20% of Sum Insured subject to maximum of Rs.50,000/-. However, the said limit in the case of domiciliary treatment for Oral Chemotherapy and Peritoneal Dialysis shall be 50% of the Sum Insured subject to a maximum of Rs.5,00,000/-. The above limits shall be on floater basis during the policy period.
b.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Reimbursement of reasonable expenses / medical costs actually incurred for immunization based on the merits of each case. If the treatment following such incidences does not require hospitalization, then such reasonable expenses which are actually incurred for immunization, injection following such incidence can be considered for reimbursement under domiciliary hospitalization section of the policy. *NOTE: FOR THE PURPOSE OF THIS SECTION THE PRE-REQUISITE CONDITIONS FOR DOMICILIARY HOSPITALIZATION CLAIM SHALL NOT APPLY.*

1.3 Hospitalization / Nursing Home charges, Surgery, Medicines, Drugs, Pathological tests, etc. incurred for donating an organ by the donor to the insured person during the course of organ transplant shall also be payable under this policy. However, cost of organ is not payable / reimbursable under the policy.

1.4 Company's overall liability in respect of all claims admitted under Sections 1.2 and 1.3 during the Period of Insurance shall not exceed the Sum insured Per Family.

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DEFINITIONS :

2.1 **HOSPITAL / NURSING HOME:-** A hospital/Nursing home means any institution established for in- patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR - has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places complies with all minimum criteria as under:-

- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest and / or recuperation, a place for the aged persons, a rehabilitation centre for drug addicts or alcoholics, a hotel or a similar place.

2.2 **SURGICAL OPERATION:** Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

2.3 **HOSPITALISATION PERIOD:** Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (twenty four) hours. However,

(A) This time limit SHALL not apply to following specific treatments taken in the Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment SHALL be considered to be taken under Hospitalisation Benefit:-

(B) Further if the treatment / procedure / surgeries of above diseases are carried out in Day Care Centre, which means any institution established for day care treatment of illness and / or injuries 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 (s) in charge, has a fully equipped operation theatre of its own, where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel, the requirement of minimum beds is overlooked.

(C) This condition of minimum 24 hours Hospitalisation will also not apply provided, medical treatment, and/or surgical procedure is:

(i) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and.

(ii) which would have otherwise required a hospitalization of more than 24 hours.

The list of Day Care procedures is attached as Annexure I

2.4 **DOMICILIARY HOSPITALISATION BENEFIT:**

Domiciliary hospitalization means medical treatment for a period exceeding three days for such an illness/disease/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:

(i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital and/ or

(ii) the patient takes treatment at home on account of non availability of room in a hospital.

However, the expenses related to Peritoneal Dialysis and oral chemotherapy are admissible under this section even if conditions mentioned in (i) and/ or (ii) above are not satisfied. Further sum insured limitation for Domiciliary Hospitalisation shall not apply for Peritoneal Dialysis and Oral Chemotherapy.

Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

a) Expenses incurred for pre and post hospital treatment and

b) Expenses incurred for treatment for any of the following diseases :

i. Asthma
ii. Bronchitis,
iii. Chronic Nephritis and Nephritic Syndrome,
iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis,
v. Diabetes Mellitus and Insipidus,
vi. Epilepsy,
vii. Hypertension,
viii. Influenza, Cough and Cold,
ix. All Psychiatric or Psychosomatic Disorders,
x. Pyrexia of unknown origin for less than 10 days,
xi. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharingitis,
xii. Arthritis, Gout and Rheumatism.

2.5 **AMBULANCE SERVICES:** Means ambulance service charges reasonably and necessarily incurred in case the insured person is to be shifted from residence to hospital or from one hospital to another hospital. The ambulance service charges are payable only if the hospitalisation expenses are admissible. Further the ambulance service charges are admissible only if such expenses are paid to registered ambulance services providers.

