THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

NEW INDIA SIXTY PLUS MEDICLAIM POLICY

PROSPECTUS

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

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

1. WHO CAN TAKE THIS POLICY?

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

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

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

2. WHAT DOES THE POLICY COVER?

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

3. WHAT IS A PRE EXISTING DISEASE?

The term Pre-existing condition/disease is defined in the Policy. It means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the Policy or its reinstatement.

4. WHAT IS ABHA NUMBER?

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.

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

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

The cost of this check-up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this check-up will be reimbursed to the proposer.

Note: Adverse Medical History means a person:

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

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

c) Is Suffering from Hypertension / Diabetes.

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

Medical Tests Required:

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

6. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

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

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

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

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

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

9. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of Hospitalization are payable subject to the terms and conditions mentioned in section 3 of the Policy Clauses. Relevant medical expenses mean expenses related to the treatment of the disease for which the insured is Hospitalized.

10. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

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

11. CAN I GET TREATED ANYWHERE?

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

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

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

a) for all cases of Hospitalization,

b) expenses paid for medical expenses prior to Hospitalization,

c) expenses paid for medical expenses after discharge from hospital, and

d) any other payment made under the Policy shall not exceed the Sum Insured and Cumulative Bonus Buffer as mentioned in the Schedule.

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

Yes. Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system of medicines is covered up to 100% of the Sum Insured during each policy year as specified in the policy schedule.

14. WHAT SUM INSURED SHOULD I CHOOSE?

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

15. HOW LONG IS THE POLICY VALID?

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

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

Yes. You can, and to get all Continuity benefits under the Policy, you should renew the Policy before the expiry of the present policy. For instance, if Your Policy commences from 29th January, 2017 date of expiry is usually on 28th January, 2018. You should renew Your Policy by paying the Renewal Premium on or before 28th January 2018.

17. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, Cataract is covered only after twenty-four months of continuous insurance. If an Insured took a Policy in October, 2015, does not renew it on time and takes a Policy only in December 2016, and renewed it on time in December 2017, any claim for Cataract would not become payable, because the Insured person was not continuously covered for twenty-four months. If, he had renewed the Policy in time in October 2016 and then in October 2017, then he would have been continuously covered for twenty-four months and therefore his claim for Cataract in the Policy beginning from October 2017 would be payable. Therefore, You should always ensure that you pay Your renewal Premium before Your Policy expires.

18. WHAT IS CUMULATIVE BONUS BUFFER?

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

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

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

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

Yes, You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum Insured, We have the right to have You examined by a Medical Practitioner authorized by Us or the TPA. Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner and subject to limits as stated below:

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

Enhancement of Sum Insured will not be considered for:

1) If You are over 70 years of age.

2) If You who had undergone more than one Hospitalization in the preceding two years.

3) If You are suffering from one or more of the following Illnesses/Conditions:

a) Any chronic Illness

b) Any recurring Illness

c) Any Critical Illness

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

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

No. Your Policy can be renewed, as long as You pay the Renewal Premium before the date of expiry of the Policy. The entry age for taking a fresh Policy is 60-80 years, but there is no age limit for renewal. However, if You do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to Our underwriting rules.

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

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation or suppression or non-cooperation being committed by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If We discontinue selling this Policy or withdraw this product, it might not be possible to renew this Policy on the same terms and conditions. In such a case You shall however have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

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

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

23. WHAT IF THE COMPANY HAS WITHDRAWN THE POLICY?

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

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

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

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

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

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

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. However, claims for Hospitalization due to accidents occurring during the first thirty days are payable. There are certain treatments where the waiting period is two years or four years. Please see Conditions 4.3.1, 4.3.2 and 4.4.7 of the Policy.

26. 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.

27. 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.

28. 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.

29. HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR

DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfills the conditions of definition of Hospital in the Policy. Within twenty-four hours of Hospitalization the TPA should be intimated. The following documents in original should be submitted to the TPA within seven days from the date of Discharge from the Hospital:

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

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

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

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

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

32. HOW MUCH WE WILL REIMBURSE?

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

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

Section	Hospitalisation Benefit	Limits
3.1.1	Room charges subject to 1% of sum insured per day and Intensive care unit (ICU) charges subject to 2% of sum insured per day (including nursing care, RMO charges, IV fluids/blood transfusion / injection	Maximum limit under Section 3.1.1 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury Please Note that basic Sum Insured will only be considered for reckoning of Per day room

	administration charges).	rent eligibility.
3.1.2	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	Maximum limit under Section 3.1.2 will be 25% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury
3.1.3	Anesthesia, Blood, Oxygen, OT charges, Surgical appliances (any disposable surgical consumables), Medicines, drugs, Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, Artificial limbs and implants other than Orthopedic.	Maximum limit under Section 3.1.3 will be 50% of the aggregate of Sum Insured and Cumulative Bonus Buffer per illness / injury

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

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

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

OPTIONAL COVER: VOLUNTARY CO-PAY

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

CO-PAYMENT:

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

a) Sum Insured and Cumulative Bonus Buffer (or)

b) 90% of the admissible claim amount Whichever is less.

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

a) Sum Insured and Cumulative Bonus Buffer (or)

b) 80% of the admissible claim amount Whichever is less.

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

HOSPITAL CASH:

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

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

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.

LIMIT ON PAYMENT FOR CATARACT:

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

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

WHAT ABOUT OTHER TREATMENTS?

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

PAYMENT OF AMBULANCE CHARGES:

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

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

PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL

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

MEDICAL EXPENSES FOR ORGAN TRANSPLANT:

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

MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:

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

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** The Company shall indemnify the Hospital or the Insured the Medical 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 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 24 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 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. 50,000 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 per policy period.

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

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)
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to a Maximum upto Rs. 1 Lakh
2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to a Maximum upto Rs. 1 Lakh
3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to a maximum upto Rs. 2.5 Lakh
4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 50,000.
5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to a Maximum of Rs 1 Lakh.
6	Intravitreal injections.	Upto 10% of Sum Insured subject to a Maximum of Rs.50,000.
7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject

		to Maximum of Rs. 50,000.
12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.

33. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at https://www.newindia.co.in/portal/#/readMore/Grievances. You may also call our Call Centre at the Toll free number 1800-209-1415, which is available 24x7.

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

34. 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. refund 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.

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

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

36. PORTABILITY:

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

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

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

38. WHAT ARE EXCLUDED UNDER THIS POLICY

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

A. 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 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

B. 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/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. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

(ii) 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele
9. Non Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Skin Disorders
14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Renal Failure
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
    21. Internal Congenital Diseases

(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. Congenital External Diseases

C. 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.

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:

D. 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.

E. 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.

F. 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

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

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

M. 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)**

N. 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)**

O. REFRACTIVE ERROR (Code- Excl15) Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

P. 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.

Q. 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

R. 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.

S. Acupressure, acupuncture, magnetic therapies.

T. Any expenses incurred on Domiciliary Hospitalization.

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

V. 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.

W. Circumcision unless Medically Necessary for treatment of an Illness not excluded here under or as may be necessitated due to an Accident.

X. Convalescence, General debility and Venereal disease.

Y. 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.

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

AA. External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and similar related items etc., and also any medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

AB. 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.

AC. Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.14.12

AD. Treatment for Sleep Apnea Syndrome, treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and CPAD (Continuous Peritoneal Ambulatory Dialysis).

AE. Treatment taken outside the geographical limits of India

AF. Vaccination and/or inoculation

AG. 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.

NEW INDIA SIXTY PLUS MEDICLAIM POLICY - PREMIUM TABLE

Premium chart for New India Sixty Plus Mediclaim Policy (Per Annum) (Excluding GST)							
For Fresh Proposals				For Renewals			
Sum	2 Lakhs	3 Lakhs	5 Lakhs	Sum	2 Lakhs	3 Lakhs	5 Lakhs
Primary Member 60 and Above	15640	20534	26390	Primary Member 60 and Above	14540	19434	25290
Spouse	14300	18744	24060	Spouse	13200	17644	22960
Premium chart f or New India Sixty Plus Mediclaim Policy for a Co-Pay of extra 10% i.e, for a total co-pay of 20%							
(Per Annum) (Excluding GST)							
For Fresh Proposals				For Renewals			
Sum	2 Lakhs	3 Lakhs	5 Lakhs	Sum	2 Lakhs	3 Lakhs	5 Lakhs
Primary Member 60 and Above	14438	18918	24278	Primary Member 60 and Above	13338	17818	23178
Spouse	13176	17233	22086	Spouse	12076	16133	20986
For Fresh & Renewal - If only single woman senior citizen is covered in the Policy, discount of 5% will be given on the Primary Member Premium							

Premium chart for New India Sixty Plus Mediclaim Policy (Per Annum) (Including GST)							
For Fresh Proposals				For Renewals			
Sum Insured	2 Lakhs	3 Lakhs	5 Lakhs	Sum Insured	2 Lakhs	3 Lakhs	5 Lakhs
Primary Member 60 and Above	18455	24230	31140	Primary Member 60 and Above	17157	22932	29842
Spouse	16874	22118	28391	Spouse	15576	20820	27093
Premium chart for New India Sixty Plus Mediclaim Policy for a Co-Pay of extra 10% i.e, for a total co-pay of 20%							
(Per Annum) (Including GST)							
For Fresh Proposals				For Renewals			
Sum	2 Lakhs	3 Lakhs	5 Lakhs	Sum	2 Lakhs	3 Lakhs	5 Lakhs
Primary Member 60 and above	17037	22323	28648	Primary Member 60 and Above	15739	21025	27350
Spouse	15547	20335	26061	Spouse	14249	19037	24763
For Fresh & Renewal - If only single woman senior citizen is covered in the Policy, discount of 5% will be given on the Primary Member Premium							