THE NEW INDIA ASSURANCE CO. LTD.

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

AROGYA PRAGATI PLUS (TOP-UP REINVENTED)

PROSPECTUS

We welcome You as Our Customer. This document explains how the **AROGYA PRAGATI PLUS (TOP-UP REINVENTED) POLICY** could provide value to You. In the document the word 'You', 'Your' means the all the members covered under the Policy. 'We', 'Our', 'Us' means The New India Assurance Co. Ltd.

AROGYA PRAGATI PLUS (TOP-UP REINVENTED) POLICY is a **SUPER TOP-UP** Policy designed to cover Hospitalisation expenses due to Illness or Accident.

If You or any Insured Person covered under this policy undergoes Hospitalisation during the policy period, and if the Total Cumulative Hospital Expenses exceed a specific amount (called the Threshold), we shall pay the medical expenses that goes beyond that Threshold, as per the terms and conditions outlined in this policy.

1. WHO CAN TAKE THIS POLICY?

Persons between the age of 18 years and 65 years can take this policy. Children from 3 months up to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously.

2. CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?

Yes. You can cover the entire family on Individual or Floater Basis.

3. WHO CAN BE COVERED UNDER THE POLICY ?

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

a) Self

b) Spouse

c) Dependent Children

d) Parents

e) Employer can also cover their Employees Maximum six members can be covered in a single policy.

4. WHAT THRESHOLDS AND SUM INSURED OPTIONS ARE AVAILABLE UNDER THE POLICY?

We offer Thresholds and Sum Insured options as below.

Threshold	Sum Insured Available
5 L to 15 L	1 L to 50 L
16 L to 50 L	5 L to 50 L
Thresholds and Sum Insured are available in multiples of 1 L	

5. WHAT DOES THRESHOLD MEAN? HOW IS IT DIFFERENT FROM SUM INSURED?

Threshold refers to the amount of Cumulative Hospitalization Expenses specified in the Schedule chosen by the Insured Person up to which no Medical Expenses can be claimed under this policy.

Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of all Insured Persons during the Policy Year.

6. CAN THE THRESHOLDS AND SUM INSURED VARY FOR EACH INSURED PERSON UNDER AN INDIVIDUAL POLICY?

Yes. Thresholds and Sum Insured can vary for each Insured Person under an Individual Sum Insured Policy.

However, for Floater Sum Insured, Single Threshold and Sum Insured shall float for all the members covered under the policy.

7. HOW DOES THE THRESHOLD GETS DETERMINED?

The following Hospitalisation expenses incurred in respect of the Insured Person/s shall be considered for determining the Threshold under the Policy:

- The admission in the Hospital should have happened during the policy period.
- The Insured should have been admitted as an inpatient (outpatient treatments are not to be considered).
- The Hospitalisation should be for an Injury or Illness.

8. WHAT ARE THE PLANS AVAILABLE UNDER THE POLICY?

Two Plans are available under the Policy which are Gold and Platinum Plans.

Description of benefits	**Gold Plan**	**Platinum Plan**
Room rent	1% of the Sum Insured (or) Rs. 15,000, whichever is less	Single AC Room
ICU charges	2% of the Sum Insured (or) Rs. 25,000, whichever is less	Actuals
Pre hospitalization expenses	30 days	60 days
Post hospitalization expenses	60 days	90 days.
Cataract surgery	Upto Rs.50,000 per Eye	Upto Rs.1,00,000 per Eye
Modern Treatments	As per the limits mentioned in 3.10 of the Policy Clause	Up to 100% of the Sum Insured
Medical second opinion for Critical illnesses	Up to Rs.2500 in a Policy Period	Up to Rs.5000 in a Policy Period
Road Ambulance	Actuals	Actuals
Air ambulance	Not available	Actuals once in a policy period.
Non-Medical items (consumables)	Not Available	Inbuilt cover upto Rs.25000
Benefits under Optional covers (On payment of Additional Premium)		
Critical Care benefit	Rs.5,00,000	Rs.5,00,000 or Rs. 7,50,000
Personal Accident benefit	50% of sum insured	

9. WHAT ARE THE SALIENT FEATURES OF THE POLICY?

- This Policy covers In-Patient Hospitalisation Expenses incurred in India.

