THE NEW INDIA ASSURANCE CO. LTD

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

SENIOR CITIZEN MEDICLAIM POLICY

PROSPECTUS

Salient features of the Policy

1.0 COVERAGE: The Policy covers reimbursement of Hospitalisation Expenses for Illness/ Injury sustained.

2.0 SCOPE OF COVER: HOSPITALISATION EXPENSES

In the event of a claim becoming admissible, the Company will pay the expenses listed below that are Reasonable and Customary, and Medically Necessary incurred by or on behalf of such Insured Person but not exceeding, in aggregate, the Sum Insured mentioned in the Schedule.

2.1.0

Hospitalisation Benefits		Limits
A	(i) Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) (ii) Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses	Up to 1% of Sum Insured per day Up to 2% of Sum Insured per day Overall limit: 25% of the Sum Insured.
B	Professional fees of Surgeon, Anaesthetist, Consultant, Specialist;	Overall limit 25% of Sum Insured
C	Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment. Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics	Overall limit 50% of Sum Insured

2.1.1 Claims in respect of the following Illness / Surgery, will be subject to the following limits:

Name of Illness/Operation	**Maximum Charges Inclusive of Room/ICU/OT Charges/ Surgeons, Anesthetist, doctors' fees, medicines, internal appliances and other charges incurred during hospitalization period**
Cataract with imported foldable lens	10000/-
Hysterectomy	22000/-
Appendicectomy	16000/-
Cholecystectomy	18000/-

Prostate	18000/-
Hemia-Inguinal	16000/-
Hernia- Ventral/Incisional	20000/-
Septoplasty	9000/-
Haemarrhoidcctomy	8000/-
Fissurectomy	9000/-
Fistulectomy	10000/-
Angiography	12000/-
Tonsillectomy	7000/-
Tympanoplasty	13000/-
Kidney stone/lithotripsy	13000/-
Arthoscopy	10000/-
PID-Disectomy	31000/-
Mastectomy(Radical)	36000/-
Exploratory Laprotomy	18000/-

2.2 Actual Pre-Hospitalisation Medical Expenses of up to 30 days, subject to maximum 5% of hospital bill.

2.3 Actual Post-Hospitalisation Medical Expenses of up to 60 days, subject to maximum of 10% of hospital bill.

2.4 **COVERAGE UNDER AYUSH TREATMENT:**Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule.

2.5 Ambulance charges, subject to a maximum of Rs.1000/-

2.6 Hospitalisation Expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the Insured. The Company's liability towards expenses incurred on the donor and the Insured recipient together shall not exceed the sum insured of the latter.

2.7 **SPECIFIC COVERAGES**:

a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 7,500 per policy period subject to it arising during treatment of covered illness.

b) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

c) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders** The Company shall indemnify the Hospital or the Insured the Medical Expenses

related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured per policy period.

The below covers are subject to the patient exhibiting any of the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions- aggressive/violent behavior or hallucinations, incoherent talking or agitation.
3. Schizophrenia- esp. Psychotic episodes.
4. Bipolar disorder- manic phase.

Treatment of any Injury due to exhibiting Suicidality shall not be covered.

Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

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

d) Puberty and Menopause related Disorders: Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 18 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

e) Age Related Macular Degeneration (ARMD) is covered after 48 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 15,000 per policy period.

f) Behavioural and Neuro developmental Disorders: *Disorders of adult personality and Disorders of speech and language including stammering, dyslexia;* are covered as Inpatient procedure after 18 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.

g) Genetic diseases or disorders are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

Note: For the coverages defined in 2.7, waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f 1st October 2020. Coverage for such illness or procedures shall only be available after completion of the said waiting periods.

