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 MEDICLAIM 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)
   e) Proposer's Brother/Sister
   f) Proposer's Ward
   g) Employers can cover their Employees

   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.

   Note:

   i. Brother/Sister can only be covered when they are financially dependent on the proposer.

ii. For the relations Employer-Employee/Brother/Sister/Ward 80D certificate shall not be given.

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 and nursing expenses as provided by the Hospital not exceeding 1.0 % of the Sum Insured (without Cumulative Bonus) per day.

B. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2.0 % of the Sum Insured (without Cumulative Bonus) per day

C. Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.

D. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during Surgery like pacemaker, Relevant Laboratory/Diagnostic test, X-Ray and other medical expenses related to the treatment.

E. Pre-Hospitalization Medical Expenses, not exceeding thirty days

F. Post-Hospitalization Medical Expenses, not exceeding sixty days

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

H. For cataract claims, the liability of the company will be restricted to 10% of Sum Insured or Rs. 50,000 whichever less, for each eye.

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.

Note:

i) 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.

ii) Reimbursement/payment of Room Rent, including but not limited to boarding and nursing expenses, incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such expenses shall not exceed 2% of the Sum Insured per day. In case of admission to a Room Rent/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines and implants, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day, for Room Rent (including but not limited to boarding and nursing expenses)/ICU/ICCU charges.

6. WHAT ARE THE OPTIONAL COVERS AVAILABLE IN THE POLICY?

Following are the optional covers available in the Policy.

OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

This cover can be opted by the Insured Person whose Sum Insured is Rs. 2,00,000 and above.

On payment of additional Premium for each Insured Person, Proportionate deduction as mentioned in Clause 3.1 (g) of Policy Document will be deleted for such members opting for such cover.

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

Premium will be charged for all the Insured persons shall be charged separately.

OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

This cover can be opted by the Insured Person whose Sum Insured is Rs. 5,00,000 and above.

On the payment of additional Premium, Clause 4.4.12 of Policy Document or sub point 4.12 of Q. 10 below, shall be deleted for the members opting for Maternity Cover. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

Special conditions applicable to Maternity Expenses Benefit:

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

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

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

Premium will be charged separately for each Insured Person opting for this cover.

OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

This cover can be opted by the Insured Person whose Sum Insured is Rs. 8,00,000 and above.

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

Sum Insured	Revised Cataract Limit
Rs. 8,00,000	Rs. 80,000
Rs. 10,00,000	Rs. 1,00,000
Rs. 12,00,000	Rs. 1,20,000
Rs. 15,00,000	Rs. 1,50,000

Benefit of this cover will be available after the expiry of thirty-six months from the date of opting this cover. Premium will be charged separately for each Insured Person opting for this cover.

7. 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.

8. 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 of Specified severity
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

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.

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

i. Pre-acceptance test is required for all the members entering after the age of 50 for the first time.

ii. However, the condition (i) shall be relaxed to 60 year's subject to the following conditions:

   a. A minimum of 3 persons should be covered in the policy.
   b. At least one of the members age should be less than 35 Years.

Irrespective of the (i) & (ii) a person 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.

Note: Adverse Medical History means a person:

i. Who has undergone more than one Hospitalization in previous two years,
ii. Who is suffering from Critical Illness, Recurring Illness or Chronic Illness.
iii. Is Suffering from Hypertension / Diabetes.
iv. Is not in good health and free from Physical and mental diseases or infirmity or medical complaints.

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

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.

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 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.

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

4.12 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.

4.13 Naturopathy Treatment.

4.14 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), Sleep Apnoea 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.

4.15 Genetic disorders and stem cell implantation/Surgery.

4.16 Domiciliary Hospitalisation

4.17 Acupressure, acupuncture, magnetic therapies

4.18 Experimental or unproven treatments/therapies

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

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

4.21 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

11. 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.

12. 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.

13. 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 14 below.

14. 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	Stapedotomy	**2**	Excision And Destruction Of A Lingual Tonsil
3	Stapedectomy	**4**	Other Operations On The Tonsils And Adenoids

5	Revision Of A Stapedectomy	**6**	Incision On Bone, Septic And Aseptic
7	Other Operations On The Auditory Ossicles	**8**	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
9	Myringoplasty (Type -I Tympanoplasty)	**10**	Suture And Other Operations On Tendons And Tendon Sheath
11	Tympanoplasty (Closure Of An Eardrum Perforation/Reconstruction Of The Auditory Ossicles)	**12**	Reduction Of Dislocation Under Ga
13	Revision Of A Tympanoplasty	**14**	Arthroscopic Knee Aspiration
15	Other Microsurgical Operations On The Middle Ear	**16**	Incision Of The Breast
17	Myringotomy	**18**	Operations On The Nipple
19	Removal Of A Tympanic Drain	**20**	Incision And Excision Of Tissue In The Perianal Region
21	Incision Of The Mastoid Process And Middle Ear	**22**	Surgical Treatment Of Anal Fistulas
23	Mastoidectomy	**24**	Surgical Treatment Of Haemorrhoids
25	Reconstruction Of The Middle Ear	**26**	Division Of The Anal Sphincter (Sphincterotomy)
27	Other Excisions Of The Middle And Inner Ear	**28**	Other Operations On The Anus
29	Fenestration Of The Inner Ear	**30**	Ultrasound Guided Aspirations
31	Revision Of A Fenestration Of The Inner Ear	**32**	SclerotherapyEtc
33	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	**34**	Incision Of The Ovary
35	Other Operations On The Middle And Inner Ear	**36**	Insufflation Of The Fallopian Tubes
37	Excision And Destruction Of Diseased Tissue Of The Nose	**38**	Other Operations On The Fallopian Tube
39	Operations On The Turbinates (Nasal Concha)	**40**	Dilatation Of The Cervical Canal
41	Other Operations On The Nose	**42**	Conisation Of The Uterine Cervix
43	Nasal Sinus Aspiration	**44**	Other Operations On The Uterine Cervix
45	Incision Of Tear Glands	**46**	Incision Of The Uterus (Hysterotomy)
47	Other Operations On The Tear Ducts	**48**	Therapeutic Curettage
49	Incision Of Diseased Eyelids	**50**	Culdotomy
51	Excision And Destruction Of Diseased Tissue Of The Eyelid	**52**	Incision Of The Vagina
53	Operations On The Canthus And Epicanthus	**54**	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
55	Corrective Surgery For Entropion And Ectropion	**56**	Incision Of The Vulva
57	Corrective Surgery For Blepharoptosis	**58**	Operations On Bartholin'S Glands (Cyst)
59	Removal Of A Foreign Body From The Conjunctiva	**60**	Incision Of The Prostate

61	Removal Of A Foreign Body From The Cornea	**62**	Transurethral Excision And Destruction Of Prostate Tissue
63	Incision Of The Cornea	**64**	Transurethral And Percutaneous Destruction Of Prostate Tissue
65	Operations For Pterygium	**66**	Open Surgical Excision And Destruction Of Prostate Tissue
67	Other Operations On The Cornea	**68**	Radical Prostatovesiculectomy
69	Removal Of A Foreign Body From The Lens Of The Eye	**70**	Other Excision And Destruction Of Prostate Tissue
71	Removal Of A Foreign Body From The Posterior Chamber Of The Eye	**72**	Operations On The Seminal Vesicles
73	Removal Of A Foreign Body From The Orbit And Eyeball	**74**	Incision And Excision Of Periprostatic Tissue
75	Operation Of Cataract	**76**	Other Operations On The Prostate
77	Incision Of A Pilonidal Sinus	**78**	Incision Of The Scrotum And Tunica Vaginalis Testis
79	Other Incisions Of The Skin And Subcutaneous Tissues	**80**	Operation On A Testicular Hydrocele
81	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues	**82**	Excision And Destruction Of Diseased Scrotal Tissue
83	Other Excisions Of The Skin And Subcutaneous Tissues	**84**	Plastic Reconstruction Of The Scrotum And Tunica Vaginalis Testis
85	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues	**86**	Other Operations On The Scrotum And Tunica Vaginalis Testis
87	Free Skin Transplantation, Donor Site	**88**	Incision Of The Testes
89	Free Skin Transplantation, Recipient Site	**90**	Excision And Destruction Of Diseased Tissue Of The Testes
91	Revision Of Skin Plasty	**92**	Unilateral Orchidectomy
93	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues	**94**	Bilateral Orchidectomy
95	Chemosurgery To The Skin	**96**	Orchidopexy
97	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues	**98**	Abdominal Exploration In Cryptorchidism
99	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue	**100**	Surgical Repositioning Of An Abdominal Testis
101	Partial Glossectomy	**102**	Reconstruction Of The Testis
103	Glossectomy	**104**	Implantation, Exchange And Removal Of A Testicular Prosthesis
105	Reconstruction Of The Tongue	**106**	Other Operations On The Testis
107	Other Operations On The Tongue	**108**	Surgical Treatment Of A Varicocele And A Hydrocele Of The Spermatic Cord
109	Incision And Lancing Of A Salivary Gland And A Salivary Duct	**110**	Excision In The Area Of The Epididymis
111	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct	**112**	Epididymectomy

113	Resection Of A Salivary Gland	**114**	Reconstruction Of The Spermatic Cord
115	Reconstruction Of A Salivary Gland And A Salivary Duct	**116**	Reconstruction Of The Ductus Deferens And Epididymis
117	Other Operations On The Salivary Glands And Salivary Ducts	**118**	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
119	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	**120**	Operations On The Foreskin
121	Incision Of The Hard And Soft Palate	**122**	Local Excision And Destruction Of Diseased Tissue Of The Penis
123	Excision And Destruction Of Diseased Hard And Soft Palate	**124**	Amputation Of The Penis
125	Incision, Excision And Destruction In The Mouth	**126**	Plastic Reconstruction Of The Penis
127	Plastic Surgery To The Floor Of The Mouth	**128**	Other Operations On The Penis
129	Palatoplasty	**130**	Cystoscopical Removal Of Stones
131	Other Operations In The Mouth	**132**	Lithotripsy
133	Transoral Incision And Drainage Of A Pharyngeal Abscess	**134**	Coronary Angiography
135	Tonsillectomy Without Adenoidectomy	**136**	Haemodialysis
137	Tonsillectomy With Adenoidectomy	**138**	Radiotherapy For Cancer
139	Parenteral Chemotherapy		

15. 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.

16. 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.

17. 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.

18. 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.

19. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Medical Expenses incurred immediately after, but not exceeding sixty 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.

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

Yes. We will pay Hospitalisation expenses upto a limit, known as **Sum Insured** and **Cumulative Bonus**. 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 and Cumulative Bonus

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.

21. CAN I GET TREATED ANYWHERE?

Yes, but the Policy covers treatment only in India.

22. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured from Rs. 2, 3, 5, 8, 10, 12 and 15 Lakhs. The premium payable is determined on the respective Age of the member for the respective Sum Insured. A discount on the number of members will be applied based on the number of members covered, which is as under:

Discount on number of members	2 members	3 members	4 members & above
	5%	10%	15%

This above discount will be given in the total premium for all the members. For example for a family of 5 and Sum Insured of 10 lakhs the premium calculation will be as under:

Proposer (46 years)	**:**	**Rs. 13,812**
Spouse (42 years)	**:**	**Rs. 7,274**
Child 1 (15 years)	**:**	**Rs. 2,895**
Child 2 (10 years)	**:**	**Rs. 2,895**

Parent (64 years)	**:**	**Rs. 29,092**

Total	**:**	**Rs. 55,968**
Disc (@ 15%)	**:**	**Rs. 8,395**

Gross Premium :		**Rs. 47,573**

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.

A digital discount of 10% is offered to customer taking fresh policy online through Company's Customer online Portal or Customer mobile app, as per directive of the government to promote digital transactions.

23. WHAT IS CUMULATIVE BONUS ?

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

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

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

Note:

a. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person who has not claimed under the expiring policy.
b. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported under the policy.
c. CB shall be available only if the Policy is renewed within the Grace Period.
d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.
e. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies, the same CB of the expiring policy shall be apportioned to each Individual of such Renewed Policies.
f. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.
g. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
h. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

24. 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.

25. 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.

In case of revision including premium or modification or withdrawal of the Policy a notice will be provided to Insured Person, 90 days before such revision or modification or withdrawal.

You can choose to migrate to any of our existing Policy, subject to Regulations of IRDAI (Protection of Policyholders' Interest) Regulations, 2017 and the Guidelines of IRDAI on Portability of Health Insurance Policies, as amended from time to time.

26. 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.

27. 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.

28. 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.

Enhancement of Sum Insured shall be allowed based on the following table:

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

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.

29. 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.

Children between 18 years to 25 years can be continue to be covered in the Policy provided they are financially dependent on the parents and one or both parents are covered simultaneously. On attaining the age of 18 years or ceasing to be financially dependent on the parents, they can, on renewal take a separate Policy. In such an event the benefits on Continuous Coverage can be ported to the new Policy. The upper age limit will not apply to a mentally challenged children and an unmarried dependent daughter(s).

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**.**

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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:

i. Claim Form duly filled and signed by the claimant.
ii. Discharge Certificate from the hospital.

iii. All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history.

iv. Bills, Receipts, Cash Memos from hospital supported by proper prescription.

v. Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.

vi. Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt.

vii. Attending doctor's / consultant's / specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis.

viii. Details of previous policies, if the details are not already with TPA or any other information needed by the TPA for considering the claim.

36. 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.

37. 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.

38. 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.

39. 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:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to one month	1/4th of the annual rate

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

The policy shall be null and void, and no benefits shall be payable in case of Fraud, misrepresentation, misdescription or nondisclosure of any material fact / particular. Premium paid shall also stand forfeited.

We may also at any time cancel the Policy on 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, we shall allow refund of premium, if no claim has been made or paid under the Policy, at short period rate which is tabulated above.

40. 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.

41. 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 taxableincome as per Section 80 D of the Income Tax Act, 1961. For details, please refer to the relevant Section of the Income Tax Act.

42. 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.**

43. 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 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.

44. WHAT IS A PPN? CAN I GO FOR REIMBURSEMENT IN A PPN?

Preferred provider network (PPN) means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time.

Yes, your claim will be admissible but Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.