THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA SIXTY PLUS MEDICLAIM POLICY

PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA SIXTY PLUS MEDICLAIM POLICY could provide value to You. In the document the word 'You', 'Your' means you, the Insured under the Policy. 'We', 'Our', 'Us' means New India Assurance Co. Ltd.

NEW INDIA SIXTY PLUS MEDICLAIM POLICY is a Policy designed to cover Hospitalization expenses.

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

   This Insurance Policy is primarily designed for Senior Citizens. The entry age is 60 years to 80 Years. At least one of the covered member should be a senior citizen i.e.

   - Only two members i.e. a senior citizen and his/her spouse can be covered on individual basis in one policy.
   - At least one insured person shall be a senior citizen
   - Children above the age of 18 Years can be a proposer for their parents where one of them is over 60 Years of age. They shall be eligible for tax rebate under section 80D accordingly

   For example, If the Husband (Primary Member) is of 61 Years and Spouse is 55 Years, they both can be covered in this Policy.

2. **WHAT DOES THE POLICY COVER?**

   This Policy is designed to give You, the Insured, protection against unforeseen Hospitalization expenses.

3. **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 there were signs or symptoms, and/or were diagnosed, and/or for which medical advice / treatment was received within forty-eight months prior to the first policy issued by Us and renewed continuously thereafter."

   If You 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 with us,

   Such a condition or disease shall be considered as Pre-existing. Any Hospitalization arising out of such pre-existing disease or condition is not covered under the Policy until forty-eight months of Continuous Coverage have elapsed for the Insured Person.

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

Pre-acceptance medical check-up is required for all the members who are not having a continuous coverage of Health Insurance Policy for the last four years with Our Company or any other Insurance Company. A person also needs to undergo this pre-acceptance medical check-up if he has an adverse medical history or if the health condition of the person/s to be Insured is such that the office in-charge feels that he / she be subjected to a medical examination.

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.

Note: Adverse Medical History means a person:

a) Who has undergone more than one Hospitalization in previous two years,

b) Who is suffering from Critical Illness, Recurring Illness or Chronic Illness.

c) Is Suffering from Hypertension / Diabetes.

d) Is not in good health and free from Physical and mental diseases or infirmity or medical complaints.

Medical Tests Required:

1	CBC	8	ROUTINE URINE EXAMINATION
2	BLOOD SUGAR FASTING & POST PRANDIAL	9	RESTING ECG
3	SGPT	10	X RAY CHEST PA VIEW
4	SGOT	11	PHYSICIAN CHECK UP
5	SERUM CHOLESTEROL	12	EYE CHECK UP FOR CATARACT & GLAUCOMA
6	SERUM TRIGLYCERIDES	13	USG ABDOMEN & PELVIS
7	SERUM HDL		

5. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

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

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

The Policy pays only where the Hospitalization is for a minimum period of twenty four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty four hours. Please refer to Clause 2.18 of the Policy for details.

7. WHAT DO I NEED TO DO AFTER I GET HOSPITALISED?

Immediately on Hospitalization or within twenty four hours of such Hospitalization, please intimate the TPA of this fact, with details of Your Policy Number, Name of the Hospital and treatment undertaken. This is an important condition of the Policy that you need to comply with.

8. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of Hospitalization are payable subject to the terms and conditions mentioned in section 3

of the Policy Clauses. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is Hospitalized.

9. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Relevant medical expenses incurred after Discharge from the Hospital for a period of SIXTY days after the date of discharge are payable subject to the terms and conditions mentioned in section 3 of the Policy Clauses. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is Hospitalized.

10. CAN I GET TREATED ANYWHERE?

Yes, the Policy covers treatment and/or services rendered only in India.

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

Yes. We will pay Hospitalization expenses up to a limit, known as Sum Insured and Cumulative Bonus Buffer subject to the terms and conditions mentioned in the **section 3** of the Policy clauses. In cases where the Insured Person was Hospitalized more than once, the **total of all amounts** paid

a) for all cases of Hospitalization,
b) expenses paid for medical expenses prior to Hospitalization,
c) expenses paid for medical expenses after discharge from hospital, and
d) any other payment made under the Policy

shall not exceed the Sum Insured and Cumulative Bonus Buffer as mentioned in the Schedule.

12. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any of the Sum Insured of Rs. Two, Three and Five Lakhs. The Premium You pay depends upon Your Age and the Sum Insured chosen. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs.