2.8 COVERAGE FOR MODERN TREATMENTS or PROCEDURES: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
2.8.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 10% of Sum Insured
2.8.2	Balloon Sinuplasty	Up to 10% of Sum Insured
2.8.3	Deep Brain stimulation	Up to 10% of Sum Insured
2.8.4	Oral chemotherapy	Up to 10% of Sum Insured
2.8.5	Immunotherapy- Monoclonal Antibody to be given as injection	Up to 10% of Sum Insured
2.8.6	Intravitreal injections	Up to 10% of Sum Insured
2.8.7	Robotic surgeries	Up to 10% of Sum Insured
2.8.8	Stereotactic radio surgeries	Up to 10% of Sum Insured
2.8.9	Bronchial Thermoplasty	Up to 10% of Sum Insured
2.8.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Up to 10% of Sum Insured
2.8.11	IONM - (Intra Operative Neuro Monitoring)	Up to 10% of Sum Insured
2.8.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	Up to 10% of Sum Insured

2.9 TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies shall be covered after **Eighteen** months of Continuous Coverage.

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.**

3.0 DEFINITIONS:

3.1 ACCIDENT: An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

3.3 ANY ONE ILLNESS means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

3.4 ASSOCIATE MEDICAL EXPENSES means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

3.5 AYUSH TREATMENT refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3.6 AYUSH HOSPITAL is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7 AYUSH DAY CARE CENTRE means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.8 BREAK IN POLICY means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

3.9 CANCELLATION: Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days.

3.10 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

3.11 CONDITION PRECEDENT: Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

3.12 CONGENITAL ANOMALY: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

3.12.1 **CONGENITAL INTERNAL ANOMALY** means a Congenital Anomaly which is not in the visible and accessible parts of the body.

3.12.2 **CONGENITAL EXTERNAL ANOMALY** means a Congenital Anomaly which is in the visible and accessible parts of the body.

3.13 CO-PAYMENT: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder / insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

3.14 DAY CARE TREATMENT: Day Care treatment refers to medical treatment, and/or surgical procedure which are:

- Undertaken under General or Local Anesthesia in a Hospital / Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a Hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.15 DEDUCTIBLE: A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

3.16 DENTAL TREATMENT: Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

3.17 DISCLOSURE TO INFORMATION NORM: The policy shall be void and all premium paid thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

3.18 DOMICILIARY HOSPITALIZATION: Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- The patient takes treatment at home on account of non-availability of room in a hospital.

3.19 HOSPITAL: A hospital means any institution established for Inpatient Care and Day Care Treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

3.20 HOSPITALISATION means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours. The time limit of 24 hours will not be applicable for following surgeries / procedures.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

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.

3.21 Day Care Centre: A day care centre means any institution established for day care treatment of Illness and/or Injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

1) has qualified nursing staff under its employment;
2) has qualified medical practitioner/s in charge;
3) Has a fully equipped operation theatre of its own where surgical procedures are carried out;

Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

3.22 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in network hospitals.

3.23 ILLNESS: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
   a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
   b. it needs ongoing or long-term control or relief of symptoms
   c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
   d. it continues indefinitely
   e. it recurs or is likely to recur

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

3.25 INPATIENT CARE: Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.26 INSURED PERSON means You and each of the others who are covered under this Policy as shown in the Schedule.

3.27 INTENSIVE CARE UNIT (ICU) means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.28 ICU (INTENSIVE CARE UNIT) CHARGES means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

3.30 MEDICAL EXPENSES: Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.31 MEDICALLY NECESSARY TREATMENT means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a medical practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32 MEDICAL PRACTITIONER: A Medical Practitioner is a person who holds a valid registration from the medical council of any state or Medical council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a state Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the insured or close family members.

3.33 NETWORK HOSPITAL means Hospitals enlisted by Us, TPA or jointly by Us and TPA to provide medical services to an insured by a cashless facility.

3.34 NON-NETWORK HOSPITAL means any Hospital, Day Care centre or other provider that is not part of the Network.

3.35 NOTIFICATION OF CLAIM means the process of intimating a claim to Us or TPA through any of the recognized modes of communication.

