THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA FLOATER MEDICLAIM POLICY - PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA FLOATER MEDICALIM POLICY could provide value to You. In the document the word 'You', 'Your' means the all the members covered under the Policy. 'We', 'Our', 'Us' means The New India Assurance Co. Ltd.

New India Floater Mediclaim is a Policy designed to cover Hospitalisation expenses.

1. **WHO CAN TAKE THIS POLICY?**

   This insurance is available to persons between the age of 18 years and 65 years. Children from 3 months up to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously. The upper age limit will not apply to a mentally challenged children and an unmarried daughter(s). The persons beyond 65 years can continue their insurance provided they are insured under the Policy with us without any break.

   Midterm inclusion is allowed for newly married spouse by charging pro-rata premium for the remaining period of the policy.

2. **CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?**

   Yes. You can cover the entire family under a Single Sum Insured. The members of the family who could be covered under the Policy are:

   a) Proposer
   b) Proposer's Spouse
   c) Proposer's Dependent Children
   d) Proposer's Parents (parents less than equal to 60 years of age will be covered only if they are dependent on the proposer)

   Minimum two members are required in this policy. This policy cannot be given to a single person. Maximum six members can be covered in a single policy.

3. **WHAT IS NEW BORN BABY COVER?**

   A New Born Baby to an insured mother, who has 24 months of Continuous Coverage, is covered for any Illness or Injury from the date of birth till the expiry of the Policy, within the terms of the Policy, without any additional Premium. Any expenses incurred towards post natal care, pre-term or pre-mature care or any such expense incurred for delivery of the New Born Baby would not be covered. Congenital External Anomaly of the New Born Baby is also not covered under the policy.

No coverage for the New Born Baby would be available during subsequent renewals until the child is declared for insurance and covered as an Insured Person.

4. WHAT DOES THE POLICY COVER?

This Policy is designed to give You and Your family, protection against unforeseen Hospitalisation expenses.

5. WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?

Policy covers following Hospitalisation Expenses:

A. Room Rent / Boarding/ Nursing Expenses and other expenses as specified in policy up to 1% of sum insured per day. This also includes Nursing Care, RMO Charges, IV Fluids / Blood Transfusion / Injection administration charges and the like, but does not include cost of materials.

B. ICU up to 2% of Sum Insured per day.

C. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees

D. Anesthetist, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, relevant laboratory diagnostic tests, etc. & similar expenses.

E. All Hospitalisation Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant.

F. For cataract claims, the liability of the company will be restricted to 10% of Sum Insured or Rs. 50000 whichever less, for each eye.

Note: Procedures / treatments usually done in outpatient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centers.

6. WHAT IS HOSPITAL CASH BENEFIT?

This policy provides for payment of Hospital Cash at the rate of 0.1% of Sum Insured per day of Hospitalisation. This benefit will be given in every case of admissible claim and for each member. This benefit is applicable only where Hospitalisation exceeds twenty four consecutive hours.

The total payment for Any One Illness shall not exceed 1% of the Sum Insured. This benefit shall be directly given by TPA / underwriting office, as the case may be.

7. WHAT IS CRITICAL CARE BENEFIT?

If during the Period of Insurance any Insured Person discovers that he/she is suffering from any Critical Illness as listed below, we will pay flat 10% of Sum Insured as additional benefit i.e. other than the admissible claim:

1. Cancer
2. First Heart attack of specified severity
3. Open chest CABG

4. Open Heart replacement or repair of Heart valves
5. Coma of specified severity
6. Kidney failure requiring regular dialysis
7. Stroke resulting in permanent symptoms
8. Major organ / bone marrow transplant
9. Permanent paralysis of limbs
10. Motor neurone disease with permanent symptoms
11. Multiple sclerosis with persisting symptoms

This will be paid only if the Hospitalisation is more than 24 hours. Any payment under this clause would be in addition to the Sum Insured and shall not deplete the Sum Insured. This benefit will be paid once in lifetime of any Insured Person. This benefit is not applicable for those Insured Persons for whom it is a pre-existing disease.

