

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY

ISSUED TO

GENERAL INSURANCE CORPORATION OF INDIA

SURAKSHA, 170, J. TATA ROAD, CHURCHGATE,

MUMBAI 400020

POLICY NO: 12070063260400000010



ISSUED BY

**THE NEW INDIA ASSURANCE COMPANY LIMITED
DIVISIONAL OFFICE NO. 120700**

**8TH FLOOR, NEW INDIA CENTRE, 17-A, COOPERAGE ROAD,
MUMBAI - 400001**

**REGD. & HEAD OFFICE: New India Assurance Bldg., 87 M.G. Road, Fort,
Mumbai - 400 001.**





THE NEW INDIA ASSURANCE COMPANY LIMITED
POLICY SCHEDULE

INSURED NAME: GENERAL INSURANCE CORPORATION OF INDIA

POLICY NO: 12070063260400000010

POLICY PERIOD: FROM 01/04/2026 TO 31/03/2027

PREMIUM: Rs. 6,66,99,092/-

GST: Rs. 1,20,05,838/-

PREMIUM WITH GST: Rs. 7,87,04,930/-

NO OF EMPLOYEES: 987 NO OF DEPENDENTS: 2291

TOTAL NO OF LIVES: 3278

LOCATION: ALL OVER INDIA

SUBJECT TO CLAUSE: AS PER GIPSA WORDINGS

THIRD PARTY ADMINISTRATOR: Health Insurance TPA of India Ltd
2nd Floor, Majestic Omnia Building,
A-110, Sector 4 Noida,
Uttar Pradesh – 201301.
Toll Free Number: 18001023600/18001803600
Email Id: - gicre@hitpa.co.in
customerservice@hitpa.co.in

For and on behalf of
THE NEW INDIA ASSURANCE CO. LTD.



DIVISIONAL MANAGER

(Duly Constituted Attorney)



**SCHEDULE ATTACHED TO AND FORMING PART OF POLICY NO.
12070063260400000010.**

The following exclusions (explained more in detail in the policy) stand deleted from the policy:

1. Exclusion 4.1 relating to Pre-existing health condition;
2. Exclusion 4.2 relating to first 30 days exclusion;
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, childbirth.
6. Exclusion 4.22 relating to Service charges/Surcharges

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

MEDICLAIM INSURANCE POLICY (GROUP – FLEXI FLOATER)

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 The New India Assurance 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, conditions, 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) up to 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 REIMBURSEMENT
a.	Room, Boarding and Nursing Expenses as provided by the Hospital & Nursing Home.	Not exceeding 1% of the Sum Insured up to 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 Class A cities/places categorized under Serial no. 2 of PSGIC's CCA circular. Not exceeding the Sum of 0.75% of the Sum insured for Sum insured up to 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 other Cities. WITH CAPPING OF RS.17,000/- IN CLASS 'A' CITIES AND Rs. 14,000/- IN OTHER CITIES-
b.	Intensive Care (IC) Unit expenses as provided by the Hospital / Nursing	Maximum reimbursement limit per day for stay in IC/CCU/ICCU/Critical Care Centre shall be double that of



	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-a-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 (In case of transfer of patient involving inter-city travel of more than 50 km. one side, will be enhanced up to Rs. 10,000/- per hospitalization.)				
f.	Maternity benefit (Please refer clause 3.26 for more details regarding the Maternity Benefits)	Maternity benefit under the policy shall be for (hospitalization of a female employee / spouse of a male employee for the limits as under: <table><tr><td>Normal Delivery</td><td>'A' Class City: Rs.65,000/-; Other cities: Rs. 55,000/-</td></tr><tr><td>Caesarean Delivery</td><td>'A' Class City: Rs.1,20,000/-; Other Cities: Rs. 85,000/-</td></tr></table> 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. (WAIVED) Maternity Benefit for Independent Child/ Family member of a dependent/Independent child shall be admissible only after completion of one year from the date of their inclusion in the policy. This waiting period of one year for maternity benefits shall be applicable for those members who will be enrolled in the policy on or after 01.04.2026.	Normal Delivery	'A' Class City: Rs.65,000/-; Other cities: Rs. 55,000/-	Caesarean Delivery	'A' Class City: Rs.1,20,000/-; Other Cities: Rs. 85,000/-
Normal Delivery	'A' Class City: Rs.65,000/-; Other cities: Rs. 55,000/-					
Caesarean Delivery	'A' Class City: Rs.1,20,000/-; Other Cities: Rs. 85,000/-					
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 day 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. 10,000/- 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 occur in the 5th year. - If the benefit 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 up to Rs.10,000/- either availed by one / more insured family members.
i.	Cataract surgeries	The payment of any claim related to Cataract will be limited to Actual or maximum of Rs. 1,00,000/- (inclusive of all charges, excluding GST) for each eye, whichever is less.



