NEW INDIA ASHA KIRAN POLICY- PROSPECTUS

We have great pleasure in presenting our unique product – **NEW INDIA ASHA KIRAN POLICY.** This prospectus document explains how the NEW INDIA ASHA KIRAN POLICY will 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.**

1. WHO CAN TAKE THIS POLICY?

THIS POLICY IS DESIGNED for families WITH ONLY GIRL CHILDREN. This insurance is available to persons between the age of 18 years and 65 years. Daughter(s) 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. The upper age limit will not apply to mentally challenged daughter(s) and 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 Born Daughter (after completing 3 months) by charging pro-rata Premium for the remaining period of the Policy.

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

Yes. You can cover the entire family under a Single Sum Insured (Floater). The members of the family who could be covered under the Policy are:

a) **Proposer**

b) **Proposer's Spouse**

c) **Proposer's Dependent Daughter (Maximum Two)**

Minimum two members, with at least one daughter, are required in this policy. This policy cannot be given to a single person. Maximum four members can be covered in a single policy. Midterm inclusion is allowed only for new born 2nd baby girl child on payment of pro - rata additional premium.

3. WHAT IS ABHA NUMBER?

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

4. WHAT DOES THE POLICY COVER?

This Policy is designed to give You and Your family, protection against unforeseen Hospitalization expenses to all insured members and Personal Accident cover to Proposer and Spouse.

5. WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?

Our liability for all claims admitted during the Period of Insurance in respect of all Insured Persons shall not exceed the Sum Insured. Subject to this, for each claim We will reimburse the following Reasonable and Customary and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

(a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of the Sum Insured per day.
(b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the Sum Insured per day.
(c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
(d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
(e)	Pre-Hospitalization Medical Expenses, not exceeding thirty days
(f)	Post-Hospitalization Medical Expenses, not exceeding sixty days
(g)	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 1. Cost of Pharmacy and Consumables 2. Cost of Implants and Medical Devices 3. 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.

Note:

(h) 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.

(i) 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, if any, of the Insured Person receiving the organ.

(j) 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.

- **LIMIT ON PAYMENT FOR CATARACT**

  Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye shall not exceed 10% of the Sum Insured or Rs. 50,000, whichever is less.

- **TREATMENTS UNDER AYURVEDIC/HOMEOPATHIC/UNANI SYSTEMS**

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

- **CRITICAL CARE BENEFIT**

If during the Period of Insurance any Insured Person discovers that he or she is suffering from any Critical Illnesses as defined under 2.9 of the Policy Clause, which results in a claim admissible under this Policy, 10% of the Sum Insured would be paid as Critical Care Benefit along with the admissible claim amount.

Critical Care Benefit is payable only once in the life time of each Insured Person and is not applicable to any Insured Persons for whom it is a Pre- Existing Condition/Disease.

Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

- **PAYMENT OF AMBULANCE CHARGES**

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

- **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, Anesthetist 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.

- **TREATMENT FOR CONGENITAL DISEASES**

Congenital Internal Disease or Defects or anomalies shall be covered 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.

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.

- **OPTIONAL COVER I: NO PROPORTIONATE DEDUCTION**

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 3.1(g) stands deleted for the members covered in the Policy as stated in the Schedule. This optional cover is available for sum insured of Rs.2 lakhs and above.

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

- **OPTIONAL COVER II: MATERNITY EXPENSES BENEFIT**

On the payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 4.4.15 stands deleted for Insured Person as mentioned in the Schedule. 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. This Optional Cover is available for Sum Insured 5 Lakhs and above.

Special conditions applicable to Maternity Expenses Benefit:

i These Benefits are admissible only if the expenses are incurred in Hospital as inpatients in India.

ii 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 miscarriage or abortion induced by accident or other medical emergency.

iii 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.

iv 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.

- **OPTIONAL COVER III: REVISION IN LIMIT OF CATARACT**

This optional cover, if opted, will be in addition to limit specified in Clause 3.2 of the Policy Clause. This Optional Cover is available for Sum Insured 8 Lakhs 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	Additional 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

Note: Benefit of this cover will be available after the expiry of thirty-six months from the date of opting this cover.

- **OPTIONAL COVER IV: NON-MEDICAL ITEMS (CONSUMABLES)**

On payment of additional Premium as mentioned in Schedule, it is declared and agreed that items listed in Annexure II (List 1) shall become payable up to Rs. 15,000/- in a policy period. This Optional Cover is available for Sum Insured of 8 Lakhs and above.

Once this optional cover is opted and a claim has been admitted under the policy, you cannot opt out of this optional cover.

- **SPECIFIC COVERAGES:**

a) **Artificial life maintenance,** including life support machine use, where such treatment will not result in recovery or restoration of normal state of Health under any circumstances. We cover the expenses up to 10% of the Sum Insured and for a maximum of 15 days per policy period for covered illness. This sub limit is applicable only for person who is declared to be in a vegetative state as certified by the treating medical practitioner.

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 10% of Sum Insured, maximum up to Rs. 75,000 per policy period.

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

Exclusion: Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or psychotherapy shall not be covered.

- **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.

Treatment or Procedure	Limit (Per Policy Period)

Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Sum Insured subject to Maximum Rs. 1 Lakh
Balloon Sinuplasty.	Up to 20% of Sum Insured subject to Maximum Rs. 1 Lakh
Deep Brain stimulation.	Up to 50% of Sum Insured Subject to maximum Rs. 1.5 Lakh
Oral chemotherapy.	Up to 10% of Sum Insured subject to Maximum Rs. 50,000.
Immunotherapy- Monoclonal Antibody to be given as injection.	Up to 25% of Sum Insured subject to Maximum Rs 1 Lakh.
Intravitreal injections.	Up to 10% of Sum Insured subject to Maximum Rs.30,000.
Robotic surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 2 Lakh.
Stereotactic radio surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
Bronchial Thermoplasty.	Up to 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Up to 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
IONM-(Intra Operative Neuro Monitoring).	Up to 10% of Sum Insured subject to Maximum Rs. 25,000.
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Up to 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.

SECTION II: PERSONAL ACCIDENT (APPLICABLE TO PROPOSER AND SPOUSE ONLY)

If the Proposer and/or Spouse shall sustain any bodily Injury resulting solely and directly from Accident then We shall pay as specified in the schedule, the sum hereinafter set forth that is to say:

If such Injury shall within twelve calendar months of its occurrence be the sole and direct cause of

Coverage		Compensation
Death of	Proposer or Spouse	100% of Sum Insured
	Proposer and Spouse	200% of Sum Insured
Permanent Total Disablement of	Proposer or Spouse	100% of Sum Insured
	Proposer and Spouse	200% of Sum Insured
Loss of both eyes / Loss of both limbs / Loss of one limb and one eye of	Proposer or Spouse	100% of Sum Insured
	Proposer and Spouse	200% of Sum Insured
Loss of one limb / one eye of	Proposer or Spouse	50% of Sum Insured
	Proposer and Spouse	100% of Sum Insured

If the dependent daughter(s) specified in the schedule, is/are minor at the time of claim, then the money will be deposited as fixed deposit in a Nationalized Bank, to be paid to daughter(s) after attaining majority.

Note: The Company shall not be liable under this Policy for Compensation under more than one of the sub-clauses, as mentioned above, in respect of same Injury or disablement.

In the event of unfortunate death of all the Insured Persons specified in the policy, no such benefits shall be payable under this Section.

Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

6. WHAT IS HOSPITAL CASH BENEFIT?

This policy provides for payment of Hospital Cash at the rate of 0.1% of Sum Insured per day of Hospitalisation. This benefit will be given in every case of admissible claim and for each member. This benefit is applicable only where Hospitalisation exceeds twenty-four consecutive hours.

The total payment for Any One Illness shall not exceed 1% of the Sum Insured. This benefit shall be directly given by TPA/underwriting office, as the case may be.

7. WHAT IS CRITICAL CARE BENEFIT?

If during the Period of Insurance any Insured Person discovers that he or she is suffering from any Critical Illnesses as defined under 2.9 of the Policy Clause, which results in a claim admissible under this Policy, 10% of the Sum Insured would be paid as Critical Care Benefit along with the admissible claim amount.