8. IS PRE-ACCEPTANCE MEDICAL CHECK-UP REQUIRED?

Pre-acceptance test is required for all the members entering after the age of 50 for the first time. A person also needs to undergo this pre-acceptance medical check-up if he has an adverse medical history. The cost of this check-up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this check-up will be reimbursed to the proposer.

9. DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does NOT cover ALL cases of Hospitalisation.

The exclusions under the policies are:

1 Treatment of any Pre-existing Condition/Disease, until 48 months of Continuous Coverage of such Insured Person have elapsed, from the Date of inception of his/her first Policy with Us as mentioned in the Schedule.

2 Any Illness contracted by the Insured person during the first 30 days of the commencement date of this Policy. This exclusion shall not however, apply if the Insured person has Continuous Coverage for more than twelve months.

3.1 Unless the Insured Person has Continuous Coverage in excess of twenty four months with Us, expenses on treatment of the following Illnesses are not payable:

1. Cataract and age related eye ailments
2. Benign prostate hypertrophy
3. Benign ear, nose, throat disorders
4. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
5. Hernia of all types
6. Piles, Fissures and Fistula in anus
7. Stones in Urinary system
8. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
9. Gastric/ Duodenal Ulcer

10. Hydrocele
11. Stone in Gall Bladder and Bile duct, excluding malignancy
12. Pilonidal sinus, Sinusitis and related disorders
13. Non Infective Arthritis
14. Gout and Rheumatism
15. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
16. Skin Disorders
17. Varicose Veins and Varicose Ulcers
18. Hypertension
19. Diabetes Mellitus

Note: Even after twenty four months of Continuous Coverage, the above illnesses will not be covered if they arise from a Pre-existing Condition, until 48 months of Continuous Coverage have elapsed since inception of the first Policy with the Company.

3.2 Unless the Insured Person has Continuous Coverage in excess of forty eight months with Us, the expenses related to treatment of

1. Joint Replacement due to Degenerative Condition, and
2. Age-related Osteoarthritis & Osteoporosis are not payable.

4.1 Injury / Illness 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), nuclear weapon/ ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel.

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

b. Change of life or cosmetic or aesthetic treatment of any description such as correction of eyesight, etc.

c. Plastic Surgery other than as may be necessitated due to an accident or as a part of any Illness.

4.3 Vaccination and/or inoculation

4.4 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.5 Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation**.**

4.6.1 Convalescence, general debility, 'Run-down' condition or rest cure, obesity treatment and its complications**,** treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, Venereal disease, intentional self-injury and Illness or Injury caused by the use of intoxicating drugs/alcohol.

4.6.2 Congenital Internal and External Disease or Defects or anomalies.

However, the exclusion for Congenital **Internal** Disease or Defects or anomalies shall not apply after **twenty four** months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. Exclusion for Congenital Internal Disease or Defects or Anomalies would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

The exclusion for Congenital **External** Disease or Defects or anomalies shall not apply after **forty eight** months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of **the average Sum Insured in the preceding four years.**

4.7 Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide, arising out of non-adherence to medical advice.

4.8 Treatment of any Bodily Injury or Illness sustained whilst or as a result of active participation in any hazardous sports of any kind.

4.9 Treatment of any Injury or Illness sustained whilst or as a result of participating in any criminal act.

4.10 Sexually Transmitted Diseases, any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.11 Charges incurred at Hospital primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any Illness or Injury for which confinement is required at a Hospital.

4.12 Expenses on vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending physician.

4.13 Maternity Expenses, treatment arising from or traceable to pregnancy, miscarriage, abortion or complications; except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certification by Gynaecologist that it is life threatening one if left untreated.