- In order for this Policy to trigger or respond, Admission should occur within the Policy Period of this Policy.
- This policy will respond only when the aggregate of all Hospitalisation expenses of one (in case of Individual Sum Insured) or all members of the policy (in case of Floater Sum Insured), exceeds the "Threshold" stated in the policy.
- This Policy will respond for each and every Hospitalisation after the Threshold has been exceeded by previous Hospitalisation expenses subject only to the Sum Insured stated in the Policy.
- The Sum Insured is the maximum liability of the company for all members of the policy.
- Thus, this Policy offers protection in excess of any Primary Health Policy/Benefit scheme that the Insured may have.
- If there is any expense in excess of Threshold, receivable from any other Insurance Company, the Insured Person has an option to recover it from either that Insurance Company or this policy, but not both.
- However, the Sum Insured under the policy will be available over and above any reimbursement received from any other entity if such amounts exceed the Threshold.

10. WHAT ARE THE COVERAGES AVAILABLE UNDER THIS POLICY?

Our liability for all claims admitted during the Policy Period in respect of all Insured Persons, including all payment related to the following, except for benefits specified under 3.14 and 3.15 of the Policy Clause, will be only up to Sum Insured as mentioned in the Policy Schedule. Subject to this, we will reimburse Reasonable and Customary and Medically Necessary Expenses admissible as per the terms and conditions of the Policy.

(a)	Room Rent including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection/Drugs and Intra venous fluid administration expenses) as provided by the hospital	
	Gold Plan	1% of the Sum Insured or Rs. 15,000 whichever is less
	Platinum Plan	Single AC room
(b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.	
	Gold Plan	2% Sum Insured or Rs. 25,000 whichever is less
	Platinum Plan	Actuals
(c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.	
(d)	Cost of Pharmacy and Consumables including Anaesthesia, Blood, Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics.	
(e)	Pre-Hospitalization Medical expenses up to 30 Days (Gold Plan) or 60 days (Platinum Plan) prior to the date of admission to the hospital.	
(f)	Post-Hospitalization Medical expenses up to 60 Days (Gold Plan) or 90 days (Platinum Plan) from the date of discharge from the hospital.	
	Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same	

proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- Cost of Diagnostics.

Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

i. 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, after taking the Threshold into consideration. Sum Insured of the renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced during the expiring Policy. Claim shall be settled on per event basis.

ii. DENTAL TREATMENT (INPATIENT)

We will cover for medical expenses incurred towards dental treatment done under anaesthesia necessitated due to an accident/injury/illness requiring Hospitalization as Inpatient treatment.

iii. COVERAGE FOR CATARACT

Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye / per insured shall not exceed the limits mentioned below subject to the condition of Threshold being breached.

Plan	Charges payable (Per Eye)
Gold Plan	Up to a maximum of Rs.50,000
Platinum Plan	Up to a maximum of Rs.1,00,000

iv. 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 during the course of organ transplant to the Insured Person, provided Our liability towards expenses incurred on the donor and the Insured recipient shall not exceed the Sum Insured.

v. AYUSH TREATMENT

We will pay up to the Sum Insured provided the treatment has been undergone in an AYUSH government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

vi. PAYMENT OF AMBULANCE CHARGES

We will pay You the charges incurred towards Road Ambulance service and/or Air Ambulance expenses that are actually incurred in India. These expenses are payable only if they are Reasonable, Customary and Medically Necessarily 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. Payment under this benefit will reduce the Sum Insured.

However, if an Insured Person, at the time of discharge from the Hospital, has to be shifted to their place of residence in an Ambulance, such expenses will also be reimbursed, provided the requirement of an Ambulance is certified by the Medical Practitioner.