Critical Care Benefit is payable only once in the life time of each Insured Person and is not applicable to any Insured Persons for whom it is a Pre- Existing Condition/Disease.

Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

If during the Period of Insurance any Insured Person discovers that he/she is suffering from any Critical Illnesses as listed below and as defined under 2.9 of the Policy Clause, which results in a claim admissible under this Policy, we will pay flat 10% of Sum Insured as additional benefit i.e. over and above the admissible claim:

a. Cancer of Specified severity
b. First Heart attack of specified severity
c. Open chest CABG
d. Open Heart replacement or repair of Heart valves
e. Coma of specified severity
f. Kidney failure requiring regular dialysis
g. Stroke resulting in permanent symptoms
h. Major organ / bone marrow transplant
i. Permanent paralysis of limbs
j. Motor neurone disease with permanent symptoms
k. Multiple sclerosis with persisting symptoms

Refer to Policy Clause 2.9 for further details.

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

Pre-acceptance test is required for all the members entering after the age of 50 for the first time. A person with an adverse medical history also needs to undergo this pre-acceptance medical check-up. 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. List of Medical Tests required are as below.

CBC	Serum HDL
Blood Sugar Fasting & Post Prandial	Routine Urine Examination (RUE)
SGPT	Resting ECG
SGOT	X RAY Chest PA View
Serum Cholesterol	Physician Check Up
Serum Triglycerides	Eye Check Up For Cataract & Glaucoma

Note: Adverse Medical History means a person:

i. Who has undergone more than one Hospitalization in previous two years,

ii. Who is suffering from Critical Illness, Recurring Illness or Chronic Illness

iii. Is Suffering from Hypertension / Diabetes.

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

9. DOES THIS INSURANCE COVER ALL CASES OF HOSPITALISATION?

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

STANDARD EXCLUSIONS

- **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.

- **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

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

- **FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)**

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

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

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

- **EXCLUSIONS**

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

- **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
- **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.
- **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
- **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.
- **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.
- **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.

- **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.

- **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.

- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**
- 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)**
- 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)**
- **REFRACTIVE ERROR (Code- Excl15)**

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

- **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.

- **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

- **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

- Acupressure, acupuncture, magnetic therapies.
- Any expenses incurred on Domiciliary Hospitalization.
- Service charges, Surcharges, Luxury Tax, Admission fees, Registration fees, Record Charges and Telephone Charges levied by the Hospital.

- Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.
- Circumcision unless Medically Necessary or as may be necessitated due to an Accident.
- Convalescence and General debility.
- Cost of braces, equipment or external prosthetic devices, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants.
- 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 and equipment, which is subsequently used at home and outlives the use and life of the Insured Person.
- 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.
- Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.14.12 of the Policy Clause.
- Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- Treatment taken outside the geographical limits of India.
- Vaccination and/or inoculation.
- 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.
- Payment or compensation in respect of death, Injury or disablements directly or indirectly arising out of or contributed to or traceable to any disability already existing on the date of commencement of this policy.
- 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 twenty-four consecutive hours.
- Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.

10. WHAT IS A PRE EXISTING DISEASE?

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

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

b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the Policy or its reinstatement.

11. 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.

In case of Death Claim, Hospitalisation is not required but the death certificate, post mortem report and police report is required.

In case of Disability, Hospitalisation is not required but medical certificate certifying the disablement and police report (if any) is required

12. 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.

13. WHAT ARE THE DAY CARE TREATMENTS COVERED UNDER THIS POLICY?

Day Care Procedures shall be as per Annexure 1 of the Policy Clause.

14. WHAT DO I NEED TO DO IF ANYBODY COVERED IN THE POLICY NEEDS TO GET HOSPITALISED?

For Hospitalization Claim

Upon the happening of any event which may give rise to a claim under the policy, please immediately intimate the TPA named in the schedule with all the details such as name of the Hospital, details of treatment, patient name, policy number etc.