4.14 Naturopathy Treatment.

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

4.16 Genetic disorders and stem cell implantation/Surgery.

4.17 Domiciliary Hospitalisation

4.18 Acupressure, acupuncture, magnetic therapies

4.19 Experimental or unproven treatments/ therapies

4.20 Change of treatment from one system of medicine to another unless recommended by the consultant/ Hospital under whom the treatment is taken.

4.21 Any expenses relating to cost of items detailed in Annexure I of Policy Document.

4.22 Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital.

4.23 Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy

10. WHAT IS A PRE EXISTING DISEASE?

The term Pre-existing condition / disease is defined in the Policy. It is defined as:

"Any condition, ailment or Injury or related condition(s) for which the Insured Person had:

a) Signs or symptoms, or
b) Been diagnosed or received Medical Advice, or
c) Been Treated for any condition or disease,

Within forty eight months prior to the commencement of the first policy."

Such a condition or disease shall be considered as Pre-existing. Any Hospitalisation arising out of such pre-existing disease or condition is not covered under the Policy.

11. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

Yes. Unless the Insured Person is Hospitalised for a condition warranting Hospitalisation, no claim is payable under the Policy. The Policy does not cover outpatient treatments.

12. HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED?

The Policy pays only where the Hospitalisation is for more than twenty four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty four hours. The 24 hours treatments are according to the table given in Point 13 below.

13. WHAT ARE THE DAY CARE TREATMENTS COVERED UNDER THIS POLICY?

Following are the day-care treatments covered under this policy (treatments done within 24 hours).

1	Adenoidectomy
2	Appendectomy

3	Anti-Rabies Vaccination
4	Coronary angiography
5	Coronary angioplasty
6	Dilatation & Curettage
7	ERCP (Endoscopic Retrograde Cholangiopancreatography)
8	ESWL (Extracorporeal Shock Wave Lithotripsy)
9	Excision of Cyst/granuloma/lump
10	**FOLLOWING EYE SURGERIES:**
A	Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
B	Corrective surgery for blepharoptosis when not congenital/cosmetic
C	Corrective Surgery for entropion / ectropion
D	Dacryocystorhinostomy [DCR]
E	Excision involving one-fourth or more of lid margin, full-thickness
F	Excision of lacrimal sac and passage
G	Excision of major lesion of eyelid, full-thickness
H	Manipulation of lacrimal passage
I	Operations for pterygium
J	Operations of canthus and epicanthus when done for adhesions due to chronic Infections
K	Removal of a deeply embedded foreign body from the conjunctiva with incision
L	Removal of a deeply embedded foreign body from the cornea with incision
M	Removal of a foreign body from the lens of the eye
N	Removal of a foreign body from the posterior chamber of the eye
O	Repair of canaliculus and punctum
P	Repair of corneal laceration or wound with conjunctival flap
Q	Repair of post-operative wound dehiscence of cornea
R	Penetrating or Non-Penetrating Surgery for treatment of Glaucoma
11	Pacemaker insertion
12	Turbinectomy/turbinoplasty
13	Excision of pilonidal sinus
14	Therapeutic endoscopic surgeries
15	Conisation of the uterine cervix
16	Medically necessary Circumcision
17	Excision or other destruction of Bartholin's gland (cyst)
18	Nephrotomy
19	Oopherectomy
20	Urethrotomy
21	PCNL(percutaneous nephrolithotomy)
22	Reduction of dislocation under General Anaesthesia
23	Transcatherter Placement of Intravascular Shunts
24	Incision Of The Breast, lump excision
25	Vitrectomy
26	Thyriodectomy
27	Vocal cord surgery
28	Stapedotomy