Note: Air Ambulance Expenses are payable only under Platinum Plan.

vii. 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.

viii. SPECIFIC COVERAGES:

a) 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 25% 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).

b) 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.

c) 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 20% of Sum Insured.

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

Note: For the coverages defined in (a) to (d), Waiting Period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020 or date of inception of first policy, whichever is later. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

e) **Treatment of Mental Illness:** The Company shall indemnify the Medical Expenses incurred towards treatment of Mental Illness subject to the condition that 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.

The following Mental Illnesses are covered after completion of 36 months of Continuous Coverage with a sub-limit up to 25% of Sum Insured per policy period.

ICD Code	ICD Code Description
F01-F09	Mental disorders due to known physiological conditions

F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic Disorders
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities

EXCLUSIONS:

- Any kind of Psychological counselling, cognitive/ family/ group/ behaviour/ palliative therapy or psychotherapy shall not be covered.

ix. 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	Gold Plan Limit (Per Policy Period)	Platinum Plan
1	Uterine Artery Embolization and HIFU (Highintensity focused ultrasound)	Upto 20% of Sum Insured subjectto Maximum Rs. 2 Lakh	Up to Sum Insured
2	Balloon Sinuplasty.	Upto 20% of Sum Insured subjectto Maximum Rs. 2 Lakh	
3	Deep Brain stimulation.	Upto 50% of Sum Insured subjectto Maximum Rs. 5 Lakh	
4	Oral chemotherapy.	Upto 10% of Sum Insured subjectto Maximum Rs. 1 Lakh	
5	Immunotherapy- Monoclonal Antibody tobe given as injection.	Upto 25% of Sum Insured subjectto Maximum Rs 3 Lakhs.	
6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.1.50 lakhs	
7	Robotic surgeries.	Upto 50% of Sum Insured subjectto Maximum Rs. 5 Lakhs.	
8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subjectto Maximum Rs. 3 Lakh.	
9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.	
10	Vaporisation of the prostrate (Green lasertreatment or holmium laser treatment).	Upto 50% of Sum Insured subjectto Maximum Rs. 2.5 Lakh.	
11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subjectto Maximum Rs. 50,000.	
12	Stem cell therapy: Hematopoietic stem cellsfor bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subjectto Maximum Rs. 2.5 Lakh.	

x. MEDICAL SECOND OPINION

In case of any Insured Person requires to undergo Surgery for any of the 18 Critical Illnesses

defined under 2.8 and 2.47 of the Policy Clause, Consultation Expenses incurred on Medical Second Opinion shall be reimbursed as per the limits mentioned below.

Plan	Charges payable (Per Policy Period)
Gold Plan	Up to a maximum of Rs.2,500
Platinum Plan	Up to a maximum of Rs.5,000

Note: In case the Policy is issued on an Individual Sum Insured basis, the above limits shall be available individually to the Insured Persons. In case the Policy is on Floater Sum Insured basis, the above limits shall be available to all Insured persons on a Floater basis.

xi. TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies shall be covered after twenty-four months of Continuous Coverage.

Congenital External Disease or Defects or anomalies shall be covered after forty-eight months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of the average Sum Insured in the preceding four years.

xii. NON-MEDICAL ITEMS (CONSUMABLES)

Items listed in Annexure II (List 1) shall become payable up to Rs. 25,000/- for Platinum Plan in a policy period. It is an inbuilt cover under Platinum Plan.

Note: For Gold Plan, this cover is not available.

xiii. WHAT ARE THE VARIOUS OPTIONAL COVERS AVAILABLE UNDER THE POLICY?

Following Optional Covers (Critical Care Benefit and Personal Accident Benefit) are available under the Policy.

These Benefits shall be paid even if the Threshold under the policy is not breached subject to the terms and conditions applicable to these Benefits.

A. CRITICAL CARE BENEFIT

If during the Policy Period, any Insured Person is diagnosed with of any of the 18 Critical Illness listed below (as defined under Definitions) for the first time, Lump Sum amount as mentioned below will be paid subject to following conditions.