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.
k.	Mortal Remains	Reimbursement up to Rs. 5,000/-, towards transportation of mortal remains from hospital to residence/funeral home in case of death of the insured person during treatment under the policy.
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.1,00,000/-. 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.15,00,000/-. 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.
C	COVID INFECTION CLAUSE	
a.	Pulse Oximeter Charges	With effect from 23/04/2021: 1) Reimbursement of actual cost of pulse Oximeter subject to ceiling of Rs 2000/- may be allowed under Staff GMC where a primary Insured Person or Deemed Primary Insured Person or his/her any covered family member is diagnosed with Corona Positive and is treated at home, on submission claim form along with Corona Positive Report and prescription from the treating doctor of the beneficiary and the invoice of pulse oximeter to HITPA. 2) The Primary/Deemed Insured Person including any covered family member will be reimbursed purchase of only one Pulse Oximeter per family, even in case of more than one Covid Positive cases in the family. 3) The benefit will be applicable from 23/04/2021 under Staff GMC Policy.
b.	Home Oxygen Bed/ICU for treatment of Covid-19.	With effect from 13/05/2021: As per the advises of the Governing Board of GIPSA, setting up of Home Oxygen



		Bed/ICU for treatment of Covid-19 shall be included within the scope of 'Domiciliary Hospitalization under Staff GMC, with the following stipulations: 1) The Insured member is corona positive as per RTPCR test report. 2) The attending doctor has prescribed hospitalization. 3) The Primary Insured Person/Deemed Primary Insured Person will give an undertaking that the hospital beds are not available in the city. 4) Home Oxygen Bed/ICU set up shall minimum include providing Oxygen Concentrator, Cardiac Monitor, PPE Kit, N95 Mask, Sanitizer, Gloves etc., 24 hours Nurse stay and Online consultation with the Doctor. 5) The limit for Set-up package charges will be Rs 20,000/- per day and Rs 2,00,000/- per Insured member, including all taxes, and subject to available Sum Insured. 6) Approval for the set-up and the charges therefore will be given by the HITPA having regard to information that may be available with it through media, internet or other sources about non availability of hospital beds and the prevalent charges for the set-up in the city concerned. 7) The reimbursement of charges for set-up for a minimum 7 days will be allowed if it is a precondition for availing the facility even though the set-up is used for less than 7 days. 8) Cost of medicines and attending doctor fees will be extra. 9) The above dispensation will come into force with effect from the date of circular and will also cover the cases which are undergoing treatment under Home Oxygen Bed/ICU set-up on the date of the circular. 10) The above dispensation will be a temporary measure and the same will be reviewed once the Covid-19 situation improves in the country.
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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.



2. 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 enactment's 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 II

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 moved 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 Pharyngitis.
 - 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:

- (i) Those insured persons who are already having two or more living children will not be eligible for this benefit
- (ii) 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 & New-born Child Cover Benefit Extension

- a) These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patients in India.
- b) 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.
- c) Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
- d) Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.
- e) Pre-hospitalisation and Post-hospitalisation benefits are not available under this section.
- f) Newly born child shall be covered from day one up to 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 DEFINITION 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 provider's 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 up to 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 up to 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 or continues indefinitely or 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

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 (WAIVED)

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

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

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 days 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. **(WAIVED)**

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 eyesight 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 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 - 111) or Lymphadenopathy Associated Virus (AV), 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 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, Be-Its Collars Caps, splints, slings, braces Stockings etc. Of any kind, Diabetic footwear, 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.
- 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 up to 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 of 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 J 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
Up to a Month	1/4 th of the annual rate
Up to 3 Months	1/2 of the annual rate
Up to 6 Months	3/4 th 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 arbitrators 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 referred 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.