29	Tympanoplasty & revision tympanoplasty
30	Arthroscopic Knee Aspiration if Proved Therapeutic
31	Perianal abscess Incision & Drainage
32	DJ stent insertion
33	FESS (Functional Endoscopic Sinus Surgery)
34	Fissurectomy / Fistulectomy
35	Fracture/dislocation excluding hairline fracture
36	Haemo dialysis
37	Hydrocelectomy
38	Hysterectomy
39	Inguinal/ventral/ umbilical/femoral hernia repair
40	Laparoscopic Cholecystectomy
41	Lithotripsy
42	Liver aspiration
43	Mastoidectomy
44	Parenteral chemotherapy
45	Haemorrhoidectomy
46	Polypectomy
47	**FOLLOWING PROSTATE SURGERIES**
A	TUMT(Transurethral Microwave Thermotherapy)
B	TUNA(Transurethral Needle Ablation)
C	Laser Prostatectomy
D	TURP(transurethral Resection of Prostate)
E	Transurethral Electro-Vaporization of the Prostate(TUEVAP)
48	Radiotherapy
49	Sclerotherapy
50	Septoplasty
51	Surgery for Sinusitis
52	Varicose Vein Ligation
53	Tonsillectomy
54	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
55	Retinal Surgeries
56	Ossiculoplasty
57	Ascitic/pleural therapeutic tapping
58	therapeutic Arthroscopy
59	Mastectomy
60	Surgery for Carpal Tunnel Syndrome
61	Cystoscopic removal of urinary stones / DJ stents
62	AV Malformations (Non cosmetic only)
63	Orchidectomy
64	Cystoscopic fulguration of tumour
65	Amputation of penis
66	Creation of Lumbar Subarachnoid Shunt
67	Radical Prostatectomy

68	Lasik surgery (non-cosmetic)
69	Orchidopexy (non-congenital)
70	Nephrectomy
71	Palatal surgery
72	Stapedectomy & revision of stapedectomy
73	Myringotomy
74	Or any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalisation and for which prior approval from TPA is mandatory.

14. WHAT DO I NEED TO DO IF ANYBODY COVERED IN THE POLICY NEEDS TO GET HOSPITALISED?

Upon the happening of any event which may give rise to a claim under the policy, please immediately intimate the TPA or underwriting office or nearest office of "The New India Assurance Co. Ltd.", whichever is applicable, named in the schedule with all the details such as name of the Hospital, details of treatment, patient name, policy number etc.

In case of emergency Hospitalisation, this information needs to be given to the TPA or underwriting office, whichever applicable, within 24 hours from the time of Hospitalisation.

This is an important condition that you need to comply with.

15. WHAT ARE THE AMBULANCE CHARGES PAID UNDER THIS POLICY?

Company will pay ambulance charges up to 1% of SI or actual whichever is less. These charges are available in case of emergency extraction from anywhere to Hospital or Hospital to Hospital.

16. IN CASE OF AYURVEDIC TREATMENT, WILL THE ENTIRE AMOUNT BE PAID?

The liability of the company in case of Ayurvedic / Homoeopathic / Unani treatment will be 25% of the Sum Insured provided the treatment is taken in a government Hospital or in any institute recognized by government or accredited by Quality Council Of India or National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures..

17. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Medical Expenses incurred immediately before, but not exceeding thirty days, the Insured Person is Hospitalised will be paid, 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 Hospitalisation claim for such Hospitalisation is admissible by Us.

18. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Medical Expenses incurred immediately after, but not exceeding thirty days, the Insured Person is discharged from the Hospital will be paid, 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 Hospitalisation claim for such Hospitalisation is admissible by Us.

19. IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALISATION?

Yes. We will pay Hospitalisation expenses up to a limit, known as **Sum Insured**. In cases where the Insured Person was Hospitalised more than once, the **total of all amounts** paid

a) for all cases of Hospitalisation,
b) expenses paid for medical expenses prior to Hospitalisation, and
c) expenses paid for medical expenses after discharge from Hospital

Shall not exceed the Sum Insured.

The Sum Insured under the policy is available for any or all the members covered for one or more claims during the tenure of the policy.