3.36 OPD TREATMENT: OPD treatment is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

3.37 PERIOD OF INSURANCE means the period for which this Policy is taken as specified in the Schedule.

3.38 PRE-EXISTING DISEASE (PED) means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

3.39 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

3.40 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

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

3.41 POLICY means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

3.42 POLICY PERIOD means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.43 POLICY SCHEDULE means the Policy Schedule attached to and forming part of Policy.

3.44 POLICY YEAR means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule

3.45 PORTABILITY: Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

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

3.47 REASONABLE AND CUSTOMARY CHARGES mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

3.48 RENEWAL: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

3.49 ROOM RENT: Room Rent means the amount charged by a Hospital for the occupancy of a bed per day (twenty four hours) basis and shall include associated medical expenses.

3.50 SUB-LIMIT means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit

3.51 SUM INSURED is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

Note: Sum Insured means Predefined Limit as shown in the schedule excluding Cumulative Bonus / Buffer.

3.52 SURGERY: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

3.53 TPA means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

3.54 UNPROVEN/EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

3.55 WAITING PERIOD means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

3.56 WE/OUR/US/COMPANY means **The New India Assurance Co. Ltd.**

3.57 YOU/YOUR means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one) in the Schedule.

4.0 EXCLUSIONS: The Company shall not be liable to make any payment under this policy in respect of:

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 18 months of continuous coverage after the date of inception of the first policy with us.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 18 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

Pre-existing conditions of Diabetes mellitus and Hypertension are covered from inception of the policy but on payment of additional premium.

4.2 SPECIFIC WAITING PERIOD (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries / treatments shall be excluded until the expiry of Ninety Days / 18 / 48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent

of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

(i) 90 Days Waiting Period

1. Cardiac Conditions

(ii) 18 Months waiting period

1. All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps
2. Benign Ear, Nose, Throat disorders
3. Benign Prostate Hypertrophy
4. Cataract & age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout & Rheumatism
7. Hernia of all types
8. Hydrocele
9. Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of uterus
10. Non Infective Arthritis
11. Piles, Fissure and Fistula in Anus
12. Pilonidal Sinus, Sinusitis and related disorders
13. Prolapse Inter Vertebral Disc unless arising from accident
14. Skin disorders
15. Stone in Gall Bladder & Bile duct
16. Stones in Urinary Systems
17. Congenital internal disease/defects
18. Varicose Veins and Varicose Ulcers
19. Puberty and Menopause related Disorders
20. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia

(iii) 48 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders
6. External Congenital Diseases

4.3 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4 EXCLUSIONS

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

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

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

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

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

4.4.2 REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

4.4.3 OBESITY/ WEIGHT CONTROL (Code- Excl06) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4.4.4 CHANGE-OF-GENDER TREATMENTS (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4.5 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.4.6 HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

4.4.7 BREACH OF LAW (Code- Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.4.8 EXCLUDED PROVIDERS (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.4.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.4.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

4.4.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

4.4.12 REFRACTIVE ERROR (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.4.16 Any expenses incurred on Domiciliary Hospitalization.

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

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

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

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

4.4.20 Circumcision unless necessary for treatment of an Illness not excluded hereunder or

as may be necessitated due to an accident.

4.4.21 Convalescence, General debility, Dementia, Alzheimer's disease and Venereal disease.

4.4.22 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.

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

4.4.24 Instruments used in treatment of Sleep Apnoea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.25 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.4.26 Stem cell implantation/Surgery for other than those treatments mentioned in clause 2.8.12

4.4.27 Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy

4.4.28 Treatment taken outside the geographical limits of India

4.4.29 Vaccination and/or inoculation

4.4.30 War (whether declared or not) and war like occurrence or invasion, acts of foreign

enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

5.0 CONDITIONS:

5.1 CONTRACT: The proposal form, declaration, Pre acceptance Health check-up and the policy issued shall constitute the complete contract of insurance.