Plan	Benefit Payable
Gold Plan	Rs. 5,00,000
Platinum Plan	Rs. 5,00,000 or Rs. 7,50,000

List of 18 Critical Illness

Sr No	List of Critical Ilnesses
1	Cancer of Specified Severity
2	Kidney Failure Requiring Regular Dialysis
3	End Stage Liver Failure
4	Major Organ Transplant/Bone Marrow Transplant
5	Open Heart Replacement or Repair of Heart Valves
6	Open Chest CABG
7	Stroke resulting in Permanent Symptoms

8	Permanent Paralysis of Limbs
9	Myocardial Infarction (First Heart Attack of Specified Severity)
10	Multiple Sclerosis with Persisting Symptoms
11	Coma of Specified Severity
12	Parkinson's Disease
13	Benign Brain Tumour
14	Alzheimer's Disease
15	Aorta Graft Surgery
16	Deafness
17	Loss of speech
18	Third Degree Burns

Special Conditions

- This Optional Cover of Critical Care Benefit is applicable for the Insured Persons in the age group of 18 years and above.
- This Benefit shall be paid even if the Threshold under the policy is not breached subject to the terms and conditions applicable to this section.
- The benefit shall be payable to the Insured Person, provided the Critical Illness is diagnosed after the first inception of Policy. On Utilization, NO further Sum shall be payable under this section during the policy period for the Insured (in case of Individual Sum Insured) or for other members (in case of Floater Sum Insured). Note: This will be paid once in a lifetime of the Insured regardless of the number of critical illness suffered.
- The diagnosis of presence of such Critical Illness needs to be supported by treating doctor's certificate regarding duration of the Critical Illness, clinical, radiological, histological, pathological, histo-pathological and laboratory evidence.
- Any payment under this Clause would be in addition to hospitalisation expenses, if any, and shall not deplete the Sum Insured.
- The coverage under this section shall terminate in the event of claim of a covered Critical Illness becoming accepted and paid by Us.
- Waiting Period: For Critical Illness Conditions - We shall not be liable to make any payment in respect of any Critical Illness which is diagnosed within the first 90 days of the Inception Date of First Policy.
- Survival Period for Critical Illnesses: Survival period of **'NIL'** days shall be applicable from the date of diagnosis of any of the above listed Critical Illnesses to be eligible for this benefit.
- Please note that claim payment will only be made with confirmatory diagnosis of the conditions covered while the Insured Person is alive (i.e. a claim would not be admitted if the diagnosis is made post-mortem).

B. PERSONAL ACCIDENT BENEFIT

If at any time during the currency of this Policy, the Insured Person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Company shall pay to the Insured or his legal representative(s) or Nominee, as the case may be, the sum hereinafter set forth, that is to say:

i. **Death:** The company shall pay the benefit equal to 50 % of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained

in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

ii. **Permanent Total Disablement:** The company shall pay the benefit equal to 50 % of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a. Total and irrecoverable loss of sight of both eyes or

b. Physical separation or loss of use of both hands or feet or

c. Physical separation or loss of use of one hand and one foot or

d. loss of sight of one eye and Physical separation or loss of use of hand or foot

e. If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

iii. **Permanent Partial Disablement:** The company shall pay the percentage of Sum Insured (as given in Annexure), specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

Special Conditions applicable to this section:

a) This Optional Cover of PA Benefit is applicable for the Insured Persons in the age group of 18-70 Years.

b) The benefit shall be payable only under any one of the sections stated above.

c) This Benefit shall be paid even if the Threshold under the policy is not breached subject to the terms and conditions applicable to this section.

d) Personal Accident Benefit shall be paid as specified in the Policy Schedule. Once a claim is admitted and paid under this Section, NO further Sum shall be payable under this section during the policy period for other members.

e) Worldwide Coverage.

f) Any Payment under this clause shall not deplete the Sum Insured.

11. WHAT SUM INSURED CAN I CHOOSE AT THE TIME OF ENTERING INTO THE POLICY AND ARE THERE ANY MEDICAL TESTS REQUIRED?

Sum Insured eligibility is as follows.

