JANATA MEDICLAIM POLICY

PROSPECTUS

Salient features of the Policy

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

2.0 Cost of treatment taken in General Ward of the Hospital / Day-Care Centre per day maximum charges Rs. 450/-.

2.1 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.

2.2 Associate 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.

2.3 Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

2.4 Pre-Hospitalisation medical Expenses up to 30 days.

2.5 Post-Hospitalisation medical Expenses up to 60 days, subject to maximum of 10% of hospital bill.

2.6 **ABHA** stands for **AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA),** a number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers.

2.7 **AYUSH:** 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.

2.8 Ambulances services – actual expenses for transportation of patient (insured) or Rs 1000/- whichever is less in case patient has to be shifted from residence to Hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

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

2.10 The total amount payable under this policy during the period of insurance will in no case exceed the Sum Insured and will be subject to the limits shown in the following schedule or actual whichever is less.

2.11 **DOMICILIARY HOSPITALISATION BENEFIT** means Medical treatment for a period exceeding three days for such illness/disease/injury which in the normal course would require care and treatment at a hospital / nursing home but actually taken whilst confined at home in India

under any of the following circumstances namely.

i) The condition of the patient is such that he / she cannot be removed to the hospital/nursing home or

ii) The patient cannot be removed to hospital/nursing home for lack of accommodation therein

Subject however that domiciliary hospitalisation benefits shall not cover :-

i) expenses incurred for pre and post hospital treatment and

ii) expenses incurred for treatment for any of the following diseases

1. Asthma
2. Bronchitis
3. Chronic Nephritis and Nephritic Syndrome
4. Diarrhoea and all types of Dysenteries including Gastro-enteritis
5. Diabetes Mellitus and Insipidus
6. Epilepsy
7. Hypertension
8. Influenza, Cough and Cold
9. All Psychiatric or Psychosomatic Disorders
10. Pyrexia of unknown Origin for less than 10 days
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharingitis
12. Arthritis, Gout and Rheumatism

Note: When treatment such as Dialysis, Chemotherapy, Radiotherapy etc. is taken in the Hospital/Nursing Home and the Insured is discharged on the same day, the treatment will be considered to be taken under Hospitalisation Benefit section.

2.12 OPD TREATMENT MEANS the 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.

2.13 HOME CARE TREATMENT means treatment availed by the Insured Person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

i. The Medical Practitioner advices the Insured Person in writing to undergo treatment at home

ii. There is continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment

iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

iv. Treatment taken at home in case of stroke, spine and/or lower limb accidental injuries only.

2.14 SCHEDULE OF PAYMENT FOR SPECIFIED DISEAES

(Amount in Rupees)

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	10800/-
Hysterectomy	22500/-
Appendicectomy	16200/-
Cheolecystectomy	18000/-
TURP	18000/-
Hemia-Inguinal	16200/-
Hernia- Ventral/Incisional	19800/-
Septoplasty	9000/-
Haemorrhoidectomy	8100/-
Fissurectomy	9000/-
Fistulectomy	10800/-
Angiography	12000/-
Angioplasty (imported stent single)	Actual or Sum Insured whichever is less
CABG	Actual or Sum Insured whichever is less
Total Knee replacement	Actual or Sum Insured whichever is less
Total hip replacement	Actual or Sum Insured whichever is less
Tonsillectomy	7200/-
Tympanoplasty	13500/-
Kidney stone/lithotripsy	13500/-
Arthroscopy	10800/-
PID-Disectomy	31500/-
Mastectomy (Radical)	36000/-
Exploratory Laprotomy	13500/- to 27000/-
Home care Treatment	10% of Sum Insured over and above the post hospitalization charges for treatment arising out of stroke, spine and/or lower limb accidental injuries
Domiciliary Treatment	15% of Sum Insured
OPD	Rs. 250 and Rs. 375 for a Sum insured of Rs. 50000 and 75000 respectively as follow up charges over and above the pre and post hospitalization charges. This limit is applicable for once in a policy period.

PER DAY CHARGES	
Room Rent (inclusive of nursing / treatment charges)	450/-
Minor Surgery (as defined) / Day care Room Rent per day	450/-
Operation Theatre Charges	1260/-
Anesthesia	630/-
Anesthetist Fees	945/-
Surgeon fees	3150/-
INTERMEDIATE SURGERY	
Room Rent	450/-
Operation Theatre Charges	1764/-
Anesthesia	882/-
Anesthetist Fees	1323/-
Surgeon fees	4410/-
MAJOR SURGERY	
Room Rent	450/-
Operation Theatre Charges	2520/-
Anesthesia	1260/-
Anesthetist Fees	1890/-
Surgeon fees	6300/-
SUPRA MAJOR SURGERY	
Room Rent	450/-
Operation Theatre Charges	5040/-
Anesthesia	2520/-
Anesthetist Fees	3780/-
Surgeon fees	12600/-
ICU Charges (per day with all intensive care infrastructure & facilities)	1800/-
Ventilator Charges (Per day)	450/-
Visit Charges (Per day irrespective of number of visits)	360/-

2.0 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. 25,000 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: Our shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 36 months with a sub-limit up to 25% of Sum Insured.

The below covers are subject to the patient simultaneously exhibiting 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 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 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured.

e) Age Related Macular Degeneration (ARMD) is covered after 36 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. 75,000 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 24 months of continuous coverage. This cover will have a sub- limit of 25% of Sum Insured.

g) Genetic diseases or disorders are covered with a sub-limit of 25% of Sum Insured per policy period with 36 months waiting periods.