20. CAN I GET TREATED ANYWHERE?

The Policy covers treatment only in India. Even within India, if premium paid for lower zone and treatment taken in higher zone, our liability towards any claim will be

a) 80% of admissible claim amount
b) Sum Insured

Whichever is less.

Illustration:

1) Insured XYZ, Sum Insured: Rs. 200000, Zone Selected: Zone III
Admissible Claim: Rs. 80000, Treatment taken in: Zone II
In such case Our liability will be 80% of the admissible claim amount i.e. Rs. 64000 (80% of Rs. 80000). Rest of the amount will be borne by the Insured i.e. Rs. 16000.
2) Insured ABC, Sum Insured: Rs. 200000, Zone Selected: Zone II
Admissible Claim: Rs. 300000, Treatment taken in: Zone I
In such case, our liability will be 80% of admissible claim amount i.e. Rs. 240000 (80% of Rs. 300000). But the claim amount cannot exceed the Sum Insured viz. Rs. 200000. Thus our total liability will be Rs. 200000.

Note: Co-pay will not be applied on the Sum Insured, it is always applicable on the admissible claim amount.

EACH ZONE IS CLASSIFIED AS BELOW: (The Cities mentioned below would include their Urban Agglomeration)	
Zone- I	**Greater Mumbai (**includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli, Ulhasnagar, Ambarnath, Badlapur) **and state of Gujarat**
Zone-II	**Delhi NCR (**includes Faridabad, Gurgaon, Mewat, Rohtak, Sonepat, Rewari, Jhajjhar, Panipat and Palwal, Meerut, Ghaziabad, Gautam Budha Nagar, Bulandshahr, and Baghpat, Alwar and NCT of Delhi**), Bangalore, Chennai, Hyderabad and Secunderabad, Pune and Kolkata**

Zone-III	Rest of India (other than those areas specified in Zone I and II)

The Insured Person can choose the Zone at the time of proposal, and can also change it at the time of renewal.

It is therefore in your interest to choose the appropriate Zone and pay the necessary premium depending upon your preference for coverage.

21. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured from Rs. 2 lakhs, 3 lakhs, 5 lakhs, and 8 Lakhs. The premium payable is determined on the following criteria:

1. The premium for the eldest member of the family. (Premium from Primary Member Premium Table)
2. Premium for additional member to be covered in this policy. (Premium from Additional Member Premium Table)
3. Sum Insured
4. Zone (As per point 20 above)

You are free to choose any Sum Insured available as specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs.

22. HOW LONG IS THE POLICY VALID?

The Policy is valid during the Period of Insurance stated in the Schedule attached to the Policy. It is usually valid for a period of one year from the date of beginning of insurance.

23. CAN THE POLICY BE RENEWED WHEN THE PRESENT POLICY EXPIRES?

Yes. You can and to get all Continuity benefits under the Policy, you should renew the Policy **before** the expiry of the present policy. For instance, if Your Policy commences from 2nd October, 2011 date of expiry is usually on 1st October, 2012. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2012.

24. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, Cataract is covered only after twenty four months of Continuous Coverage. If an Insured took a Policy in October, 2008, does not renew it on time and takes a Policy only in December 2009, and renewed it on time in December 2010, any claim for Cataract would not become payable, because the Insured Person was not continuously covered for twenty four months. If, he had renewed the Policy in time in October 2009 and then in October 2010, then he would have been continuously covered for twenty four months and therefore his claim for Cataract in the Policy beginning from October 2010 would be payable. For other benefits under the Policy such as cost of health checkup, Continuous Coverage is necessary. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires.

25. IS THERE ANY GRACE PERIOD FOR RENEWAL OF THE POLICY?

Yes. If Your Policy is renewed within thirty days of the expiry of the previous Policy, then the Continuity Benefits would not be affected. But even if You renew Your Policy within thirty days of expiry of previous Policy, any Illness contracted or Injury sustained or Hospitalisation commencing during the break in insurance is not covered. Therefore it is in your own interest to see that you renew the Policy before it expires.