Age Entry	Health Condition	Pre Acceptance Medical Examination	Sum Insured Eligibility
Up to 55Years	With No Medical Conditions / PED / Claims History / Adverse History	Not Required	Up to 50 Lakhs
	With PED/Claims History	Required	Up to 30 Lakhs
56 to 65 Years	With No Medical Conditions/PED/Claims History	Required	Up to 30 Lakhs
	With PED/Claims History	Required	Up to 15 Lakhs
66 Years above	Only Renewals on As-Is Where-is Basis Will Be Accepted.		
	No Issuance of Fresh Policies or Enhancement of Sum Insured or Reduction of Threshold is allowed.		

List of Medical Tests Required are as follows

Complete blood count (CBC)	Routine Urine Analysis (RUA)
Blood Sugar (Fasting & PP)	Resting ECG
SGPT	X Ray Chest - PA view
SGOT	Physician Check-Up
Serum Cholesterol	Serum HDL
Serum Triglycerides	Eye Check-Up For Cataract & Glucoma
USG of Abdomen and Pelvis	HbA1c Test

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

Note:

- Underwriter / Medical Officer may prescribe further tests based on the Medical Reports or Medical History of the Individuals.
- The tests have to be taken not more than 30 days prior to the date of submission of the proposal.

12. I HAVE A NEW INDIA TOP-UP MEDICLAIM POLICY. CAN I MIGRATE TO THIS POLICY?

Yes. Insureds holding New India Top Up policy can Migrate into the Arogya Pragati Plus (TOP-UP Reinvented) Policy. Expiring Sum Insured will be protected and further Enhancement of Sum insured is subject to the Sum Insured Eligibility and Enhancement of Sum Insured conditions.

Credit and Continuity Benefit will be given for the number of years they have been under New India Top Up policy and to the extent of Sum Insured under New India TOP-UP Mediclaim Policy.

Migration will be allowed only at the time of renewal of New India TOP-UP Mediclaim Policy.

Migration is not allowed to Platinum Plan for persons suffering from Critical/Recurring/Chronic Illnesses.

Proposal form is Mandatory for Migration in to this Policy.

13. WHETHER THE PREMIUN IS UNIFROM ACROSS INDIA?

Yes. Uniform premium is applicable across India.

14. DO YOU OFFER ANY DISCOUNT IF THE POLICY IS TAKEN ON FLOATER SUM INSURED BASIS?

We offer discount on the number of members covered which is as under:

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

15. DO YOU OFFER ANY DISCOUNT FOR HAVING A RETAIL HEALTH POLICY OF NEW INDIA ASSURANCE?

Yes. We offer a loyalty discount of 5% for having an Active Retail Health Policy of our Company.

Note: In order to be eligible for this Discount, the Sum Insured of the Base Policy should be 5 L and above. Critical Illness Policies such as New India Cancer Guard, New India Criti Protect Policy and any such other Policies shall not be considered as Base Policy for availing this Discount.

Policies eligible for 5% Discount are

- New India Mediclaim Policy
- New India Floater Mediclaim Policy
- Yuva Bharat Health Policy
- Young India Digi Health Policy
- New India Asha Kiran Policy
- New India Premier Mediclaim Policy
- Arogya Sanjeevani Policy, New India Assurance Co Ltd.
- New India Sixty Plus Mediclaim Policy

16. IS THERE ANY DISCOUNT OFFERED FOR PURCHASING THIS POLICY IN DIGITAL PLATFORMS?

Yes. We offer a Digital discount of 10% for both fresh and renewals for customers buying online without intermediary.

17. IS THERE ANY STAFF DISCOUNT OFFERED FOR PURCHASING THIS POLICY?

Yes. We offer a Staff discount of 10% for both fresh and renewals for NIA Employees without intermediary.

Note: Digital Discount and Staff Discount cannot be clubbed together.

18. DO YOU OFFER ANY CUMULATIVE BONUS UNDER THE POLICY?

No. Cumulative Bonus is not offered under this Policy.