2.1 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)
2.12.1	Uterine Artery Embolization and HIFU (High intensity focusedultrasound)	Upto 10% of Sum Insured
2.12.2	Balloon Sinuplasty.	Upto 10% of Sum Insured
2.12.3	Deep Brain stimulation.	Upto 10% of Sum Insured
2.12.4	Oral chemotherapy.	Upto 10% of Sum Insured
2.12.5	Immunotherapy- Monoclonal Antibody to be given asinjection.	Upto 10% of Sum Insured
2.12.6	Intravitreal injections.	Upto 10% of Sum Insured

2.12.7	Robotic surgeries.	Upto 10% of Sum Insured
2.12.8	Stereotactic radio surgeries.	Upto 10% of Sum Insured
2.12.9	Bronchial Thermoplasty.	Upto 10% of Sum Insured
2.12.10	Vaporisation of the prostrate (Green laser treatment orholmium laser treatment).	Upto 10% of Sum Insured
2.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured
2.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrowtransplant for haematological conditions to be covered.	Upto 10% of Sum Insured

ii. 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 / 24 / 36 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 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. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

1. Any Skin disorders
2. All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps
3. Benign Ear, Nose, Throat disorders
4. Benign Prostate Hypertrophy
5. Cataract & age-related eye ailments
6. Gastric/ Duodenal Ulcer
7. Gout & Rheumatism
8. Hernia of all types
9. Hydrocele
10. Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of

uterus

11. Non-Infective Arthritis
12. Piles, Fissure and Fistula in Anus
13. Pilonidal Sinus, Sinusitis and related disorders
14. Prolapse Inter Vertebral Disc unless arising from Accident
15. Stone in Gall Bladder & Bile duct
16. Stones in Urinary Systems
17. Unknown Congenital Internal Anomaly
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) 36 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

iii. 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.

PERMANENT EXCLUSIONS:

A. 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 up to 10% of Sum Insured per policy period.

B. 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.

C. 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

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

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

J. 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)**

K. 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)**

L. REFRACTIVE ERROR (Code- Excl15)

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

M. 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.

N. 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

O. 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.

P. 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.

Q. 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.

R. Circumcision unless required to treat Injury or Illness.

S. Vaccination & Inoculation.

T. 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.

U. All types of Dental treatments except arising out of an Accident.

V. Convalescence, general debility.

W. Bodily injury or sickness due to wilful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, suicide or attempt thereat.

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.

X. Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act.

Y. Instrument 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.

AA. Stem cell implantation / surgery for other than those treatments mentioned in clause 2.12.12.

BB. Domiciliary treatment.

CC. Treatment – taken outside India.

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

EE. Service charges or any other charges levied by hospital, except registration/admission charges.

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

4.1 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

4.2 CAN I CANCEL THE POLICY?

Yes. You may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period at pro rata basis, subject to minimum charges of Rs.

The insurer shall refund-

a. refunds proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non- disclosure of material facts or fraud

In the event of death of insured in the middle of policy year/during the course of policy period, the premium for the unexpired policy period shall be refunded proportionately.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

4.3 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.

4.4 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.

4.5 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.

4.6 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.

4.7 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.

4.8 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

4.9 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.

4.10 CAN I GET TREATED ANYWHERE?

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

4.11 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.

You also have an option of opting for discount in premium at the time of renewal in lieu of the accrued Cumulative Bonus. In case for opting for discount as above the accrued Cumulative Bonus will become zero. The discount table is as follows:

Cumulative Bonus (% of Sum Insured)	Discount (% of Base Premium)
5	0.65
10	1.2
15	1.7
20	2.2
25	2.6

30	2.95

4.12 COST OF HEALTH CHECK UP: In addition to cumulative bonus the Insured shall be entitled for reimbursement of cost of medical checkup once at the end of a block of every four consecutive underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average sum Insured under the policies excluding Cumulative Bonus. This benefit will be allowed only when the insurance has been continued with our company for 4 claim free years.

IMPORTANT:

Both Health Check-up 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 disease/ sickness/injury originating or suffered during the break in the period of cover.

4.13 AGE LIMIT:

This Insurance is available to persons between the ages of 18 years to 60 years. Children between ages of 3 months to 18 years can be covered only if the parents are also covered under the policy. Insured may renew his Policy beyond the age of 60 years provided there is no break in Insurance.

4.14 FAMILY:

A family comprising the Insured and any one or more of the following can take this Policy:

i. Spouse

ii. Dependent Children

iii. Dependent Parents

4.15 PAYMENT OF PREMIUM (Excluding GST)

SI	3m-5Y	6-35 Y	36-40 Y	41-45 Y	46-50 Y	51-55 Y	56-60 Y	61-65 Y	66-70 Y
50000	867	809	924	1271	1617	1791	2079	2368	2657
75000	1299	1213	1386	1906	2426	2715	3119	3523	3985

Note: Pre-existing conditions i.e. Diabetes and Hypertension have to be compulsorily covered by payment of additional premium at the rate of 20% of basic premium for each pre-existing condition. This additional premium will be payable at every subsequent renewal.

4.16 WHAT IS FREE LOOK PERIOD?

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies of less than a year, renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

If the insured has not made any claim during the Free Look Period, the insured shall be

entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

4.17 PORTABILITY AND MIGRATION:

Migration: means, a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

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 can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy

Portability: means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

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 policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy