THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA MEDICLAIM POLICY

PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA MEDICLAIM 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 MEDICLAIM is a Policy designed to cover Hospitalisation expenses.

1. **WHO CAN TAKE THIS POLICY?**
   All the persons proposed for this Insurance should be between the age of 18 years and 65 years. Children between the age of 3 months and 18 years are covered provided one or both parents are covered concurrently. Children between 18 years to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously. On attaining the age of 18 years or ceasing to be financially dependent on the parents, they can, on renewal take a separate Policy. In such an event the benefits on Continuous Coverage can be ported to the new Policy. The upper age limit will not apply to a mentally challenged children and an unmarried dependent daughter(s). The persons beyond 65 years can continue their Insurance provided they are Insured under the Policy with us without any break.
   Midterm inclusion is allowed for newly married spouse by charging pro-rata Premium for the remaining period of the Policy. A New Born Baby, born to an Insured mother, will be covered from date of birth till the expiry of the Policy, without any additional Premium. No coverage for the New Born Baby would be available during subsequent Renewals unless the child is declared for Insurance and covered as an Insured Person.

2. **CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?**
   Yes. You can cover Your family members in one policy, with separate Sum Insured for each Insured Person.

   The members of the family who could be covered under the Policy are:

   a) Proposer
   b) Proposer's Spouse
   c) Proposer's Children
   d) Proposer's Parents

3. **WHAT DOES THE POLICY COVER?**
   This Policy is designed to give You, the Insured, protection against unforeseen Hospitalisation expenses.

4. **WHAT IS A PRE EXISTING DISEASE?**
   The term Pre-existing condition/disease is defined in the Policy. It is defined as:

   "Any condition, ailment or Injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice / treatment was received

within forty eight months prior to the first policy issued by Us and renewed continuously thereafter."

If You had:

a) Signs or symptoms, or
b) Been diagnosed or received Medical Advice, or
c) Been Treated for any condition or disease within forty eight months prior to the commencement of the first policy with us,

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

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

Pre-acceptance medical check-up is required for all the members entering after the age of 50 years. 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 Hospitalisation 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.

6. **IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?**

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

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

The Policy pays only where the Hospitalisation is for more than twenty four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty four hours. Please refer to Clause 2.17 of the Policy for details.

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

Immediately on Hospitalisation or within twenty four hours of such Hospitalisation, 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 Hospitalisation are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is Hospitalised.

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. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is Hospitalised.

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 Hospitalisation expenses up to a limit, known as **Sum Insured**. In cases where the Insured Person was Hospitalised more than once, the **total of all amounts** paid

a) for all cases of Hospitalisation,
b) expenses paid for medical expenses prior to Hospitalisation,
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 as mentioned in the Schedule.

13. **WHAT SUM INSURED SHOULD I CHOOSE?**
You are free to choose any Sum Insured ranging from Rs. One Lakh to Fifteen Lakhs. The Premium You pay depends upon Your Age and the Sum Insured chosen. You are free to choose any Sum Insured available in the range specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs, as explained in Point 15 below. Sum Insured of Rs. 4 lakh, 6 lakh and 7 lakh are not available for a fresh Policy and is only available in case of renewal with same Sum insured.

14. **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.

15. **IN CASE OF AYURVEDIC TREATMENT, WILL THE ENTIRE AMOUNT BE PAID?**
The liability of the company in case of Ayurvedic / Homoeopathic / Unani treatment will be 25% of the Sum Insured provided the treatment is taken in a government Hospital or in any institute recognized by government or accredited by Quality Council Of India or National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures

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 2nd October, 2016 date of expiry is usually on 1st October, 2017. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2017.

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,

2008, does not renew it on time and takes a Policy only in December 2009, and renewed it on time in December 2010, any claim for Cataract would not become payable, because the Insured person was not continuously covered for twenty four months. If, he had renewed the Policy in time in October 2009 and then in October 2010, then he would have been continuously covered for twenty four months and therefore his claim for Cataract in the Policy beginning from October 2010 would be payable. For other benefits under the Policy such as cost of health checkup, continuous Insurance is necessary. 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 to your Mediclaim 2012 Policy, on migration to New India Mediclaim is protected. But for claim free renewal after migration to New India Mediclaim No accrual would be made to the Cumulative Bonus Buffer. The Cumulative Bonus Buffer will be available until it is completely used.

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 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.

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

We may agree for a request for increase in Sum Insured at the time of renewal. But We are not obliged to agree to this request, if we feel the Person is not in good health. Moreover, for persons aged over 60, such a request could entail subjecting the Person for Medical Examination and other Medical tests. (In case the risk is accepted, 50% of the reasonable cost of Medical Examination would be reimbursed).

Enhancement of Sum Insured is subject to the limits mentioned below:

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

Enhancement of Sum Insured will not be considered for:

1) Any Insured Person over 65 years of age.
2) Any Insured Person who had undergone more than one Hospitalisation in the preceding two years.
3) Any Insured Person suffering from one or more of the following Illnesses / Conditions:
    a) Any chronic Illness
    b) Any recurring Illness
    c) Any Critical Illness

In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 and 4.3 would apply to the additional 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. 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.**

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

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

24. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to You for providing Cashless facility for all hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

25. WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization expenses at the time of discharge from hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid, and You would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Network Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx The list of Network Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Network Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a Hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if

the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

26. **CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?**
Yes it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

27. **HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?**
In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfills the conditions of definition of Hospital in the Policy. Within twenty four hours of 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.

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

29. **WILL THE ENTIRE AMOUNT OF THE CLAIMED EXPENSES BE PAID?**
The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalization as per Policy conditions and is supported by proper documents, except the expenses which are excluded.

30. **HOW MUCH WE WILL REIMBURSE?**
Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus Buffer, Our liability for claims

admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus Buffer. Subject to this, We will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room Rent, boarding and nursing expenses as provided by the Hospital not exceeding 1.0 % of the Sum Insured per day
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2.0 % of the Sum Insured per day
3.1 (c)	Surgeon, Anesthetist, Medical Practitioner, Consultants' Specialist fees.
3.1 (d)	Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during Surgery like pacemaker, Relevant Laboratory/Diagnostic test, X-Ray and other medical expenses related to the treatment.
3.1 (e)	Pre-Hospitalization Medical expenses
3.1 (f)	Post-Hospitalization Medical expenses

PROPORTIONATE DEDUCTION

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

LIMIT ON PAYMENT FOR CATARACT

Our liability for payment of any claim relating to Cataract, for each eye, shall not exceed 20% of the Sum Insured subject to a maximum of Rs. 50,000. The said limit 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.

HOSPITAL CASH

For those Insured Persons, whose Sum Insured is more than or equal to Rs. three lakhs, we will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation 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 Hospitalisation 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.

ADDITIONAL BENEFIT - HEALTH CHECK-UP

The Insured Person shall be entitled for reimbursement of the cost of Medical check-up at the end of a block of every three Claim Free Years. Such payment shall be restricted

to Rs. 5,000 or 1% of the average Sum Insured of the Insured Person in the preceding three years, whichever is less. This benefit is available only once in three years.

Any payment made under this clause shall not be considered as a claim for the purpose of Clauses 5.11 of this Policy.

PAYMENT OF AMBULANCE CHARGES

We will pay You the charges for Ambulance services not exceeding 1% of the Sum Insured, 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 Hospitalfor better medical facilities.

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 shall not exceed the aggregate of the Sum Insured and Cumulative Bonus Buffer, if any, of the Insured Person receiving the organ.

DAY ONE BABY COVER

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy. Any expense incurred towards post natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered. Congenital External Anomaly of the New Born Baby is also not covered under the policy.

No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for insurance and covered as an Insured Person.

MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS

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

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

Following are the optional covers available in the Policy.

OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION

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

On payment of additional Premium for each Insured Person, Proportionate deduction as mentioned in Clause 3.2 of Policy Document will be deleted for such members opting for such cover.

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

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

OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT

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

On the payment of additional Premium, Clause 4.4.14 of Policy Document or sub point 4.14 of Q. 33 below, shall be deleted for the members opting for Maternity Cover. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

Special conditions applicable to Maternity Expenses Benefit:

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

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

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

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

OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT

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

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

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

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

OPTIONAL COVER IV: VOLUNTARY CO-PAY

If the Insured person opts for voluntary co-pay of 20%, a discount of 15% shall be of given on the premium payable for the Insured Person.

32. **WHAT WILL HAPPEN WHEN MY SUM INSURED IS EXHAUSTED DURING POLICY PERIOD?**

If during the Policy period the Sum Insured is exhausted for any Insured, then the Sum Insured shall be reinstated back to the original Sum Insured chosen by the Insured, provided our liability under the Reinstated Sum Insured shall be subject to the following conditions:

1. Such Reinstatement of Sum Insured shall be effected only where the Sum Insured is Rs. Five Lakhs or more.
2. Such Reinstatement shall take effect only after the Date of Discharge from the Hospital for that claim which resulted in exhaustion of the Sum Insured.
3. No Illness or Injury, for a Hospitalisation occurring during the Period of Insurance till the Date of Reinstatement, for which a Claim is paid or admissible, shall be considered under the Reinstated Sum Insured.

Reinstatement shall be available only once for any Insured during a Policy Period.

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 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

34. **CAN I CANCEL THE POLICY?**

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

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

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

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

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

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

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

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

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.

36. **WHAT ARE EXCLUDED UNDER THIS POLICY**

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

1 Treatment of any Pre-Existing Condition/Disease, until forty eight months of Continuous Coverage of such Insured Person have elapsed, from the Date of inception of his/her first Policy with Us as mentioned in the Schedule.

2 Any Illness contracted by the Insured person (except Injury) during the first 30 days of the commencement date of this Policy. This exclusion shall not however, apply if the Insured person has Continuous Coverage for more than twelve months.

3.1 Unless the Insured Person has Continuous Coverage in excess of twenty four months with Us, expenses on treatment of the following Illnesses are not payable:

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

Note: Even after twenty four months of Continuous Coverage, the above Illnesses will not be covered if they arise from a Pre-existing Condition, until 48 months of Continuous Coverage have elapsed since inception of the first Policy with the Company.

3.2 Unless the Insured Person has Continuous Coverage in excess of forty eight months with Us, the expenses related to treatment of

1. Joint Replacement due to Degenerative Condition,
2. Age-related Osteoarthritis & Osteoporosis

are not payable.

4.1 Injury / Illness directly or indirectly caused by or arising from or attributable to War, invasion, Act of Foreign enemy, War like operations (whether war be declared or not), nuclear weapon/ ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel.

4.2 a. Circumcision unless Medically Necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident

b. Change of life/sex change or cosmetic or aesthetic treatment (except for burns/Injury) of any description such as correction of eyesight, etc.

c. Plastic Surgery other than as may be necessitated due to an Accident or as a part of any Illness.

4.3 Vaccination and/or inoculation.

4.4 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.5 Dental treatment or Surgery of any kind unless necessitated by Accident and requiring Hospitalisation.

4.6 Convalescence, general debility, 'Run-down' condition or rest cure, obesity treatment and its complications, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, Venereal disease, intentional self-Injury and Illness or Injury caused by the use of intoxicating drugs/alcohol.