2.6 **MATERNITY EXPENSES AND NEWBORN CHILD COVER BENEFIT EXTENSION:**

a. Those insured persons who are already having two or more living children will not be eligible for this benefit

b. Claim in respect of only first two living children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any valid and effective renewal thereof.

Special conditions applicable to Maternity Expenses & Newborn Child Cover Benefit Extension

c. These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patients in India.

d. A waiting period of 9 months is waived for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine Pregnancy.

e. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.

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

g. Pre Hospitalisation and post Hospitalisation benefits are not available under this section.

h. Newly born child shall be covered from day one upto the age of 3 months and expenses incurred for treatment taken in hospital as in patient shall only be payable subject to the full sum insured.

3. **OTHER DEFINITIONS AND INTERPRETATIONS:**

3.1 **INSURED PERSON:-** Means Employees / retired employees and their family members as per the records of insured (company).

3.2 **ENTIRE CONTRACT:-** This policy, schedule, proposal/ declaration given by the insured/insured persons constitute a complete contract. Only Insurer may alter the terms and conditions of the policy and such alterations made by the insurer shall only be evidenced by a duly signed endorsement on the policy with the Company stamp.

3.3 **TPA (THIRD PARTY ADMINISTRATOR):-** means any company / body who has obtained licence from IRDA to practice as a third party administrator and is appointed as TPA by the Company.

3.4 **NETWORK PROVIDER:-** means hospitals or healthcare providers enlisted by an insurer, or by a TPA and insurer together, to provide medical services to an insured on payment , by a cashless facility.

3.5 **HOSPITALISATION PERIOD:-** The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 (twenty four) hours

3.6 **PRE-HOSPITALISATION:** Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.7 **POST-HOSPITALISATION:** Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.8 **MEDICAL PRACTITIONER:** A Medical practitioner is a person who holds a valid registration from the Medical Council of any state 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.

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

3.10 **PRE EXISTING HEALTH CONDITION OR DISEASE:** Any condition, ailment or injury or related condition(s) for which the insured had signs or symptoms, and / or were

diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

3.11 **IN-PATIENT:** An Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.12 **REASONABLE AND CUSTOMARY CHARGES:** Reasonable and customary charges means 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 .

In networked hospital means rates are pre-agreed between Network Hospital and the TPA / Company, for surgical / medical treatment that is necessary for treating the insured person who was hospitalized.

NOTE: Any expenses other than the above have to be borne by the insured person himself.

3.13 **CASHLESS FACILITY:** It means a facility extended by the insurer to the insured where the payments of the costs of the 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 of pre- authorization approved.

3.14 **I.D. CARD:** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

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

3.16 **ILLNESS:** 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.

a **Acute condition** - Acute condition is 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.

b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

3.17 **INJURY**

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

3.18 **MEDICAL ADVICE**

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

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3.19 **MEDICAL EXPENSES**

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 doctors in the same locality would have charged for the same medical treatment.

3.20 **CONGENITAL ANOMALY**

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly.

b. External Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

WAIVED

3.21 **LIMIT OF INDEMNITY:** means the amount stated in the schedule which represents maximum liability for any and all claims admissible during the policy period in respect of that insured family.

3.22 **ANY ONE ILLNESS:** Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge ,whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

3.23 **PERIOD OF POLICY:** This insurance policy is issued for the period as shown in the schedule.

4. **EXCLUSIONS:-**

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:-

4.1 Pre-existing health condition or disease or ailment / injuries :- Waived

4.2 First 30 day Exclusion: - Waived

4.3 Time bound Exclusions: - Waived

If the continuity of the renewal is not maintained then subsequent cover SHALL be treated as fresh policy and clauses 4.1., 4.2, & 4.3 SHALL apply, unless otherwise agreed to by the Company and suitable endorsement is passed on the policy.