26. CAN THE SUM INSURED BE INCREASED AT THE TIME OF RENEWAL?

Yes. You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum Insured, We have the right to have You examined by a Medical Practitioner authorized by Us or the TPA (50% of Medical examination cost will be reimbursed to the Insured Person). Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

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

Enhancement of Sum Insured will not be considered for:

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

In respect of any increase in Sum Insured, exclusion 4.1, 4.2, 4.3.1 and 4.3.2 would apply to the additional Sum Insured from the date of such increase.

27. IS THERE AN AGE LIMIT UPTO WHICH THE POLICY WOULD BE RENEWED?

No. Your Policy can be renewed, as long as you pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal. However, if you do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to our underwriting rules. In such cases, it is possible that a fresh Policy could not be issued by us. It is therefore in your interest to ensure that Your Policy is renewed before expiry**.**

28. CAN THE INSURANCE COMPANY REFUSE TO RENEW THE POLICY?

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation or non-disclosure of material facts or non-cooperation being committed by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If we discontinue selling this Policy, it might not be possible to renew this Policy on the same

terms and conditions. In such a case you shall, however, have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

29. CAN I MAKE A CLAIM IMMEDIATELY AFTER TAKING A POLICY?

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. However, claims for Hospitalisation due to accidents occurring even during the first thirty days are payable. There are certain treatments where the waiting period is two years or four years.

30. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to you for providing Cashless facility for all Hospitalisation that come under the scope of the policy. The TPA also settles reimbursement claims within the scope of the Policy.

31. WHAT IS CASHLESS HOSPITALISATION?

Cashless Hospitalisation is service provided by the TPA on Our behalf whereby you are not required to settle the Hospitalisation expenses at the time of discharge from Hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid and you would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Networked Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx. The list of Networked Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Networked Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a Hospital which is not a Network Hospital. In such cases you may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

32. CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes, it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

33. HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON- NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfills the conditions of definition of Hospital in the Policy. Within twenty four

hours of Hospitalisation the TPA should be intimated. The following documents in original should be submitted to the TPA within seven days from the date of Discharge from the Hospital:

- Claim Form duly filled and signed by the claimant.
- Discharge Certificate from the hospital.
- All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history.
- Bills, Receipts, Cash Memos from hospital supported by proper prescription.
- Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
- Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt.
- Attending doctor's / consultant's / specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis.
- Details of previous policies, if the details are not already with TPA or any other information needed by the TPA for considering the claim.

34. HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALISATION EXPENSES?

The Policy allows reimbursement of medical expenses incurred before and after admissible Hospitalisation up to a certain number of days. For reimbursement, send all bills in original with supporting documents along with a copy of the discharge summary and a copy of the authorization letter to his/her TPA / underwriting office, whichever applicable. The bills must be sent to the TPA / underwriting office within 7 days from the date of completion of treatment. You must also provide the TPA / underwriting office with additional information and assistance as may be required by the Company / TPA in dealing with the claim.

35. WILL THE ENTIRE AMOUNT OF THE CLAIMED EXPENSES BE PAID?

The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalisation as per Policy conditions and is supported by proper documents, except the expenses which are excluded.

36. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes. A claim, which is not covered under the Policy conditions, can be rejected. Claims may also be rejected in the event of misrepresentation, misdescription or nondisclosure of any material fact/particular. In case You are not satisfied by the reasons for rejection, You can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/Content.aspx?pageid=73. You may also call our Call Centre at the Toll free number **1800-209-1415**, which is available 24x7.

You also have the right to represent Your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

37. CAN I CANCEL THE POLICY?

Yes, You can. But the Refund that would be made in case the Policy is cancelled would not be proportionate to the unexpired term of the Policy. Such Refund would be made **only if no claim has been made or paid under the Policy,** and the Refund would be at our Short Period rate table given below:

Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

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

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

Mid-term Deletion of members will be on short scale basis.