5.2 COMMUNICATION*:* Every notice or communication to be given or made under this Policy other than that relating to the claim shall be delivered in writing at the address of the policy issuing office as shown in the schedule. The claim shall be reported to the TPA appointed for providing claim services as per the procedure mentioned in the guidelines circulated by the TPA to the policyholders. In case TPA services are not availed then claim shall be reported to the policy issuing office only.

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

5.4 PHYSICAL EXAMINATION: Any Medical Practitioner authorized by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged disease/illness/injury requiring Hospitalization. Non co-operation by the Insured Person will result into rejection of his/her claim.

5.5 FRAUD, MISREPRESENTATION, CONCEALMENT: The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.

5.6 <u>MULTIPLE POLICIES:</u>

1. In case of multiple policies taken by You during a period from Us or one or more Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of his/her policies. In all such cases We, if chosen by You, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
2. Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then We shall independently settle the claim subject to the terms and conditions of this Policy.
3. If the amount to be claimed exceeds the Sum Insured under a single policy after, You

shall have the right to choose Insurers from whom You wants to claim the balance amount.

4. Where an Insured has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Note: The insured Person must disclose such other insurance at the time of making a claim under this Policy.

This condition shall not apply for Health Check-up Benefit.

5.7 CANCELLATION CLAUSE: The Company may at any time cancel this Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending the Insured 30 days' notice by registered letter at the Insured's last known address and in such event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. The Company shall however, remain liable for any claim, which arose prior to the date of cancellation. The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period scale of rate only (table given here below) provided no claim has occurred up to the date of cancellation.

Period On Risk	Rate Of Premium To Be Charged
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

5.8 FREE LOOK PERIOD:

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

The insured will be allowed a period of at least 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 the insured has not made any claim during the free look period, the insured shall be entitled to:

1) A refund of the premium paid less any expenses incurred by the insurer 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 or;
3) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

5.9 DISCLAIMER OF CLAIM: If the TPA / Company shall disclaim liability to the Insured for any claim hereunder and if the insured shall not, within 12 calendar months from the date or receipt of the notice of such disclaimer, notify the TPA / Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.10 All medical/surgical treatment under this policy shall have to be taken in India.

5.11 CUMULATIVE BONUS:

The Sum Insured under Policy shall be increased by 5% at each renewal in respect of each claim free year of insurance, subject to maximum of 30%. 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 shall also be reduced in proportion to the 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.

5.12 PORTABILITY AND MIGRATION:

Migration:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then You will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

Portability:

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an India General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

6.1 AGE LIMIT:

This Insurance is available to persons between the ages of 60 years to 80 years. Insured may renew his Policy beyond the age of 80 years provided there is no break in Insurance.

6.2 PRE-ACCEPTANCE HEALTH CHECK-UP:

Every Person has to undergo pre-acceptance health check-up. In case the proposal is accepted by the company then 50% of the cost of this health check-up will be borne by the company.

6.3 PAYMENT OF PREMIUM

Excluding GST/-

Sum Insured	60-65	66-70	71-75	76-80	81-85	86 and above
100000	4043	4463	4935	5408	5948	6489
150000	6006	6626	7329	8033	8836	9639

Note: Additional Premium to cover Pre-existing Diabetes and Hypertension from the inception of policy - 10% of basic premium for each condition.

6.4 DISCOUNTS:

- 10% for voluntary excess of Rs. 10,000/-
- 10% Family Discount in case spouse is also covered.

6.5 RENEWAL OF POLICY:

The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to deficiency of service.

The Company shall renew this Policy if the Insured shall remit the requisite Premium to the Company prior to expiry of the Period of Insurance stated in the Schedule.

The Company shall be entitled to decline renewal if:

1. Any fraud, moral hazard/misrepresentation or suppression by the Insured or any one acting on your behalf is found either in obtaining insurance or subsequently in relation thereto, or non-cooperation of the Insured Person, or
2. The Company has discontinued issue of the Policy, in which event the Insured shall however have the option for renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy, or
3. The Insured fails to remit Premium for renewal before expiry of the Period of Insurance. The Company may accept renewal of the Policy if it is effected within thirty days of the expiry of the Period of Insurance. On such acceptance of renewal, the Company, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.