13. 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.

14. 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 29th January, 2017 date of expiry is usually on 28th January, 2018. You should renew Your Policy by paying the Renewal Premium on or before 28th January 2018.

15. 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 insurance. If an Insured took a Policy in October, 2015, does not renew it on time and takes a Policy only in December 2016, and renewed it on time in December 2017, 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 2016 and then in October 2017, then he would have been continuously covered for twenty-four months and therefore his claim for Cataract in the Policy beginning from October 2017 would be payable. Therefore, You should always ensure that you pay Your renewal Premium before Your Policy expires.

16. WHAT IS CUMULATIVE BONUS BUFFER?

The Cumulative Bonus Buffer accrued under any of our policies, on migration to New India Sixty Plus Mediclaim Policy is protected. But for claim free renewal after migration to New India Sixty Plus Mediclaim Policy No accrual would be made to the Cumulative Bonus Buffer. The Cumulative Bonus Buffer will be available until it is completely used in case of a claim.

17. 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 disease contracted or injuries sustained or Hospitalization 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.

18. 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. Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner and subject to limits as stated below:

Age <= 50 years	Up to Sum Insured of 5 lakhs without Medical Examination.
Age 51 – 65 Years	By one slab without Medical Examination.
Age 51 – 65 Years	Up to Sum Insured of 5 lakhs with Medical Examination.
Age 66 – 70 Years	By one slab with Medical Examination.

Enhancement of Sum Insured will not be considered for:

1) If You are over 70 years of age.
2) If You who had undergone more than one Hospitalization in the preceding two years.
3) If You are suffering from one or more of the following Illnesses/Conditions:
- **a)** Any chronic Illness
- **b)** Any recurring Illness
- **c)** Any Critical Illness

In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to such additional or enhanced Sum Insured from such date.

19. 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. The entry age for taking a fresh Policy is 60-80 years, 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.

20. 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 suppression 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 or withdraw this product, 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.

In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

Renewal can also be refused if the Policy is not renewed before expiry of the Policy or within the Grace Period.

21. WHAT IF THE COMPANY HAS WITHDRAWN THE POLICY?

If we have withdrawn the Policy, in which event You shall have the option for Renewal under any similar Policy being issued by Us, provided however, benefits payable shall be subject to the terms contained in such other Policy

In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

22. CAN I RENEW THE POLICY WITH THE SAME RATES AND TERMS?

The Renewal is subject to the revision of rates & terms in future.

In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

23. 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 Hospitalization due to accidents occurring during the first thirty days are payable. There are certain treatments where the waiting period is two years or four years. Please see Conditions 4.3.1, 4.3.2 and 4.4.7 of the Policy.

24. 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 hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

25. WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization 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 Network Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx The list of Network Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Network 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.

26. 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.

27. 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 Hospitalization 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 diagnosis.
- 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.

28. HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALIZATION EXPENSES?

The Policy allows reimbursement of medical expenses incurred before and after admissible Hospitalization 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 your TPA. The bills must be sent to the TPA within 7 days from the date of completion of treatment. You must also provide the TPA with additional information and assistance as may be required by the company/TPA in dealing with the claim.

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

The amount of the claim payable is subject to the terms and conditions mentioned in Section 3 of the Policy Clauses and is related with the Hospitalization as per Policy conditions and is supported by proper documents, except the expenses which are excluded.

30. HOW MUCH WE WILL REIMBURSE?

Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus Buffer, Our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus Buffer.

Subject to above, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible under the following heads.

Section	Hospitalisation Benefit	Limits
A	Room charges subject to 1% of sum insured per day and Intensive care unit (ICU) charges subject to 2% of sum insured per day (including nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges).	Maximum limit under Section 3.1.1 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury Please Note that basic Sum Insured will only be considered for reckoning of Per day room rent eligibility
B	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	Maximum limit under Section 3.1.2 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury
C	Anesthesia, Blood, Oxygen, OT charges, Surgical appliances (any disposable surgical consumables), Medicines, drugs, Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, Artificial limbs and implants other than Orthopedic.	Maximum limit under Section 3.1.3 will be 50% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury

Claims in respect of the following Treatments/ Surgeries including all types of implants used in the surgery, will be subject to the following limits (including Pre & Post Hospitalization expenses) and the Co-Payment/voluntary co-payment and sub limits mentioned in section above(A,B&C)are not applicable if a claim is admissible under the below mentioned specified Treatments/Surgeries.