In case of emergency Hospitalisation, this information needs to be given to the TPA, within 24 hours from the time of Hospitalisation.

For Personal Accident:

In case of death claim:

- Nominee as specified in the policy schedule should immediately notify the policy issuing office
- Submit the claim form along with death certificate, post mortem report, police report and original policy.

In case of Injury claim:

- Notify the policy issuing office immediately.
- Submit Police report if any.
- Submit claim form along with medical certificate certifying the disablement.

These are important conditions that you need to comply with.

15. WHAT ARE THE AMBULANCE CHARGES PAID UNDER THIS POLICY?

Company will pay ambulance charges up to 1% of SI or actual whichever is less. These charges are available in case of emergency extraction from anywhere to Hospital or Hospital to Hospital.

16. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Medical Expenses incurred immediately before, but not exceeding thirty days, the Insured Person is Hospitalised will be paid, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

17. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Medical Expenses incurred immediately after, but not exceeding sixty days, the Insured Person is discharged from the Hospital will be paid, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

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

Yes. We will pay Hospitalisation expenses upto 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, and

c) expenses paid for medical expenses after discharge from Hospital Shall not exceed the Sum Insured.

The Sum Insured under the policy is available for any or all the members covered for one or more claims during the tenure of the policy.

For Personal accident, the coverage will be as described under Section II of Q.4

19. CAN I GET TREATED ANYWHERE IN INDIA?

The Policy covers treatment only in India. Even within India, if premium is paid for lower Zone and treatment taken in higher Zone, our liability towards any claim will be 80% of admissible claim amount or Sum Insured, whichever is less. Zone Classification is given below.

Illustration:

1) Insured XYZ, Sum Insured: Rs. 200000, Zone Selected: Zone III :

Admissible Claim: Rs. 80000, Treatment taken in: Zone II

In such case Our liability will be 80% of the admissible claim amount i.e. Rs. 64000 (80% of Rs. 80000). Rest of the amount will be borne by the Insured i.e. Rs. 16000.

2) Insured ABC, Sum Insured: Rs. 200000, Zone Selected: Zone II Admissible Claim: Rs. 300000, Treatment taken in: Zone I

In such case, our liability will be 80% of admissible claim amount i.e. Rs. 240000 (80% of Rs. 300000). But the claim amount cannot exceed the Sum Insured viz. Rs. 200000. Thus, our total liability will be Rs. 200000.

Note: Co-pay will not be applied on the Sum Insured, it is always applicable on the admissible claim amount.

Zone- I	**Greater Mumbai** (includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli,Ulhasnagar, Ambarnath, Badlapur) and **State of Gujarat**
Zone-II	**Delhi NCR** (includes Faridabad, Gurgaon, Mewat, Rohtak, Sonepat, Rewari, Jhajjhar, Panipat and Palwal, Meerut, Ghaziabad, GautamBudha Nagar, Bulandshahr, and Baghpat, Alwar and NCT of Delhi), **Bangalore, Chennai, Hyderabad and Secunderabad, Pune and Kolkata**
Zone-III	**Rest of India (other than those areas specified in Zone I and II)**

The Cities mentioned below would include their Urban Agglomeration. The Insured Person can choose the Zone at the time of proposal, and can also change it at the time of renewal. It is therefore in your interest to choose the appropriate Zone and pay the necessary premium depending upon your preference for coverage.

20. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured from Rs. 2, 3, 5, 8, 10, 12 and 15 Lakhs. The premium payable is determined based on the following criteria:

a. The premium for the eldest member of the family. (Premium from Primary Member Premium Table)

b. Premium for All additional members to be covered in this policy. (Premium from Additional Member Premium Table)

c. Premium for the daughter(s) shall be 50% of her premium from Additional Member Premium Table.

d. Sum Insured

e. Zone

You are free to choose any Sum Insured available as specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs.

21. 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.

22. 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, 2021 date of expiry is usually on 1st October, 2022. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2022.

The Company, with prior approval of lRDAl, may withdraw, 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.

