THE NEW INDIA ASSURANCE CO. LTD.

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

AROGYA SANJEEVANI POLICY, THE NEW INDIA ASSURANCE CO. LTD

PROSPECTUS

We welcome You as Our Customer. This document explains how the **AROGYA SANJEEVANI POLICY**, The New India Assurance Co. Ltd could provide value to You. In the document the word 'You', 'Your' means you, the Insured under the Policy. 'We', 'Our', 'Us' means New India Assurance Co. Ltd.

AROGYA SANJEEVANI POLICY, The New India Assurance Co. Ltd is a Policy designed to cover Hospitalisation expenses incurred in India.

1. **WHO CAN TAKE THIS POLICY?**

   All the persons proposed for this Insurance should be between the age of 18 years and 65 years. Children between the age of 3 months and 18 years are covered provided one or both parents are covered concurrently. Children between 18 years to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously. On attaining the age of 18 years or ceasing to be financially dependent on the parents, they can, on renewal take a separate Policy. In such an event the benefits on Continuous Coverage can be ported to the new Policy. The upper age limit will not apply to mentally challenged children and an unmarried dependent daughter(s). The persons beyond 65 years can continue their insurance provided they are Insured under the Policy with us without any break.

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

   Yes. You can cover Your family members in one policy.

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

   a) Proposer
   b) Proposer's Spouse
   c) Proposer's Children
   d) Proposer's Parents
   e) Proposer's Parents-In Law

   Note:

   1. **Individual Sum Insured**: Maximum 10 members can be covered under the policy
   2. **Floater Sum Insured**: Minimum 2 members and Maximum 10 members can be covered under the Floater Policy.
   3. 1 Proposer, 1 Spouse, 2 Parents, 2 Parents in Law and 4 Children are allowed.
   4. For the relation Parents-In Law 80 D certificate shall not be given.

3. **WHAT DOES THE POLICY COVER?**

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

4. WHAT IS ABHA NUMBER?

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

5. WHAT IS A PRE-EXISTING DISEASE?

The term Pre-existing condition/disease is defined in the Policy. It is defined as:

Pre-Existing disease means any condition, ailment, injury or disease

i. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer and its reinstatement or
ii. 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

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

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

Yes. It is required for persons above 50 Years and for Sum Insured of 5.5 Lakhs and above. However, the condition 50 Years shall be relaxed to 60 years' subject to the following conditions:

a. A minimum of 3 persons should be covered in the policy.
b. At least one of the members age should be less than 35 Years.

Irrespective of the above conditions, a person needs to undergo this pre-acceptance medical check-up if he has an adverse medical history. The cost of this check-up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this check- up will be reimbursed to the proposer.

Note: Adverse Medical History means a person:

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.

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

We may agree for a request for increase in Sum Insured at the time of renewal. But We are not obliged to agree to this request, if the Person is not in good health.

Sum Insured can be increased subject to the fulfillment of the above conditions.

In respect of any enhancement of Sum Insured, exclusions policy clause 6.1, 6.2 and 6.3 would apply to the additional Sum Insured from such date.

8. **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.

9. **HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED?**
The Policy pays only where the Hospitalisation is for more than twenty-four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty-four hours. Please refer to the **Annexures-C** of policy clause for the list of Day Care Procedures.

10. **WHAT DO I NEED TO DO AFTER I GET HOSPITALISED?**
Immediately on Hospitalisation or within twenty-four hours of such Hospitalisation, please intimate the TPA of this fact, with details of Your Policy Number, Name of the Hospital and treatment undertaken. This is an important condition of the Policy that you need to comply with.

11. **IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?**
Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of Hospitalisation are payable. Relevant medical expenses mean expenses related to the treatment of the disease for which the insured is Hospitalised.

12. **IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?**
Yes. Relevant medical expenses incurred after Discharge from the Hospital for a period of SIXTY days after the date of discharge are payable. Relevant medical expenses mean expenses related to the treatment of the disease for which the insured is Hospitalised.

13. **CAN I GET TREATED ANYWHERE IN INDIA?**
Yes, the Policy covers treatment and/or services rendered only in India.

14. **IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALISATION?**
Yes. We will pay Hospitalisation expenses up to a limit, known as **Sum Insured**. In cases where the Insured Person was Hospitalised more than once, the **total of all amounts** paid

    a) for all cases of Hospitalisation,
    b) expenses paid for medical expenses prior to Hospitalisation,
    c) expenses paid for medical expenses after discharge from hospital, and
    d) any other payment made under the Policy

    Shall not exceed the Sum Insured and Cumulative Bonus as mentioned in the Schedule.

    Note: For Floater Policy 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.

15. **WHAT SUM INSURED SHOULD I CHOOSE?**
You are free to choose any Sum Insured ranging from Rs. 50,000 to Ten Lakhs (in multiples of 50,000). The Premium You pay depends upon Your Age and the Sum Insured chosen. You are free to choose any Sum Insured available in the range specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs.