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

Policy can be renewed lifelong provided the renewal is done before the expiry or within the Grace Period of 30 days.

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.

20. WHAT IS THE PERIOD OF INSURANCE OR THE POLICY PERIOD?

The Policy Period or the Period of Insurance is one year as stated in the Policy Schedule. However, the Policy Term can be 1 Year or 2 Years or 3 Years.

21. WHAT ARE THE SPECIAL CONDITIONS APPLICABLE FOR LONG TERM POLICIES AND IS THERE ANY DISCOUNT FOR TAKING THE POLICY UP TO 3 YEARS?

- Policy Term, Discounts, Sum Insured and Threshold applicable are illustrated with example as follows:

Policy Term	Policy Period	Threshold	Sum Insured	Discount in %
One year	1.1.2024 to 31.12.2024	5,00,000	10,00,000	0
Two years	1.1.2024 to 31.12.2024	5,00,000	10,00,000	5
	1.1.2025 to 31.12.2025	5,00,000	10,00,000	
Three years	1.1.2024 to 31.12.2024	5,00,000	10,00,000	7
	1.1.2025 to 31.12.2025	5,00,000	10,00,000	
	1.1.2026 to 31.12.2026	5,00,000	10,00,000	

- No modifications during midterm of policy term for the following is allowed:
  - i. Increase of Threshold or Sum Insured
  - ii. Decrease of Threshold or Sum Insured
  - iii. Plan Change
  - iv. Opting in or out of optional covers
  - v. Addition of members except newly wedded spouse of new born baby (after completion of 3 months).
    - In cases where the policy term exceeds one year, Threshold, Sum Insured, Sub-limits (if applicable) are reckoned separately for each year.
    - There is no provision for carrying over these benefits from one policy year to another. It's essential to understand that benefits and coverages specific to the second or third year cannot be utilized during the first year itself meaning the benefits are not cumulative.
    - The terms, conditions, and exclusions stipulated in the Policy or any associated Endorsements are integral to the contract and must be adhered to. These provisions apply separately to each policy year.

22. IS THERE ANY BENEFIT FOR TAKING THE POLICY FOR UP TO 3 YEARS?

i. Renewal Burden: Long-term health insurance policy reduce the burden of renewing the policy every year. You can purchase a policy with a duration of multiple years (e.g., 2 to 3 years), providing continuous coverage without annual renewals.

ii. Premium Stability: Health insurance premiums can be revised periodically, often leading to increased costs. Long-term health insurance can help you avoid these premium hikes, ensuring that Your hard-earned money is safeguarded.

iii. Cost-Effective Premiums: We offer discounts on the policy premium for long-term health insurance plans. Buying a policy with a duration of two to three years is more cost-effective than renewing insurance every year for the same duration.

iv. Peace of Mind: Ultimately, a long-term health insurance policy provides peace of mind,

knowing that you have a reliable and stable insurance plan in place.

23. IS INSTALLMENT FACILITY AVAILABLE UNDER THE POLICY?

No, it is not available.

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

Yes. Policy has to be renewed within 30 days of the expiry of the Policy.

25. 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 -

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.

26. WHETHER AYUSH COVER IS COVERED?

Yes. It is covered up to the Sum Insured.

27. IS THERE AN OPTION TO MIGRATION TO ANY OTHER POLICY?

Yes. You can choose to migrate to any of our existing Policy, subject to IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations,2024 and the Guidelines of IRDAI on Migration of Health Insurance Policies, as amended from time to time.

28. IS THERE AN OPTION FOR PORTABILITY?

Yes. You can choose to Port to any of our existing Policy, subject to IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations,2024 and the Guidelines of IRDAI on Portability of Health Insurance Policies, as amended from time to time.

29. IN CASE OF REVISION/WITHDRAWAL WILL THERE BE ANY COMMUNICATION TO POLICYHOLDER?

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

In case of revision or modification or withdrawal of the Policy a notice will be provided to Policyholder, 90 days before the expiry of the policy for such revision or modification or withdrawal.