4.7 Congenital Internal and External Disease or Defects or anomalies.

However, the exclusion for Congenital Internal Disease or Defects or anomalies shall not apply after twenty four months of Continuous Coverage, if it was unknown to You or to the Insured Person at the commencement of such Continuous Coverage. Exclusion for Congenital Internal Disease or Defects or Anomalies would not apply to a New Born Baby during the year of Birth and also subsequent renewals, if Premium is paid for such New Born Baby and the renewals are effected before or within thirty days of expiry of the Policy.

The exclusion for Congenital External Disease or Defects or anomalies shall not apply after thirty six months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of the average Sum Insured of the Insured Person in the preceding four years.

4.8 Bodily Injury due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide, Illness arising out of non-adherence to medical advice.

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

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

4.11 Sexually Transmitted Diseases, any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.12 Charges incurred at Hospital primarily for diagnosis, x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any Illness or Injury for which confinement is required at a Hospital

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

4.14 Maternity Expenses, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certification by Gynaecologist that it is life threatening one if left untreated.

4.15 Naturopathy and Siddha Treatment

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

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

4.18 Genetic disorders and stem cell implantation/Surgery.

4.19 Domiciliary Hospitalisation.

4.20 Acupressure, acupuncture, magnetic therapies

4.21 Experimental or unproven treatments/ therapies.

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

4.23 Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy

PREMIUM TABLE

Sum Insured (Rs.)	BASIC COVER (Rs. per annum) (Service taxes extra)						
	<35	36-45	46-50	51-55	56-60	61-65	>65
1,00,000	2,708	2,867	4,640	6,924	8,941	11,787	16,236
2,00,000	3,679	3,898	6,428	9,694	12,714	16,907	23,911
3,00,000	4,051	4,294	7,136	10,808	14,272	19,049	26,814
4,00,000	4,659	4,938	8,199	12,410	16,350	21,797	30,754
5,00,000	5,420	5,747	9,532	14,418	18,954	25,243	35,693
6,00,000	5,854	6,208	10,292	15,564	20,439	27,208	38,510
7,00,000	6,288	6,669	11,052	16,709	21,925	29,174	41,327
8,00,000	6,722	7,130	11,812	17,854	23,410	31,139	44,144
10,00,000	7,600	8,062	13,349	20,170	26,414	35,113	49,841
12,00,000	8,263	8,766	14,510	21,919	28,682	38,114	54,142
15,00,000	9,369	9,940	16,445	24,836	32,465	43,120	61,316

Sum Insured (Rs.)	OPTIONAL COVER I : NO PROPORTIONATE DEDUCTION						
	<35	36-45	46-50	51-55	56-60	61-65	>65
2,00,000	1,418	1,506	2,483	3,741	4,852	6,419	9,201
3,00,000	980	1,040	1,715	2,584	3,351	4,434	6,355
4,00,000	875	929	1,531	2,307	2,993	3,960	5,675
5,00,000	770	817	1,348	2,031	2,634	3,485	4,995
6,00,000	729	774	1,276	1,922	2,493	3,298	4,727
7,00,000	687	730	1,203	1,813	2,351	3,111	4,459
8,00,000	646	686	1,131	1,704	2,210	2,924	4,191
10,00,000	662	703	1,159	1,747	2,265	2,997	4,296
12,00,000	644	684	1,127	1,699	2,203	2,915	4,178
15,00,000	458	487	802	1,209	1,568	2,075	2,974

OPTIONAL COVER II : MATERNITY EXPENSES BENEFIT						
5,00,000	6,00,000	7,00,000	8,00,000	10,00,000	12,00,000	15,00,000
5,000	6,000	7,000	8,000	10,000	12,000	15,000

Sum Insured (Rs.)	OPTIONAL COVER III : REVISION IN LIMIT OF CATARACT				
	46-50	51-55	56-60	61-65	>65
8,00,000	444	1,049	2,269	3,645	3,893
10,00,000	555	1,311	2,836	4,556	4,866
12,00,000	666	1,573	3,404	5,467	5,839
15,00,000	832	1,967	4,255	6,834	7,299