4.4 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

4.5 Circumcision (unless necessary for treatment of a disease not excluded under the policy or as may be necessitated due to any accident), vaccination, inoculation, cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.6 (a) Surgery for correction of eye sight excepting

(i) for keratotomy of insured having more than minus 5 refractive error

(ii) in case, it is performed for therapeutic reasons like recurrent corneal erosions, nebular opacities and non healing ulcers

(b) cost of spectacles,

(c) contact lenses,
(d) hearing aids etc.

4.7 Any dental treatment or surgery, unless arising from injury and which requires hospitalisation, which is corrective, cosmetic or of aesthetic in nature, filling of cavity, root canal treatment including treatment for wear and tear etc

4.8 Convalescence, general debility, "run down" condition or rest cure, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and / or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.

4.9 Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

4.10 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymohadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.

4.11 Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period OR expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission such as referral fee to family doctors, out station consultants / Surgeons fees, Doctor's home visit charges/ Attendant / Nursing charges during pre and post hospitalisation period. etc.

4.12 Expenses incurred on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician and / or all non medical expenses including personal comfort and convenience items or services.

4.13 Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications arising of these including changes in chronic condition as a result of pregnancy. WAIVED

4.14 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.

4.15 Genetic disorders and stem cell implantation / surgery.

4.16 Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc. Of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc. And also any medical / non medical equipment which is subsequently used at home.

4.17 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc...

4.18 Change of treatment from one system to another system of medicine unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.

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4.19 Any treatment arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

4.20 Outpatient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.21 Massages, Steam bathing, Shirodhara and like treatment under Ayurveda undertaken.

4.22 Any kind of Service charges/Surcharges, unless payable to the Govt. Authority, levied by the hospital. WAIVED

5 CONDITIONS

5.1 **ENTIRE CONTRACT:** the policy, schedule, proposal form, prospectus and declaration given by the Insured shall constitute the complete contract of insurance. Only insurer may alter the terms and conditions of this policy/ contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

5.2 **COMMUNICATION:** Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.

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

5.4 **NOTICE OF CLAIM:** Immediate written notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / illness / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by Fax, Email. Such written notice should be given within 48 (forty eight) hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier unless waived in writing.

5.5 **CLAIM DOCUMENTS and TIME LIMITS:-** The claim documents should be submitted to the Company / TPA as under :-

(a) **Hospitalisation and Pre –hospitalisation claims** – Immediately after discharge from the hospital but in any case not beyond 30 days from the date of discharge from the hospital.

(b) **Post-hospitalisation claims** – Within 90 days from the date of discharge from the hospital.

They shall be submitted along with originals of hospital Bills/Cash memos/reports, claim form and list of documents as listed below:-

i. Original bills, receipts and discharge certificate / card from the hospital.
ii. Medical history of the patient recorded by the Hospital.
iii. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
iv. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.
v. Attending Consultants' / Anaesthetists' / Specialists' certificates regarding diagnosis and bill / receipts etc. in original.
vi. Surgeons' original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
vii. Any other information required by TPA / the Company.

All documents must be duly attested by the insured person.

In case of post hospitalisation treatment all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days or in any case not beyond 90 days from the date of discharge from the hospital, to the Company / T.P.A. In addition, insured should also provide to the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

NOTE: Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise the claim is liable for rejection.

5.6 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME :

i) Claim in respect of Cashless Access Services SHALL be through the TPA/ Insurer provided treatment is undertaken in a network hospital / Nursing Homes and is subject to pre admission authorization. The TPA/ Insurer shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself SHALL issue a pre-authorisation letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as In-patient.

ii) The TPA/ Insurer reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the TPA/ Insurer. In such circumstances denial of Cashless Access should in no way be construed as denial of claim. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA/ Insurer for reimbursement within 30 (thirty) days of the discharge from Hospital / Nursing Home.

iii) Should any information be available to the TPA/ Insurer which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the TPA/Insurer before the patient is discharged from the Hospital and notice to the effect given to the treating hospital / the insured.