You can choose to migrate to any of our existing Policy, subject to Regulations of IRDAI (Protection of Policyholders’ Interest) Regulations, 2017 and the Guidelines of IRDAI on Portability and Migration of Health Insurance Policies, as amended from time to time.

Please note that:

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

23. 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 Coverage. If an Insured took a Policy in October, 2019, does not renew it on time and takes a Policy only in December 2020, and renewed it on time in December 2021, 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 2020 and then in October 2021, then he would have been continuously covered for twenty-four months and therefore his claim for Cataract in the Policy beginning from October 2021 would be payable. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires.

24. 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 Illness contracted or Injury 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.

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

Yes. You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum Insured, we have the right to have You examined by a Medical Practitioner authorized by Us or the TPA (50% of Medical examination cost will be reimbursed to the Insured Person). Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

Enhancement of Sum Insured shall be allowed based on the following table:

Age<=50 years	Enhancement up to Sum Insured of 15 lakhs without Medical Examination.
Age 51-60 Years	Enhancement by two slabs without Medical Examination
Age 51-60 Years	Enhancement up to 15 Lakhs with Medical Examination
Age 61-65 Years	Enhancement by one slab with Medical Examination

Enhancement of Sum Insured will not be considered for:

1) Insured Persons over 65 years of age.

2) Insured Person who had undergone Hospitalization in the preceding two years.

3) Insured Persons suffering from one or more of the following Illnesses/Conditions:

    i) Any chronic Illness/ Ailment

ii) Any recurring Illness/ Ailment

iii) Any Critical Illness

In respect of any increase in Sum Insured, exclusion 4.1, 4.2, 4.3 would apply to the additional Sum Insured from the date of such increase.

26. WHAT IS PORTABILITY AND MIGRATION?

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

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then you can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc. in the previous policy to the migrated policy

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

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If policyholder is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an Indian General or Health Insurer, then policyholder can transfer the credit gained to the extent of the sum insured, no claim bonus, specific waiting period for pre-existing diseases, moratorium period etc from the existing insurer to the acquiring insurer in the previous policy

27. 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.

Children between 18 years to 25 years can be continued to be covered in the Policy 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).

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.

28. 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

non- disclosure of material facts 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.

29. 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 Hospitalisation due to accidents occurring even during the first thirty days are payable. There are certain treatments where the waiting period is 90 days, two years or four years.

30. 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 Hospitalisation that come under the scope of the policy. The TPA also settles reimbursement claims within the scope of the Policy.

31. WHAT IS CASHLESS HOSPITALISATION?

Cashless Hospitalisation is service provided by the TPA on Our behalf whereby you are not required to settle the Hospitalisation 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 Networked Hospital. You may visit our Website at http://newindia.co.in/listofhospitals.aspx. The list of

Networked Hospitals can also be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Networked 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.

32. 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 Us / TPA on the merits of the case and as per policy terms and conditions.

33. 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 Fifteen days from the date of Discharge from the Hospital:

i. Claim Form duly filled and signed by the claimant

ii. All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history

iii. Numbered Bill/Receipt and Discharge certificate / card from the Hospital.

iv. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.

v. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.

vi. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.

vii. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.

viii. Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

ix. In case of Post-Hospitalisation treatment, submit all claim documents within 15 days after completion of such treatment.

x. Provide TPA with authorization to obtain medical and other records from any Hospital, Laboratory or other agency.

34. HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALISATION 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 his/her TPA/underwriting office, whichever applicable. The bills must be sent to the TPA/underwriting office within 15 days from the date of completion of treatment. You must also provide the TPA/underwriting office with additional information and assistance as may be required by the Company/TPA in dealing with the claim.

35. 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 Hospitalisation as per Policy conditions and is supported by proper documents, except the expenses which are excluded.

Personal Accident claims will be paid as mentioned Point 5 –Section II, without any deductions. Hospitalisation cover is independent of Personal Accident cover. Upon happening of accident if the Insured Person is Hospitalised, Hospitalisation will be paid in addition to compensation being paid under Personal Accident coverage.

36. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes. A claim, which is not covered under the Policy conditions, can be rejected. Claims may also be rejected in the event of misrepresentation, misdescription or nondisclosure of any material fact/particular. In case of any grievance the insured person may contact the company through

Website: https://www.newindia.co.in/portal/readMore/Grievances

Toll free: 1800-209-1415

E-mail, Fax and Courier: As mentioned in the above address Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at https://www.newindia.co.in/portal/readMore/Grievances

For updated details of grievance officer, kindly refer the link https://www.newindia.co.in/portal/readMore/Grievances

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Please refer to Annexure III of the Policy Clause.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irdai.gov.in

37. 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.

The insurer shall refund-

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

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

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

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

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

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

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

38. 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.

lf the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a) 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

b) 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

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

39. 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.

40. WHAT WILL HAPPEN TO THE POLICY WHEN THE DAUGHTER/S BECOMES FINANCIALLY DEPENDENT OR A BOY CHILD IS BORN AFTER TAKING THE POLICY?

The Company shall offer an option to migrate to suitable Health Insurance policy once the daughter/s become financially independent or a Boy child is born after taking the policy.

New India Asha Kiran Policy - Premium Chart (Excluding GST)

Sum Insured	Zone	PRIMARY MEMBER Premiums applicable at different ages (Rs. per annum excluding GST)								
		0-20 Y	21-30 Y	30-35 Y	36-40 Y	41-45 Y	46-50 Y	51-55 Y	56-60 Y	61-65 Y
2,00,000	**I**	3,223	4,385	5,216	6,394	8,300	10,137	14,156	17,325	29,211
3,00,000	**I**	4,496	5,936	6,695	8,166	10,607	12,953	18,822	22,993	38,873
5,00,000	**I**	6,412	8,709	9,805	11,998	13,934	17,027	25,616	31,321	53,183
8,00,000	**I**	7,873	10,687	12,045	14,733	17,118	20,901	31,449	39,058	65,295
10,00,000	**I**	8,987	12,206	13,742	16,815	19,528	23,863	35,901	43,610	74,048
12,00,000	**I**	9,770	13,269	14,940	18,280	21,230	25,944	39,029	47,344	80,390
15,00,000	**I**	11,076	15,043	16,937	20,724	24,068	29,411	44,245	53,576	90,970
Sum Insured	**Zone**	**0-20 Y**	**21-30 Y**	**30-35 Y**	**36-40 Y**	**41-45 Y**	**46-50 Y**	**51-55 Y**	**56-60 Y**	**61-65 Y**
2,00,000	**II**	2,929	3,985	4,748	5,805	7,537	9,217	12,873	15,750	26,561
3,00,000	**II**	4,092	5,401	6,080	7,423	9,637	11,772	17,108	20,909	35,332
5,00,000	**II**	5,826	7,913	8,919	10,901	12,673	15,481	23,289	28,468	48,348
8,00,000	**II**	7,152	9,716	10,949	13,389	15,565	19,003	28,593	35,509	59,363
10,00,000	**II**	8,165	11,091	12,500	15,278	17,761	21,698	32,640	39,637	67,316
12,00,000	**II**	8,876	12,057	13,589	16,609	19,308	23,587	35,484	43,032	73,082
15,00,000	**II**	10,063	13,669	15,406	18,829	21,889	26,741	40,227	48,696	82,700
Sum Insured	**Zone**	**0-20 Y**	**21-30 Y**	**30-35 Y**	**36-40 Y**	**41-45 Y**	**46-50 Y**	**51-55 Y**	**56-60 Y**	**61-65 Y**
2,00,000	**III**	2,633	3,587	4,280	5,233	6,791	8,300	11,592	14,172	23,909
3,00,000	**III**	3,687	4,868	5,466	6,679	8,667	10,592	15,393	18,822	31,808
5,00,000	**III**	5,242	7,117	8,033	9,805	11,411	13,934	20,961	25,616	43,514
8,00,000	**III**	6,431	8,746	9,855	12,058	14,013	17,103	25,739	31,962	53,431
10,00,000	**III**	7,346	9,975	11,260	13,742	15,993	19,528	29,378	35,665	60,585
12,00,000	**III**	7,985	10,844	12,241	14,940	17,387	21,230	31,937	38,720	65,773
15,00,000	**III**	9,053	12,294	13,877	16,937	19,711	24,068	36,205	43,816	74,430