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 married spouse can be included within 3 months 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 Vie insured such as intentional misrepresentation I 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 WITHDRAWAL CLAUSE: This product may be withdrawn in future. However, in such an event the policy holder shall be duty 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 there under.

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.



COVERAGE, SUB LIMITS, EXCLUSIONS, TERMS AND CONDITIONS PERTAINING TO MODERN TREATMENT METHODS/ADVANCEMENT IN TECHNOLOGIES AND MENTAL ILLNES, STRESS OR PSYCHOLOGICAL DISORDERS AND NEUROLOGICAL 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)	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
B	Balloon Sinuplasty	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
C	Deep Brain Stimulation	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
D	Oral Chemotherapy	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
E	Immunotherapy- Monoclonal Antibody to be given as injection	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
F	Intravitreal Injections	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
G	Robotic Surgeries (including Robotic Assisted Surgeries)	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs.
H	Stereotactic Radio Surgeries	Up to 50% of Sum Insured subject to a maximum of



		Rs. 15 Lacs per policy period for claims involving Stereotactic Radio Surgeries
1	Bronchial Thermoplasty	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
J	Vaporization of the Prostate (Green laser treatment or holmium laser treatment)	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
K	Intra Operative Neuro Monitoring (IONM)	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 Lacs
L	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only	Up to 50% of Sum Insured per policy period subject to a maximum of Rs. 15 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 postgraduate degree (Homoeopathy) in Psychiatry.

Exclusions

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 -Excl 04

- 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 - Excl 05

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.

III) Obesity/Weight Control: Code- Excl 06

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 - Excl 07

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- Excl 08

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- Excl 09

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 -Excl 10

Expenses or 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 — Excl 11

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 up to 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- Excl 12

(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- Excl 13

(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-Excl 14

(XII) Refractive Error- Code- Excl 15

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

(XIII) Unproven Treatments- Code -Excl 16

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- Excl 17

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- Excl 18 (WAIVED)

- a) Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean 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.



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

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.

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 fulfilment 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 and 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 & Guidebook, 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 (NOT APPLICABLE TO STAFF GMC)

The company may at any time cancel the policy (on grounds of fraud, moral hazard or misrepresentation or non-cooperation) 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 (NOT APPLICABLE TO STAFF GMC)

- 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:

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: (NOT APPLICABLE TO STAFF GMC)

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.

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 non-cooperation.

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): (NOT APPLICABLE TO STAFF GMC)

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.

Not exceeding 60% - 5% Discount
Not exceeding 50% - 15% Discount
Not exceeding 40% - 25% Discount
Not exceeding 30% - 30% Discount
Not exceeding 25% - 30% Discount

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 the event of Insured has any grievance relating to the insurance, the Insured may contact the Grievance Cell at our Regional Office at :Grievance Cell, The New India Assurance Co Ltd, Mumbai Regional Office III, 3rd floor, 17/A Cooperage Road, Mumbai- 400001, or DO 120700, 8th Floor, 17/A Cooperage Road, Mumbai 400001. In order to unsatisfactorily response, insured may contact office of the Insurance Ombudsman. The contact details of Insurance Ombudsman are available on Insurance Ombudsman website : <https://www.cioins.co.in/>.

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 Benefit: (Part of Annexure I)

The special conditions applicable to Maternity Expenses Benefit Scheme are:

These benefits are admissible only if the treatment is taken in hospital / nursing home as in – patient in India.

Claim in respect of only first two children and/or operations associated therewith are admissible.

Those already having two or more living children will not be eligible for this benefit.

Delivery, miscarriage or abortion induced by accident or other medical emergency irrespective of the period from the date of conception are covered.

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

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

MTP

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

In case of mis-carriage / abortion induced by accident or any other medical emergency and consequent hospitalization for the purpose, the expenses would be admitted up to the limits of the hospitalization benefits (not under the Maternity expenses benefits extension) even though such mis-carriage / abortion takes place after the first two living children.

Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there. It means pre and post expenses pertaining only to hospitalization for a specific period / treatment before or after delivery is payable. The hospitalization expenses of the actual delivery is payable.

Meaning of First Two Children

The Maternity benefit is admissible for two living children.

If the first child is a living child and the second pregnancy results into involuntary medical termination of pregnancy (upon medical advice of a gynaecologist) and thereafter the third delivery results in a living child, the benefit shall be payable as per following:

In the first case for delivery of first child

In the second case for medical termination of pregnancy / abortion as the case may be

In the third case for delivery of the second living child.

This means that between the birth of first living child and the birth of second living child, involuntary medical termination of pregnancies / abortion would be payable / admissible, provided the same are necessitated to save one's life upon the advice of a gynaecologist.

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.



3.28 Extending the Company contribution to twins in case of second delivery:

It has been decided that Company contribution shall be extended in cases where twins are born during the second delivery, subject to the terms and conditions of the policy.

3.29 Clarification on Mid-term inclusion of Newly wed spouse and New born baby in Staff GMC and Time limit to enroll spouse and dependent / independent parent-in-laws by a newly married employee:

It is decided that a newly married employee may enroll the spouse, dependent/independent parents-in-law, and newborn child under the Staff Group Medclaim Policy within 90 days from the date of marriage (for spouse and parents-in-law) or from the date of birth (for newborn child). The same time limit is also allowed for enrollment of spouse and new born child of already covered dependent/independent children of employee (serving/retired). Delay in submission of application beyond the prescribed time limits may be condoned by the General Manager (HR) as per the prevailing guidelines, in genuine and deserving cases, based on the merits of each case, subject to the condition that such condonation is allowed only up to the next policy renewal period subject to:

- Full renewal premium covering the period of break is to be collected.
- Claim occurred during the period of break in cover is not payable.
- The cover will commence from the date of payment of renewal premium.

3.30 Issuance of Medclaim Coverage Certificate in cases where an employee serving/retired opts to exclude Independent Children and their family (Spouse and Children) from the staff GMC:

The Companies are advised to provide Medclaim coverage certificate for continuity benefits in cases where an employee serving/retired opts to exclude Independent Children and their family (Spouse and Children) from the staff GMC. This Medclaim certificate will enable the employee to get Continuity benefits of Medclaim coverage while shifting the Medclaim coverage from staff Group Medclaim policy to Individual/Floater Medclaim policy for their independent Children & their family (spouse and children). It may kindly be noted that once the Independent Children and their families go out of the staff GMC, they cannot be included in this policy again.



ANNEXURE II forming part of GIC GMC Policy

List of Day Care Procedures

- 1 Adenoidectomy
- 2 Appendectomy
- 3 Anti-Rabies Vaccination
- 4 Coronary angiography
- 5 Coronary angio-plasty
- 6 Dilatation & Curettage
- 7 ERCP (Endoscopic Retrograde Cholangiopancreatography)
- 8 ESWI (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 Infection
 - (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 Oophorectomy
- 20 Urethrotomy
- 21 PCNL (percutaneous nephrolithotomy)



- 22 Reduction of dislocation under General Anaesthesia
- 23 Transcatheter Placement of Intravascular Shunts
- 24 Incision of The Breast, lump excision
- 25 Vitrectomy
- 26 Thyroidectomy
- 27 Vocal cord Surgery
- 28 Stapedotomy
- 29 Tympanoplasty & revision tympanoplasty
- 30 Arthroscopic Knee Aspiration if Proved Therapeutic
- 31 Perianal abscess Incision & Drainage
- DJ stent insertion
- 32 FESS (Functional Endoscopic Sinus Surgery)
- 33 Fissurectomy / Fistulectomy
- 34 Fracture/dislocation excluding hairline fracture
- 35 Haemodialysis
- 36 Hydrocelectomy
- 37 Hysterectomy
- 38 Inguinal/ventral/ umbilical/femoral hernia repair
- 39 Laparoscopic Cholecystectomy
- 40 Lithotripsy
- 41 Liver aspiration
- 42 Mastoidectomy
- 43 Parenteral chemotherapy
- 44 Haemorrhoidectomy
- 45 Polypectomy
- 46 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)
- 47 Radiotherapy
- 48 Sclerotherapy
- 49 Septoplasty
- 50 Surgery for Sinusitis
- 51 Varicose Vein Ligation
- 52 Tonsillectomy
- 53 Surgical treatment of a varicocele and a hydrocele of the spermatic cord
- 54 Radical Prostatectomy
- 55 Ossiculoplasty
- 56 Ascitic/pleural therapeutic tapping
- 57 therapeutic Arthroscopy
- 58 Mastectomy
- 59 Surgery for Carpal Tunnel Syndrome
- 60 Cystoscopic removal of urinary stones / DJ stents
- 61 AV Malformations (Non cosmetic only)
- 62 Orchidectomy



