THE NEW INDIA ASSURANCE CO. LTD.

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

NIA MODERN TREATMENT RIDER

Policy Clause

1. **Preamble:** The Rider is granted by Us under Base Policy based on the information provided by the Proposer / Policyholder in their proposal, and is subject to the definitions, terms and conditions, exclusions, and endorsements of the **Base policy**. The accuracy and completeness of the information provided by the policyholder is crucial in determining the Rider's terms and conditions.

   The meanings assigned to the terms defined below apply to their usage throughout the Rider and as applicable.

2. **Definitions:**

Standard Definition

2.1 Deductible: Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Specific Definitions

2.2 Base Policy: Base Policy means any Retail Health Product of New India Assurance Co Ltd to which the Rider shall be attached**.**

The other standard and specific definitions will be as per base policy and will have the meaning ascribed to them wherever they appear in this Rider where appropriate.

3. **Benefits covered under this Rider**

In consideration of the premium paid, subject to the terms, conditions, exclusions and definitions contained herein the company agrees to pay for the Modern Treatment Procedures and The limit stated for the same under the Base policy stands modified, as stated hereunder:

The following Modern Treatment or Procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 100% of Sum insured**.**

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation.
d. Oral chemotherapy.
e. Immunotherapy- Monoclonal Antibody to be given as injection
f. Intravitreal injections.
g. Robotic surgeries.
h. Stereotactic radio surgeries.
i. Bronchial Thermoplasty.
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).
k. IONM - (Intra Operative Neuro Monitoring).
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured for which the Insured Person is covered as mentioned in the Policy Schedule.

Provided that,

a) The Rider can be purchased along with the **Base Policy** and cannot be purchased in isolation or as a separate product.
b) Modern treatment procedure Rider can be purchased only at the time of inception or at renewal of the Base policy and cannot be opted in/out during the course of policy.
c) In case of a payment of a claim under Modern Treatments, this Rider cannot be opted out at the time of Renewal.
d) Modern treatment procedures are payable only once during a policy period (this is applicable only to surgical procedures i.e. except for Oral Chemotherapy, Intravitreal Injections and Immunotherapy- Monoclonal Antibody to be given as injection)
e) A deductible of 10% is applicable on the admissible claim amount of every claim as follows. Example is given in Annexure for Illustration.
    a. Deductible shall be applied on the claim amount that exceeds the sublimit stated under the Base Policy.
    b. Deductible shall not be applicable up to the Sub-limits under the base policy.
f) No pre and post hospitalization expenses are payable for claims under Oral Chemotherapy.

4. Standard Condition:

4.1 DISCLOSURE OF INFORMATION: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

4.2 CONDITION PRECEDENT TO ADMISSION OF LIABILITY:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

4.3 COMPLETE DISCHARGE

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4.4 DISCLOSURE OF INFORMATION

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

4.5 FRAUD

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

i. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
ii. the active concealment of a fact by the insured person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

4.6 FREE LOOK PERIOD

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen 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.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

4.7 MULTIPLE POLICIES

i. ln case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. ln all such cases the Insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. lnsured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

Note: The Insured Person must disclose such other Insurance at the time of making a claim under this Policy.

4.8 MORATORIUM PERIOD

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

4.9 NOMINATION:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

4.10 CLAIM SETTLEMENT (PROVISION FOR PENAL INTEREST)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. ln the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. ln such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. ln case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
v. "Bank rate" shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due.

4.11 RENEWAL OF POLICY

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

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.

4.12 WITHDRAWAL OF POLICY

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

4.13 POSSIBILITY OF REVISION OF TERMS OF THE POLICY, INCLUDING THE PREMIUM RATES

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.

4.14 REDRESSAL OF GRIEVANCE

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.

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

4.15 PORTABILITY AND MIGRATION:

Migration:

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 will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

Portability:

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 such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an India General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

Specific Conditions:

4.16 The Rider Cover shall be available only if the same is specifically mentioned in the Base Policy Schedule.

4.17 Any claim under this Rider Cover will be subject to an admissible claim under the Base Policy.

4.18 The Total Liability for Modern Treatments in any case shall not exceed the Sum Insured under the Base Policy.

4.19 The Entry Age for this Rider shall be up to the Entry Age of the respective Base Policy subject to the below conditions. However, This Rider is not available for persons suffering from or suffered in the past one or more of the following Illnesses/Conditions:

- Cancer (even if treatment is completed)
- Age related macular degeneration
- Sickle cell anaemia
- Thallassemia Major

4.20 All other terms, conditions and exclusions wherever and to the extent applicable shall be as per the Base policy.

Annexure

<table>
<tr><td colspan="2">Sum Insured: 5L</td><td colspan="3">For example, Sub-limt for a Modern Treatment Upto 10% of Sum Insured subject to Maximum upto Rs. 1 Lakh i.e. 50,000 for a SI of 5 L without Rider Option, however with this Rider option the Claim payable amount under the Policy Period will be Rs. 5 L subject to the T&Cs and Deductible</td></tr>
<tr><td>Claim</td><td>Claim Admissible Amount</td><td>Claim Payable Amount</td><td>Remarks</td><td>Balance Sublimit after payment of Claim</td></tr>
<tr><td>Claim 1</td><td>30,000</td><td>30,000</td><td>Deductible not applied as the claim admissible amount is within the sublimit of Rs. 50,000</td><td>20,000</td></tr>
<tr><td>Claim 2</td><td>15,000</td><td>15,000</td><td>Deductible not applied as the claim admissible amount is within the balance sublimit of the Rs. 20,000</td><td>5,000</td></tr>
<tr><td>Claim 3</td><td>40,000</td><td>Rs, 36,500
Bifurcation is as follows
[5,000 - Balance Sublimit amount
Plus
31,500 - (After Applying 10% Deductible on 35,000)]</td><td>Deductible applied on 35,000 as Rs. 5,000 was only available out of the Actual Sublimit of Rs. 50,000</td><td>0</td></tr>
<tr><td>Claim 4</td><td>60,000</td><td>54,000</td><td>Deductible applied on 60,000 as the amount exceeded the sublimit of 50,000)</td><td>0</td></tr>
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