Sum Insured	Zone	ADDITIONAL MEMBER Premiums applicable at different ages (Rs. per annum excluding GST)								
		0-20 Y	21-30 Y	30-35 Y	36-40 Y	41-45 Y	46-50 Y	51-55 Y	56-60 Y	61-65 Y
2,00,000	**I**	435	624	884	1075	1,906	2,322	4,920	6,013	18,988
3,00,000	**I**	600	840	1,100	1,359	2,442	2,992	6,518	7,973	25,242
5,00,000	**I**	857	1,247	1,638	1,998	3,199	3,919	8,875	10,857	34,550
8,00,000	**I**	1054	1,525	2,011	2,454	3,936	4,810	10,881	13,320	42,412
10,00,000	**I**	1,200	1,748	2,295	2,800	4,484	5,493	12,438	15,116	48,105
12,00,000	**I**	1,305	1,900	2,495	3,044	4,874	5,972	13,521	16,411	52,225
15,00,000	**I**	1,480	2,154	2,828	3,451	5,525	6,771	15,329	18,570	59,099
Sum Insured	**Zone**	**0-20 Y**	**21-30 Y**	**30-35 Y**	**36-40 Y**	**41-45 Y**	**46-50 Y**	**51-55 Y**	**56-60 Y**	**61-65 Y**
2,00,000	**II**	399	573	798	970	1,733	2,114	4,470	5,458	17,256
3,00,000	**II**	550	761	1002	1,229	2,217	2,717	5,918	7,245	22,946
5,00,000	**II**	781	1,126	1,487	1,817	2,913	3,560	8,064	9,866	31,412
8,00,000	**II**	957	1,386	1,829	2,232	3,576	4,367	9,896	12,113	38,558
10,00,000	**II**	1095	1,580	2,085	2,548	4,082	4,989	11,301	13,736	43,735
12,00,000	**II**	1,189	1,717	2,266	2,770	4,439	5,423	12,286	14,913	47,480
15,00,000	**II**	1,349	1,946	2,569	3,139	5,031	6,148	13,928	16,875	53,730
Sum Insured	**Zone**	**0-20 Y**	**21-30 Y**	**30-35 Y**	**36-40 Y**	**41-45 Y**	**46-50 Y**	**51-55 Y**	**56-60 Y**	**61-65 Y**
2,00,000	**III**	365	520	712	867	1,560	1,906	4,019	4,920	15,523
3,00,000	**III**	502	679	905	1,100	1,990	2,442	5,321	6,518	20,650
5,00,000	**III**	706	1021	1,338	1,638	2,628	3,199	7,253	8,875	28,274
8,00,000	**III**	859	1,247	1,650	2,011	3,215	3,936	8,912	10,909	34,705
10,00,000	**III**	990	1,431	1,874	2,295	3,684	4,484	10,165	12,356	39,366
12,00,000	**III**	1076	1,555	2,037	2,495	4,005	4,874	11,051	13,415	42,738
15,00,000	**III**	1,220	1,763	2,310	2,828	4,540	5,525	12,528	15,180	48,363

Premium will increase by 2% for every year after the age of 65 years for both Primary and Additionalmembers.

Optional Covers – Per Member Premium (Excluding GST)							
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
5,00,000	770	817	1,348	2,031	2,634	3,485	4,995
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					
SI	5,00,000	8,00,000	10,00,000	12,00,000	15,00,000
(Rs.)	5,000	8,000	10,000	12,000	15,000

Sum Insured (Rs.)	OPTIONAL COVER III : REVISION IN LIMIT OF CATARACT				
	<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

Optional Cover IV: For Non-Medical Items (Consumables): This optional cover is for covering medical consumables (non-Payable items). It is applicable for Sum Insured of 8 L & above, and is payable up to a maximum of Rs. 15,000 per policy period. The premium charged for this add on cover will be rated Rs 1500/- per member.