5.7 Any medical practitioner authorised by the TPA/Company shall have deemed permission to examine the Insured Person in case of any alleged injury or Disease requiring

Hospitalisation when and so often as the same may reasonably be required on behalf of the TPA/Company.

5.8 **SUBROGATION:** Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

5.9 **DISCLOSURE TO INFORMATION NORM**
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

5.10 **REPUDIATION:** The Insurer shall repudiate the claim if not covered / not payable under the policy. The Insurer shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the *Grievance Redressal Cell of the company of the employee* against the repudiation.

5.11 **CANCELLATION CLAUSE:** Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. (Such cancellation by the Company shall be only on grounds of moral hazards such as Intentional misrepresentation / malicious suppression of facts intended to misleading the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy). The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium after charging premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to the date of cancellation.

Period on Risk	Rate of premium to be charged
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

5.12 **ARBITRATION CLAUSE:** If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitraters and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

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5.13 **DISCLAIMER OF CLAIM:** It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.14 **PAYMENT OF CLAIM:** The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period anywhere in India and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

5.15 **MID-TERM INCLUSION :-**

(i) Newly wed spouse can be included within 3 mths or at renewal of the policy.

(ii) Mid-term inclusion is permitted for new born baby.

IMPORTANT

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

7 **RENEWAL OF POLICY:**

a) The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.

b) Notwithstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic; premium due must be paid by the proposer to the company before the due date.

c) The Company shall not ordinarily deny the renewal of this policy unless on moral hazard grounds of the Insured such as Intentional misrepresentation / malicious suppression of facts intended to mislead the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy.

8 **PRODUCT WITHDRAWL CLAUSE:** This product may be withdrawn in future. However, in such an event the policy holder shall be duly informed of the options available.

9 **SUM INSURED:** The Company's liability in respect of all claims admitted in during the period of Insurance shall not exceed the sum insured opted under the policy.

10 **AUTHORITY TO OBTAIN RECORDS:**

a) The Insured person hereby agrees to and authorises the disclosure to the insurer or the TPA or any other person nominated by the insurer of any and all Medical records and information held by any Institution / Hospital or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability thereunder.

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b) The insurer and the TPA agree that they SHALL preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and SHALL only use it in connection with any claim made under this policy or the insurer's liability there under.

11. **QUALITY OF TREATMENT** : The insured hereby acknowledges and agrees that payment of any claim by or on behalf of the insurer shall not constitute on part of the insurance company a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the insured person, it being agreed and recognized by the policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

12. **ID CARD:** The card issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the policy holder's expense and the policy holder and each insured person agrees to hold and keep harmless, the insurer and the TPA against any or all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use, misuse of such ID cards prior to their return.

13. **IRDA REGULATION NO 5:** This policy is subject to regulation 5 of IRDA (Protection of Policy Holder's Interest) Regulation, 2002

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ANNEXURE I forming part of PSGICs GMC Policy

List of Day Care Procedures

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:
(i) Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
(ii) Corrective Surgery for blepharoptosis when not congenital/cosmetic
(iii) Corrective Surgery for entropion/ectropion
(iv) Dacryocystorhinostomy [DCR]
(v) Excision involving one-fourth or more of lid margin, full-thickness
(vi) Excision of lacrimal sac and passage
(vii) Excision of major lesion of eyelid, full-thickness
(viii) Manipulation of lacrimal passage
(ix) Operations for pterygium
(x) Operations of canthus and epicanthus when done for adhesions due to chronic Infec
(xi) Removal of a deeply embedded foreign body from the conjunctiva with incision
(xii) Removal of a deeply embedded foreign body from the cornea with incision
(xiii) Removal of a foreign body from the lens of the eye
(xiv) Removal of a foreign body from the posterior chamber of the eye
(xv) Repair of canaliculus and punctum
(xvi) Repair of corneal laceration or wound with conjunctival flap
(xvii) Repair of post-operative wound dehiscence of cornea
(xviii) Penetrating or Non-Penetrating Surgery for treatment of Glaucoma
(xix) Retinal Surgeries
(xx) Lasik Surgery (non-cosmetic)
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