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

Enhancement of Sum Insured shall be allowed as per the underwriting guidelines. However, it is not allowed:

- If the Person is suffering from or has suffered from any Critical/Chronic/Recurring Illnesses
- If the Person has undergone more than two hospitalizations in the past 2 years for any conditions except Cataract, Haemorroidectomy, Inguinal Hernia without complications and Simple Fractures without Implants.

31. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider who will provide Cashless facility for all Hospitalization that come under the scope of the policy. The TPA also settles reimbursement claims within the scope of the Policy. Details of TPA will be printed in the Policy Schedule.

32. 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

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

33. IS HOSPITALISATION ALWAYS NECESSARY TO CLAIM UNDER THE POLICY?

It is necessary to have a Hospitalization for a minimum period of 24 hours to be eligible for claiming under the Policy. However, due to medical advancements for certain medical procedures, 24-hour hospitalization may not be necessary. The list of such procedures are

printed under the policy clause.

34. DO YOU COVER PRE & POST HOSPITALISATION EXPENSES?

Yes. Pre-Hospitalization Expenses are covered upto 30 Days under Gold Plan or 60 days under Platinum Plan and Post Hospitalization Expenses are covered upto 60 Days under Gold Plan or 90 days Platinum Plan.

35. 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.

36. 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.

37. DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does NOT cover ALL cases of Hospitalisation. No claim will be payable under this Policy for the following:

i. 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.

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/procedure falls under the waiting period specified for preexisting 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
4. Critical Care Benefit

(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. Puberty and Menopause related Disorders
19. 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.
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.

iv. 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

v. 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.

vi. 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 comorbidities 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

vii. 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.

viii. 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.

ix. 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.

x. 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.

xi. 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.

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

xiii. 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)**

xiv. 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)**

xv. REFRACTIVE ERROR (Code- Excl15)

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

xvi. 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.

xvii. 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

xviii. 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.

SPECIFIC EXCLUSIONS

xix. Acupressure, acupuncture and magnetic therapies.

xx. Any expenses incurred on Domiciliary Hospitalization.

xxi. Service charges, Surcharges, Luxury Tax, Admission fees, Registration fees, Record Charges and Telephone Charges levied by the Hospital.

xxii. Bodily Injury or Illness due to intentional self-inflicted Injury and attempted suicide.

xxiii. Circumcision unless Medically Necessary or as may be necessitated due to an Accident.

xxiv. Convalescence and General debility.

xxv. Cost of braces, equipment or external prosthetic devices, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants.

xxvi. External Medical / Non-medical equipment used for diagnosis and/or treatment including CPAP/BIPAP, Oxygen Concentrator, Infusion pump, Ambulatory devices (walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads) and sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, Alpha / Water Bed and medical equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

xxvii. Naturopathy Treatments.

xxviii. 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.

xxix. Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.10.12

xxx. Expenses incurred for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

xxxi. Treatments or Investigations or Services taken outside the geographical limits of India.

xxxii. Vaccination and/or inoculation

xxxiii. 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.

xxxiv. Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.

xxxv. Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours.

Specific Exclusions applicable to Optional Cover – Critical Care Benefit

i. Any Pre-existing Condition, ailment or disease, or its related conditions arising from it.

ii. We shall not be liable to make any payment in respect of any Critical Illness which is diagnosed within the first 90 days of the Inception Date of First Policy. This 90 days waiting period shall not be applicable on renewals to the extent of sum insured under the previous policy.

iii. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.

iv. Any Critical Illness directly caused due to intentional self-injury, suicide or attempted suicide.

v. Any Critical Illness caused due to and/or treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

vi. Any Critical Illness caused by any treatment necessitated due to participation as a professional in hazardous or adventure sport, 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

vii. Any Critical Illness caused by any unproven/ experimental treatment, service and supplies for or in connection with any treatment. Unproven/ experimental treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

viii. Any Critical Illness caused due to 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 reason.