- 63 Cystoscopic fulguration of tumour
- 64 Amputation of penis
- 65 Creation of Lumbar Subarachnoid Shunt
- 66 Free skin transplantation, donor site
- 67 Free skin transplantation, recipient site
- 68 Orchidopexy (non-congenital)
- 69 Nephrectomy
- 70 Palatal Surgery
- 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 skin 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 Reconstruction 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 on fracture, 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 haemorrhoids
- 104 Division of the anal sphincter
- 105 Ultrasound guided aspirations
- 106 Incision of the Ovary
- 107 Inflation of the Fallopian tubes
- 108 Dilatation of the cervical canal
- 109 Consolation 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
- 122 Haemophilia treatment allowing self infusion based on the prescription of the attending doctor. A valid Doctor's prescription will be mandatory for claim eligibility.
- 123 Any other surgeries / procedures agreed by the TPA and The Company which require less than 24 hours Hospitalization and for which prior approval from TPA is mandatory.



PART OF ANNEXURE II

Expenses relating to Diagnostic Tests without Hospitalization

Following Diagnostic Tests without hospitalization shall be covered subject to the following:

1. MRI charges
2. Contrast MRI charges
3. CT Scan charges
4. Contrast CT Scan/Angio CT charges
5. Sonography charges (Excluding maternity related)
6. Biopsy
7. Gastroscopy
8. Colonoscopy
9. Holter Monitor Test
10. PET Scan charges

- Reimbursement of expenses shall be admissible only for the specified diagnostic tests and no equivalent or alternative diagnostic test shall be considered for this purpose.
- The maximum reimbursable amount under this benefit shall be 1% of Sum Insured or Rs. 20,000 per family per policy year, whichever is less, within the overall Sum Insured.
- For reimbursement, the diagnostic tests must be recommended by an MD doctor or a doctor with equivalent qualification and must be supported by valid documents and certification indicating the present medical complaints necessitating the tests.
- However, where the tests are recommended through a prescription issued by a Government Hospital, the above qualification requirement may be waived.
- Expenses incurred without hospitalization shall be payable only once per insured per specified diagnostic test during the policy period.



ANNEXURE III

Restoration of Sum Insured – Staff Group Mediclaim Policy

1. This benefit shall be applicable only to insured members who have opted for Sum Insured of Rs. 25 Lakhs or above under the Staff Group Mediclaim Policy.
2. If the Sum Insured is partially or completely exhausted due to claims admitted (paid or accepted as payable) during the Policy Period, a Restored Sum Insured equal to 100% of the Base Sum Insured shall be automatically and immediately made available for the same Policy Period.
3. The Restored Sum Insured will be available only once to the whole family on floater basis during a Policy Period.
4. Such restored Sum Insured can be utilized only for illness / disease unrelated to the illness(es) / disease(s) for which claim(s) was / were made for the same insured person.
5. If the Restored Sum Insured is not utilized in a Policy Period, it shall not be carried forward to any subsequent Policy Period.
6. The restored Sum Insured shall be subject to all existing policy terms, exclusions, sub-limits, and waiting periods as applicable under the Staff GMC Policy.
7. The decision of the Competent Authority regarding admissibility of claims under the restoration benefit and interpretation of these provisions shall be final and binding.