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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
(i) TUMT(Transurethral Microwave Thermotherapy)
(ii) TUNA(Transurethral Needle Ablation)
(iii) Laser Prostatectomy
(iv) TURP(transurethral Resection of Prostate)
(v) 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 Radical Prostatectomy
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 Free skin transplantation, donor site
68 Free skin transplantation, receipient site
69 Orchidopexy (non-congenital)
70 Nephrectomy
71 Palatal Surgery

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72 Stapedectomy& revision of stapedectomy
73 Myringotomy
74 Life saving blood transfusions
75 Reconstruction of the middle ear
76 Fenestration of the Inner ear
77 Excision and destruction of diseased tissue of the nose.
78 Operations on the turbinates (nasal concha)
79 Nasal Sinus Aspiration
80 Incision of the tear glands
81 Minor Operations of on the tear duct
82 Incision of the skin and subcutaneous tissues
83 Surgical wound toilet(wound debridement) and removal of diseased tissue of the skir subcutaneous tissues
84 Local excision of diseased tissue of the skin and subcutaneous tissues
85 Destruction of diseased tissue in the skin and subcutaneous tissues
86 Incision, excision and destruction of diseased tissue of the tongue
87 Partial glossectomy
88 Glossectomy
89 Resconstruction of the tongue
90 Incision and lancing of the salivary gland and a salivary duct
91 Resection of a salivary gland
92 Reconstruction of a salivary gland and a salivary duct
93 External Incision and drainage in the region of the mouth, jaw and face
94 Incision of the hard and soft palate
95 Incision , excision and destruction in the mouth
96 Transoral incision and drainage of a pharyngeal abscess
97 Excision and destruction of a lingual tonsil
98 Closed reduction onfracture, laxation or epiphyseolysis with osteosynthesis
99 Suture and other operations on tendons and tendon sheath
100 Operation on the nipple
101 Incision and excision of tissues in the perianal region
102 Surgical treatment of anal fistula
103 Surgical treatment of haeomorrhoids
104 Division of the anal sphincter
105 Ultrasound guided aspirations
106 Incision of the Ovary
107 Inufflation of the Fallopian tubes
108 Dilatation of the cervical canal
109 Consisation of uterine cervix
110 Incision of the vagina
111 Local excision and destruction of diseased tissue of the vagina and pouch of Douglas
112 Incision of the vulva
113 Operations on Bartholin's gland (cyst)
114 Incision of the prostate
115 Transurethral excision and destruction of prostate tissue
116 Incision of the scrotum and tunica vaginalis testis
117 Excision and destruction of the diseased scrotal tissue
118 Incision of the testes
119 Abdominal exploration in cryptorchidism
120 Operations on the penis foreskin
121 Local excision and destruction of diseased tissue of the penis

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122 Any other surgeries / procedures agreed by the TPA and the Company which require than 24 hours Hospitalization and for which prior approval from TPA is mandatory.

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COVERAGE, SUB LIMITS, EXCLUSIONS, TERMS AND CONDITIONS PERTAINING TO MODERN TREATMENT METHODS/ADVANCEMENT IN TECHNOLOGIES AND MENTAL ILLNESS, STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS

1. COVERAGE & SUBLIMITS:

DETAILS MENTIONED HEREUNDER ARE SPECIFIC TO MODERN TREATMENT MENTHODS/ ADVANCEMENT IN TECHNOLOGIES AND MENTAL ILLNESS/ NEURODEGENERATIVE DISORDERS.ALL OTHER TERMS & CONDITIONS ARE AS PER EXPIRING POLICY OR REVISION ADOPTED BY GIPSA, IF ANY.