Treatments/Surgeries	2 Lakhs	3 Lakhs	5 Lakhs
Angiography (CT Angiogram excluded)	14000	20000	25000
Cataract (each eye)	15000	20000	25000
Hydrocele Surgery	20000	30000	50000
Dialysis (With a cap of 1500 per sitting)	25000	35000	50000
Fissurectomy	27000	38000	45000
Fistulectomy	27000	38000	45000
Surgery of Hernia	30000	40000	60000
Appendectomy	30000	40000	60000
Transurethral resection of the prostate (TURP)/ BPH surgery	30000	40000	60000
Hysterectomy	30000	40000	60000
Cholecystectomy	30000	40000	60000
Arthroscopic Surgery	30000	40000	60000
Haemorrhoidectomy	30000	40000	60000
Renal stones related surgical procedures	38000	55000	70000
All major Surgical and Medical Treatment for Fractures and Dislocations	50000	70000	100000
PID-Discectomy	70000	80000	100000
PTCA (Angioplasty)	75000	120000	150000
Joint Replacement for Major Joints (Per Joint)	80000	100000	150000
Major Spinal Surgeries	100000	150000	200000
All Major Cancer Surgeries	140000	200000	275000
Major Organ Transplant (Including Donor Expenses)	150000	200000	300000
CABG (Coronary Artery Bypass Graft)	150000	200000	275000
Note: In case of multiple surgeries in one sitting, in same incident and on same site, highest grade surgery will be approved at 100%, second surgery at 50% and third surgery at 25% of the capped amount specified above in section 3.2.			

ATTENDANT BENEFIT: We will pay a benefit of up to Rs. 5000/-, Rs. 7000/- and Rs, 10,000/- per hospitalization for the Sum Insured of Two, Three and Five Lakhs respectively subject to the limit of Maximum Rs. 800 per day or actuals whichever is less and after duly submitting relevant supporting documents. This amount will reduce the Sum Insured.

OPTIONAL COVER: VOLUNTARY CO-PAY

If You opt for a voluntary co-pay of an extra 10% i.e. for a total co-pay of 20%, a discounted Premium given in the table shall be charged.

CO-PAYMENT:

You shall bear a Co-Payment of 10% of the final claim admissible amount and Our liability shall be restricted to the payment of the balance amount subject to the available Sum Insured and Cumulative Bonus Buffer i.e., In the Claims admitted, the Company's liability will be:

a) Sum Insured and Cumulative Bonus Buffer **(or)**

b) 90% of the admissible claim amount

Whichever is less.

If You opt for voluntary co-pay of extra 10% i.e for a total co-payment of 20% then the Claims admitted, the Company's liability will be:

a) Sum Insured and Cumulative Bonus Buffer **(or)**

b) 80% of the admissible claim amount

Whichever is less.

Co-Payment is not applicable if a Claim is admissible under section 3.2 of the policy clause.

HOSPITAL CASH:

We will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalization admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty-four consecutive hours. Payment under this clause shall reduce the Sum Insured.

Hospital Cash will be payable for completion of every twenty-four hours and not part thereof.

LIMIT ON PAYMENT FOR CATARACT:

Our liability for payment of any claim relating to Cataract, for each eye shall not exceed the limit mentioned in the section 3.2 of the Policy clause.

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

WHAT ABOUT OTHER TREATMENTS?

If the expenses for illness/treatments listed under section 3.2 of the policy clause barring cataract are exceeding the amount capped thereunder, the balance admissible expenses can be claimed from other policies of New India, if any.

PAYMENT OF AMBULANCE CHARGES:

We will pay You the charges for Ambulance services not exceeding 1% of the Sum Insured per Hospitalization, Reasonably and Medically Necessarily incurred for shifting any Insured Person to Hospital for admission in Emergency Ward or ICU, or from one Hospital to another Hospital for better medical facilities.

PRE & POST HOSPITALIZATION EXPENSES: We will pay You the Pre & Post Hospitalization expenses of 30 days, 60 days respectively subject to the maximum limit of 10% of the Sum Insured if the Claim has been accepted under section 3.1 of the Policy clause.

PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

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

MEDICAL EXPENSES FOR ORGAN TRANSPLANT:

If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ) incurred on the donor, provided Our liability towards expenses incurred on the donor and the insured recipient will be limited to amount stated in section 3.2 of the Policy Clause

MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

31. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. 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 https://www.newindia.co.in/portal/#/readMore/Grievances. 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 https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

32. CAN I CANCEL THE POLICY?

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

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

1. A refund of the premium paid less any expenses incurred by Us on medical examination and the stamp duty charges or;
2. where the risk has already commenced and the option of return of the policy is exercised by You, a deduction towards the proportionate risk premium for period on cover or;
3. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

If you choose to cancel the policy after expiry of Free Look Period, the refund would be at our Short Period rate table given below:

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

The refund would be made **only if no claim has been made or paid under the Policy**

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

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

33. 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. Income Tax laws are subject to change.

34. PORTABILITY:

This policy is subject to portability guidelines issued by IRDAI and as amended from time to time.

35. CAN I TAKE MULTIPLE POLICIES OF NEW INDIA SIXTY PLUS MEDICLAIM POLICY?

No, You are allowed to take only Single Policy of New India Sixty Plus Mediclaim Policy.

36. WHAT ARE EXCLUDED UNDER THIS POLICY

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

1 Treatment of any Pre-Existing Condition/Disease, until forty eight 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 (except Injury) 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. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism

7. Hernia of all types
8. Hydrocele
9. Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from Accident
13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Renal Failure

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,
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 Medically Necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident

b. Change of life/sex change or cosmetic or aesthetic treatment (except for burns/Injury) 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 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.

4.7 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.

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 of the Insured Person in the preceding four years.

4.8 Bodily Injury due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide.

4.9 Treatment of any Bodily Injury or Illness sustained whilst or as a result of active participation in the following hazardous sports.

Bobsledding; Bungee Jumping; Canopying; Hang Gliding; Heli-skiing; Horseback Riding; Jet, Snow, and Water Skiing; Kayaking; Martial Arts; Motorcycling; Mountain Biking; Mountain Climbing (under 14,000 feet); Paragliding; Parasailing; Safari; Scuba Diving, Skydiving; Snowboarding; Snowmobiling; Spelunking; Surfing; Snorkeling Trekking; White water Rafting; Wind Surfing; Zip Lining, Equestrian; Fencing; Rugby.

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

4.11 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.

4.12 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

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

4.14 Maternity Expenses, 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.

4.15 Naturopathy, Siddha Treatment and AYUSH treatments are not covered in this Policy.

4.16 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), CPAD (Continuous Peritoneal

Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and similar related items etc., and also any medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

4.17 Any expenses relating to cost of items detailed in Annexure II (of policy document).

4.18 Stem cell implantation/Surgery.

4.19 Domiciliary Hospitalisation.

4.20 Acupressure, acupuncture, magnetic therapies

4.21 Experimental or unproven treatments/ therapies.

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.

Premium Table

Premium chart for New India Sixty Plus Mediclaim Policy (Per Annum) (Excluding GST)							
For Fresh Proposals				**For Renewals**			
Sum Insured	**2 Lakhs**	**3 Lakhs**	**5 Lakhs**	**Sum Insured**	**2 Lakhs**	**3 Lakhs**	**5 Lakhs**
Primary Member (60-80 Years)	Rs. 14,218	Rs. 18,667	Rs. 23, 991	**Primary Member (60-80 Years)**	Rs. 13,218	Rs. 17,667	Rs. 22, 991
Spouse	Rs. 13,000	Rs 17,040	Rs. 21,873	**Spouse**	Rs. 12, 000	Rs 16,040	Rs. 20,873
Premium chart for New India Sixty Plus Mediclaim Policy for a Co-Pay of extra 10% i.e, for a total co-pay of 20%, (Per Annum) (Excluding GST)							
For Fresh Proposals				**For Renewals**			
Sum Insured	**2 Lakhs**	**3 Lakhs**	**5 Lakhs**	**Sum Insured**	**2 Lakhs**	**3 Lakhs**	**5 Lakhs**
Primary Member (60-80 Years)	Rs. 13,125	Rs. 17,198	Rs. 22,071	**Primary Member (60-80 Years)**	Rs. 12,125	Rs. 16,198	Rs. 21,071
Spouse	Rs. 11,978	Rs. 15,666	Rs. 20,078	**Spouse**	Rs. 10,978	Rs. 14,666	Rs. 19,078
For Fresh & Renewal- If only single woman senior citizen is covered in the Policy, discount of 5% will be given on the Primary Member Premium							