ix. Any Critical Illness caused by treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

x. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,

xi. Participation by the Insured Person in any flying activity, except as a bona fide, fare paying passenger of a recognized airline on regular routes and on a scheduled timetable.

xii. Congenital External Anomalies, or any complications or conditions arising therefrom including any developmental conditions of the Insured.

xiii. Any Critical Illness caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any Critical Illness caused due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

xiv. Any Critical Illness based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he/ she is licensed for.

xv. Any Critical Illness caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.

xvi. Any Critical Illness caused due to cosmetic or plastic surgery or any treatment to change the 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.

xvii. Any critical illness caused due to surgical treatment of obesity that does not fulfil all the below conditions

a. Surgery to be conducted is upon advice of doctor

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

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

d. Body Mass Index (BMI)

i. Greater than equal to 40 or

ii. Greater than or equal to 35 in conjunction with any of the following sever co-morbidities following failure of less invasive methods of weight loss

1. Obesity related cardiomyopathy

2. Coronary heart disease

3. Severe sleep apnea

4. Uncontrolled Type 2 Diabetes

xviii. Any Critical Illness caused by sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

xix. Any Critical Illness resulting from a physical condition which existed prior to first risk inception date which was not disclosed.

xx. Any Critical Illness, caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.

xxi. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

xxii. Procedures / treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours.

Specific Exclusions applicable to Optional Cover – Personal Accident Benefit.

i. Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to 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.

ii. Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

- from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
- whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.
- whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.

  [Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]
- arising or resulting from the Insured Person committing any breach of law with criminal intent.

iii. Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person 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.

iv. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

- Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
- Nuclear weapons material
- The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- Nuclear, chemical and biological terrorism

v. Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

Base Premium

Premium Calculator shall be provided as an Excel Sheet or as a web-link for calculating the premium.

Premium shown shall be applicable for Gold Plan. 15% Additional Premium shall be applicable on the Platinum Plan

Optional Covers (Available for Persons 18 Y and above) - Premium

Critical Care Benefit:

Age Band	5 L	7.5 L
18 - 25	475	713
26 - 30	740	1110
31 - 35	1065	1598
36 - 40	1430	2145
41 - 45	2405	3608
46 - 50	4605	6908
51 - 55	7615	11423
56 - 60	12910	19365
61 - 65	19190	28785
66 - 70	32740	49110
71 - 75	65215	97823
76 - 80	118360	177540
81 & above	208115	312173

Personal Accident Benefit

Coverage: Death + Permanent Total Disablement (PTD) + Permanent Partial Disability (PPD)

Sum Insured for PA =50% of selected Sum Insured under TOP UP Policy

Office Premium Rate: Rs 0.65 per mille

For example, Sum Insured under this Policy is 10 L, PA Sum Insured shall be 5 L. Hence the Premium shall be Rs. 325 [(500000*.65)/1000]

Discounts

- **Floater Discount**

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

- **Loyalty Discount:** 5% Loyalty discount for having an Active Retail Health Policy of our Company.

  Note: In order to be eligible for this Discount, the Sum Insured of the Base Policy should be 5 L and above. Critical Illness Policies such as New India Cancer Guard, New India Criti Protect Policy and any such other Policies shall not be considered as Base Policy for availing this Discount.

Policies eligible for 5% Discount are New India Mediclaim Policy, New India Floater Mediclaim Policy, Yuva Bharat Health Policy, Young India Digi Health Policy, New India Asha Kiran Policy, New India

Premier Mediclaim Policy, Arogya Sanjeevani Policy, New India Assurance Co Ltd and New India Sixty Plus Mediclaim Policy.

- **Digital Discount:** 10% Discount is applicable for Fresh and Renewals for customers on taking this policy through Customer Portals and Mobile Applications.
- **Staff Discount:** 10% Discount is applicable for Fresh and Renewals for NIA Employees on taking this policy without intermediary.

  Note: Digital Discount and Staff Discount cannot be clubbed together.

- **Long Term Policy Discount**

Policy Term	Discount in %
One year	0
Two years	5
Three years	7