A. MODERN TREATMENT METHODS /ADVANCEMENT IN TECHNOLOGIES

All the following procedures will be covered in the policy, if treated as In-Patient care or as a part of domiciliary hospitalization or as day care treatment in the hospital, within the sub-limits in the complete policy period which is as defined below:

Sr. No.	Treatment Methods & Advancement in Technology	Sub Limit
A	Uterine Artery Embolization & High Intensity Focused Ultrasound (HIFU)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period for claims involving Uterine Artery Embolization & HIFU
B	Balloon Sinuplasty	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period for claims involving Balloon Sinuplasty
C	Deep Brain Stimulation	Upto 50% of Sum Insured per policy period for claims involving Deep Brain Stimulation subject to a maximum of Rs. 10 Lacs
D	Oral Chemotherapy	Upto 20% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Oral Chemotherapy
E	Immunotherapy- Monoclonal Antibody to be given as injection	Upto 20% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period
F	Intra vitreal Injections	Upto 10% of Sum Insured subject to a maximum of Rs. 1 Lac per policy period
G	Robotic Surgeries (including Robotic Assisted Surgeries)	Upto 75% of Sum Insured subject to a maximum of Rs. 10 Lacs per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies Upto 30% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Robotic Surgeries for other diseases
H	Stereotactic Radio Surgeries	Upto 30% of Sum Insured subject to a maximum of Rs. 5 Lacs per policy period for claims involving Stereotactic Radio Surgeries
I	Bronchial Thermoplasty	Upto 20% of Sum Insured subject to a maximum of Rs. 3 Lacs per policy period for claims involving

		Bronchial Thermoplasty
J	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	Upto 20% of Sum Insured subject to a maximum of Rs. 2 Lacs per policy period
K	Intra Operative Neuro Monitoring (IONM)	Upto 15% of Sum Insured subject to a maximum of Rs. 1 Lacs per policy period for claims involving Intra Operative Neuro Monitoring
L	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only	Upto 50% of Sum Insured per policy period subject to a maximum of Rs. 10 Lacs

B. MENTAL ILLNESS,STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS:

Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 7.42) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusios

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

Relevant Definitions are -

Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub-normality of intelligence.

Psychiatrist means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

2. EXCLUSIONS:

A. GENERAL 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:

I) Investigation & Evaluation – Code –Excl04

a). Expenses related to any admission primarily for diagnostics and evaluation purposes only.

b). Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

II) 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 a 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.

III) Obesity/Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfill 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):

- greater than or equal to 40 or

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

i). Obesity – related cardiomyopathy

ii). Coronary heart diseases

iii). Severe Sleep Apnea.

iv). Uncontrolled Type 2 Diabetes.

IV) 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.

V) Cosmetic or Plastic Surgery- Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burns(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.

VI) 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.

VII) 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.

VIII) 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 policy holders are not admissible. However, in case of life-threatening situations following an accident, expenses upto the stage of stabilization is payable but not complete claim.

IX) Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – **Code- Excl12**

X) 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**

XI) 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**

XII) Refractive Error- Code- Excl15

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters.

XIII) 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.

XIV) Sterility and Infertility- Code- -Excl17

Expenses related to sterility and infertility. This includes:

i). Any type of contraception, sterilization.

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

Iii). Gestation Surrogacy.

iv). Reversal of sterilization.

XV) Maternity- Code- ExcI18

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

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

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B. <u>EXCLUSIONS SPECIFIC TO MENTAL ILLNESS, STRESS OR PSYCHOLOGICAL DISORDERS AND NEURODEGENERATIVE DISORDERS</u>:

1. Any treatment undertaken as Outpatient is not covered.
2. Any treatment undertaken as domiciliary hospitalization is not covered.
3. Any kind of Psychological counseling, cognitive/ family/ group/ behavior/ palliative therapy, or other kinds of psychotherapy for which hospitalization is not necessary is not covered.
4. Any treatment for mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

5. Any Treatment for Mental Illness/ disorder/ stress due to alcoholism/ drugs/ substance abuse.

3. CONDITIONS:

It is a condition precedent that the expenses incurred in respect of medically necessary treatment, are reasonable and customary; and in any case the liability of the Company, in respect of one or all the Insured Persons stated in the schedule, shall be upto the limit specified in the Policy and/or schedule of the Policy, but not exceeding the Sum Insured as stated in the schedule, for all claims arising during the Policy Period mentioned in the schedule.