In the event of claim free policy Cumulative Bonus (CB) will be applicable on renewal as under:

Expiring Policy Status	Cumulative Bonus (CB) Allowed
Policy with CB	5% increase in CB Maximum 30%
Policy without CB	5%

7.0 COMPANY'S LIABILITY:

The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the of sum insured and subject to Co Payment clause.

8.0 CO PAYMENT:

In all the claims Company's liability will be:

a) **Sum Insured, or**
b) **90% of the admissible claim amount.**

Whichever is less.

9.0 COST OF HEALTH CHECK UP

The Insured shall be entitled for reimbursement of cost of health check-up undertaken once at the expiry of a block of every four continuous claim free years of Company's Policy. The reimbursement shall not exceed 1% of average sum insured, excluding cumulative bonus, for preceding four years.

IMPORTANT

Both Health checkup and Cumulative Bonus provisions are applicable only in respect of continuous insurance without break. In exceptional circumstances, the break beyond 30 days could be condoned by the Company subject to medical examination and exclusion of Illness/Injury originating or suffered during the break in the period of cover.

10.0 PROTECTION OF POLICY HOLDERS' INTEREST: This policy is subject to IRDAI (Protection of Policyholders' Interests) Regulation, 2017.

11.0 NOTICE OF CLAIM:

Preliminary notice of claim with particulars relating to Policy Number, name of insured person in respect of whom claim is to be made, nature of illness/injury and Name and Address of the attending Medical Practitioner/Hospital/Nursing Home should be given to the TPA within 10 days from the date of hospitalization in respect of reimbursement of claims.

Final claim along with hospital receipted original Bills/Cash memos**, claim form and list of documents as listed below etc. should be submitted** to the Policy issuing Office/TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company/TPA such additional information and assistance as the Company/TPA may require in dealing with the claim.

i. Bill, Receipt and Discharge certificate / card from the Hospital.
ii. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
iii. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological
iv. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
v. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
vi. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Waiver: Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the Company/TPA that under the circumstances in which the insured was placed it was not possible for him or any other person to give such

notice or file claim within the prescribed time limit. This waiver cannot be claimed as a matter of right.

12.0 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICE

Claims in respect of Cashless facility will be through the agreed list of Network Hospital / Nursing Home/Day Care Centre and is subject to pre-admission authorization. The TPA shall, upon getting the related medical information from the insured person /network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital /Nursing Home/Day Care Centre mentioning the sum guaranteed as payable and also the ailment for which the person is seeking to be admitted as a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless facility is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his /her treating doctor's advice and later on submits the full claim papers to the TPA for reimbursement.

13.0 REPUDIATION OF CLAIMS

A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by the Company for settlement and denial of the claims by the appropriate authority.

With Our prior approval Communication of repudiation shall be sent to You, explicitly mentioning the grounds for repudiation, through Our TPA.

14.0 PAYMENT OF CLAIM

The insurer shall settle the claim, including rejection, within thirty days of the receipt of the last necessary document.

On receipt of the duly completed documents either from the insured or hospital the claim shall be processed as per the conditions of the policy. Upon acceptance of claim by the insured for settlement, the insurer or their representative (TPA) shall transfer the funds within seven working days. In case of any extra ordinary delay, such claims shall be paid by the insurer or their representative (TPA) with a penal interest at a rate which is 2% above the bank rate at the beginning of the financial year in which the claim is reviewed.

All admissible claims shall be payable in Indian Currency only.

15.0 ARBITRATION: If the Company admits liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration.

The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

No reference to Arbitration shall be made unless the Company has Admitted liability for a claim in writing.

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

16.0 MORATORIUM PERIOD: After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

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

18.0 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 http://newindia.co.in/public.asp. 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

19.0 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.

20.0 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.

21.0 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.

22.0 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.

23.0 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.**

24.0 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, 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

25.0 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 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.