38. WHAT IS FREE LOOK PERIOD?

The free look period shall be applicable at the inception of first policy.

You will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

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

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

2) Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover.

39. IS THERE ANY BENEFIT UNDER THE INCOME TAX ACT FOR THE PREMIUM PAID FOR THIS INSURANCE?

Yes. Payments made for health insurance in any mode other than cash are eligible for deduction from taxable income as per Section 80 D of the Income Tax Act, 1961. For details, please refer to the relevant Section of the Income Tax Act.

40. IS CONGENITAL DISEASES COVERED IN THE POLICY?

Yes. **Congenital Internal Disease** or Defects or anomalies shall be covered after **twenty four** months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. Exclusion for Congenital Internal Disease or Defects or Anomalies would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

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

41. IF THE CLAIM EVENT FALLS WITHIN TWO POLICY PERIODS, HOW MUCH WILL BE PAID?

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of Premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

PREMIUM CHART

Sum Insured (Rs.)	Zone	PRIMARY MEMBER Premiums applicable at different ages (Rs. per annum)								
		0-20	21-30	30-35	36-40	41-45	46-50	50-55	55-60	60-65
200,000	I	1,860	2,530	3,010	3,690	4,790	5,850	8,170	10,000	16,860
300,000	I	2,780	3,670	4,140	5,050	6,560	8,010	11,640	14,220	24,040
500,000	I	4,270	5,800	6,530	7,990	9,280	11,340	17,060	20,860	35,420
800,000	I	5,680	7,710	8,690	10,630	12,350	15,080	22,690	28,180	47,110
200,000	II	1,690	2,300	2,740	3,350	4,350	5,320	7,430	9,090	15,330
300,000	II	2,530	3,340	3,760	4,590	5,960	7,280	10,580	12,930	21,850
500,000	II	3,880	5,270	5,940	7,260	8,440	10,310	15,510	18,960	32,200
800,000	II	5,160	7,010	7,900	9,660	11,230	13,710	20,630	25,620	42,830
200,000	III	1,520	2,070	2,470	3,020	3,920	4,790	6,690	8,180	13,800
300,000	III	2,280	3,010	3,380	4,130	5,360	6,550	9,520	11,640	19,670
500,000	III	3,490	4,740	5,350	6,530	7,600	9,280	13,960	17,060	28,980
800,000	III	4,640	6,310	7,110	8,700	10,110	12,340	18,570	23,060	38,550

Sum Insured (Rs.)	Zone	ADDITIONAL MEMBER Premiums applicable at different ages (Rs. per annum)								
		0-20	21-30	30-35	36-40	41-45	46-50	50-55	55-60	60-65
200,000	I	250	360	510	620	1,100	1,340	2,840	3,470	10,960
300,000	I	370	520	680	840	1,510	1,850	4,030	4,930	15,610
500,000	I	570	830	1,090	1,330	2,130	2,610	5,910	7,230	23,010
800,000	I	760	1,100	1,450	1,770	2,840	2,470	7,850	9,610	30,600
200,000	II	230	330	460	560	1,000	1,220	2,580	3,150	9,960
300,000	II	340	470	620	760	1,370	1,680	3,660	4,480	14,190
500,000	II	520	750	990	1,210	1,940	2,370	5,370	6,570	20,920
800,000	II	690	1,000	1,320	1,610	2,580	3,150	7,140	8,740	27,820
200,000	III	210	300	410	500	900	1,100	2,320	2,840	8,960
300,000	III	310	420	560	680	1,230	1,510	3,290	4,030	12,770
500,000	III	470	680	890	1,090	1,750	2,130	4,830	5,910	18,830
800,000	III	620	900	1,190	1,450	2,320	2,840	6,430	7,870	25,040

Once the Insured Person crosses the age of 65 years, the applicable premium on renewal will be loaded by 2% per year. This loading is applicable on premium for the age band of 60 years to 65 years.

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