GENERAL TERMS &CONDITIONS

3.1 Disclosure of Information

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.

3.2 Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

3.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

3.4 Records to be maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

3.5 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

3.6 Notice & Communication

a. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
b. Such communication shall be sent to the address of the Company or through any

other electronic modes specified in the Policy Schedule.

c. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

3.7 Physical examination: Any medical practitioner authorised by the company shall be allowed to examine the insured person in case of any alleged injury or disease requiring hospitalisation as and when the same may reasonably be required on behalf of the company.

3.8 Claim procedure

Notification of Claim: In case of a claim, the insured person/insured person's representative shall intimate the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Claim notification in case of cashless facility	**TPA must be informed:**
In case of planned hospitalization	At least 72 hours prior to the insured person's ' admission to network provider/PPN
In case of emergency hospitalization	Within 24 hours of the insured person's admission to network provider/PPN

Claim notification in case of reimbursement	**Company/TPA must be informed:**
In case of planned hospitalization	At least 72 hours prior to the insured person's admission to hospital
In case of emergency hospitalization	Within 24 hours of the insured person's admission to hospital

3.8.1 Procedure for cashless claims:

1. Treatment may be taken in a network provider/PPN and is subject to preauthorization by the TPA.
2. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
3. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN will issue pre-authorization letter to the hospital after verification.
4. At the time of discharge, the insured person must verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
5. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
6. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the TPA for reimbursement.

3.8.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA/company within the prescribed time limit.

3.8.3 Documents:

The claim is to be supported with the following documents and submitted within the prescribed time limit:

1. Completed claim form
2. Original bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary from the hospital etc.
3. Original cash-memo from the hospital(s)/chemist(s) supported by proper prescription
4. Original payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
5. Attending medical practitioner's certificate regarding diagnosis arid bill receipts etc. ,
6. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
7. Any other document required by company/TPA

Note: In the event of a claim lodged as per contribution clause of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed as above and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	Time limit for submission of documents to company/TPA
Reimbursement of hospitalisation and pre hospitalisation expenses	Within 15 days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within-15 days from completion of post hospitalisation treatment

3.9 Claim settlement:

1. On receipt of the final document(s) or investigation report (if any), as the case may be, the company shall within a period of 30 days offer a settlement of the claim to the insured person.
2. If the company, for any reasons, decides to reject a claim under the policy, shall communicate to the insured person in writing and within a period of 30 days from the receipt of the final document(s) or investigation report (if any), as the case may be.
3. Upon acceptance of an offer of settlement as stated above by the insured person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the company.
4. In the cases of delay in the payment, the company shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid

3.10 Services offered by a TPA

The TPA shall render health care services covered under the policy like issuance of ID cards & guide book, hospitalization & preauthorization services, call centre, acceptance of claim related documents, claim processing and other related services The services offered by a TPA shall not include

1. Claim settlement and rejection with respect to the policy. However, TPA may handle admission of claims and recommend to the company on the settlement of the claim.
2. Any service directly to the

insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered with the company.

3.11 Waiver:

Time limit for claim notification and submission of documents may be waived in cases where it is proved to the satisfaction of the company, that the circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

3.12 Payment of claim:

All claims under the policy, shall be payable in Indian currency through NEFT/ RTGS only.

3.13 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

3.14 Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policy holder 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.
b. Policyholder 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(s) shall independently settle the claim subject to the terms and conditions of this policy.
c. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

3.15 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:—

a. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true.
b. The active concealment of a fact by the Insured Person having knowledge or belief of the fact.

c. Any other act fitted to deceive; and
d. Any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

3.16 Cancellation

The company may at any time cancel the policy (on grounds of fraud, moral hazard or misrepresentation or noncooperation) by sending the insured 30 (thirty) days' notice by registered letter at insured's last known address and in such event the company will not allow any refund.

The insured person may at any time cancel the policy and in such an event the company shall allow refund of premium after charging premium at company's short period rate mentioned below provided no claim occurred up to the date of cancellation.

Period of risk	Rate of premium to be charged
Up to 1month	1/4 of the annual rate
Up to 3 months.	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

3.17 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

3.18 Arbitration

a. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration the same shall be referred to a panel of three arbitrators, comprising two arbitrators one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

b. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided if the Company has disputed or not accepted liability under or in respect of the policy.

c. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

3.19 Disclaimer:

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If the company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the company in writing that he does not accept such disclaimer and intends to recover his claim from the company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

3.20 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

a. The waiting periods specified above shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
b. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

3.21 Renewal of Policy

The policy may be renewed by mutual consent. The company is not bound to give notice that it is due for renewal. Renewal of the policy cannot be denied other than on grounds of fraud, moral hazard, misrepresentation, or noncooperation.

In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

If not renewed within Grace Period after due renewal date, the Policy shall terminate.

3.22 Low Claim Ratio Discount (Bonus):

Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the Group Mediclaim Policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims ratio under the Group Mediclaim Policy	Discount %
Not exceeding 60%	5
Not exceeding 50%	5

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Not exceeding 40%	25
Not exceeding 30%	30
Not exceeding 25%	30

3.23 Withdrawal of product:

In case the policy is withdrawn in future, the company will provide the option to the insured person to switch over to a similar policy at terms and premium applicable to the new policy.

3.24 Revision of terms of the policy including the premium rates:

The company, in future, may revise or modify the terms of the policy including the premium rates based on experience after following the due procedure as laid down by IRDAI. The insured person will be notified three months before the changes are affected.

3.25 Redressal of grievance:

In case of any grievance relating to servicing of the policy, the insured person may submit in writing to the policy issuing office or regional office for redressal. If the grievance remains unaddressed, insured person may contact Customer Relationship Management Dept.,.....NAME OF THE INSURANCE COMPANY

If the insured person is not satisfied. the grievance may be referred to "Health Insurance Management Dept.", NAME OF THE INSURANCE COMPANY. The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. •

3.26 Add on cover:

Whereas the insured designated in the schedule hereto has by a proposal, dated as stated in the schedule which shall be the basis of this contract and is deemed to be incorporated herein, has applied to NAME OF THE INSURANCE COMPANY (herein after called the company) for the insurance herein after set forth and has paid the premium as consideration for such insurance in respect of the insured person as mentioned in the schedule.

3.26 Maternity Expenses Cover:

Subject otherwise to the terms, definitions, and conditions of the policy, the exclusion 4.7 stands deleted, and subject to the terms, definitions, exclusions, and conditions contained herein, it is hereby understood and agreed that the company shall pay up to the limit, as stated in the schedule with respect of delivery or termination up to first two deliveries or terminations-of pregnancy, during the lifetime of the insured person, if covered under the policy, as described below.

A. Cover:

1. Medical expense for delivery (normal or caesarean).
2. Medical expense for lawful medical termination of pregnancy.
3. Pre-natal and post-natal hospitalisation expenses per delivery or lawful medical termination of pregnancy.

B. Exclusions:

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

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1. Delivery or termination within a waiting period of 9 months. However, the waiting period may be waived only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency.
2. Delivery or termination after first two deliveries or terminations during the lifetime of the insured person.
3. Surrogate or vicarious pregnancy
4. Ectopic pregnancy as it is already covered under base cover
5. Pre and post hospitalisation expenses.

3.27 Condition:

In the event of cancellation of the cover by the insured or the company during the policy period, premium will not be refunded**.**

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