16. 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.

17. IN CASE OF AYUSH TREATMENT, WILL THE ENTIRE AMOUNT BE PAID?

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.

18. 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, 2019 date of expiry is usually on 1st October, 2020. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2020.

19. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, Cataract is covered only after twenty-four months of continuous insurance. If an Insured took a Policy in October, 2018, does not renew it on time and takes a Policy only in December 2019, and renewed it on time in December 2020, 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 2019 and then in October 2020, then he would have been continuously covered for twenty-four months and therefore his claim for Cataract in the Policy beginning from October 2020 would be payable. Therefore, you should always ensure that you pay Your Renewal Premium before Your Policy expires.

20. WHAT IS CUMULATIVE BONUS?

Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Note:

a. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person, if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
b. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
c. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
e. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
f. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
g. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
h. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

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

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

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

No. Your Policy can be renewed, as long as You pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal. However, if You do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to Our underwriting rules. In such cases, it is possible that a fresh Policy could not be issued by Us. It is therefore in Your interest to ensure that Your Policy is renewed before **expiry.**

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

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

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

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

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

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. However, claims for Hospitalization due to accidents occurring during the first thirty days are payable. There are certain treatments where the waiting period is two years or three years. Please refer to the terms and conditions of the policy for the same.

25. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

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

26. 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 or 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.

27. CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes, it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

28. HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

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

a. Duly Completed claim form
b. Photo Identity proof of the patient
c. Medical practitioner's prescription advising admission
d. Original bills with itemized break-up
e. Payment receipts

f. Discharge summary including complete medical history of the patient along with other details.
g. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
h. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
i. Sticker/Invoice of the Implants, wherever applicable.
j. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
k. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
l. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
m. Legal heir/succession certificate, wherever applicable
n. Any other relevant document required by Company/TPA for assessment of the claim.

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

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

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

The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalization as per Policy conditions and is supported by proper documents, except the expenses which are excluded.

31. HOW MUCH WE WILL REIMBURSE?

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

a. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
b. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
d. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

a. Expenses incurred on treatment of cataract subject to the sub limits
b. Dental treatment, necessitated due to disease or injury.
c. Plastic surgery necessitated due to disease or injury
d. All the day care treatments (As per Annexure C attached herewith).
e. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

a. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
b. 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.

AYUSH Treatment

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

Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per eye in one policy year.

Pre-Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

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 50% of Sum Insured, specified in the policy schedule, during the policy period:

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. Intra vitreal 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.

The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

32. CAN ANY CLAIM BE REJECTED OR REFUSED?

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

You also have the right to represent your case to the Insurance Ombudsman. The updated contact details of the office of the Insurance Ombudsman could be obtained from http://ecoi.co.in/ombudsman.html

33. 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

34. 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.

35. WHAT IS MORATORIUM PERIOD?

After completion of five continuous years under this policy no look back would be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of five 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.

36. 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

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;

37. 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 30 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

38. IS THERE ANY CO-PAYMENT UNDER THE POLICY?

Yes, Co-Payment of 5% is applicable on all the claims.

39. IS IT NECESSARY TO HAVE A NOMINEE UNDER THE POLICY?

YES

40. IS INSTALLMENT FACILITY AVAILABLE UNDER THE POLICY?

Yes, it is available, subject to the below terms & conditions.

1. The premium shall be paid on or before the instalment due date as mentioned in the Policy Schedule.
2. Grace Period of 15 days and 30 days would be given for monthly and quarter/half yearly/Annual Installment respectively.
3. If the Premium is paid in installment mode during policy period, then the coverage will be available during grace period.
4. All claims that fall beyond such premium installment due date shall not be payable under the policy. However, we will be liable to pay in respect of all claims where the treatment/admission/accident has commenced/occurred before the date of termination of such Policy.
5. In case of a claim, you will be liable to pay the balance premium due under the policy

before the claim is Intimated.

6. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
7. No interest will be charged If the installment premium is not paid on due date.

41. WHAT ARE THE WAITING PERIODS AND EXCLUSIONS UNDER THIS POLICY?

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

- **Pre-Existing Diseases (Code- Excl01)**
  - 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.
  - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
  - 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.
  - 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)**
  - Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 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.
  - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
  - If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
  - The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
  - 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.
  - **24 Months waiting period**
    - Benign ENT disorders
    - Tonsillectomy
    - Adenoidectomy
    - Mastoidectomy
    - Tympanoplasty
    - Hysterectomy
    - All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
    - Benign prostate hypertrophy

- Cataract and age related eye ailments
- Gastric/ Duodenal Ulcer
- Gout and Rheumatism
- Hernia of all types
- Hydrocele
- Non Infective Arthritis
- Piles, Fissures and Fistula in anus
- Pilonidal sinus, Sinusitis and related disorders
- Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
- Varicose Veins and Varicose Ulcers
- Internal Congenital Anomalies
- Treatment for joint replacement unless arising from accident
- Age-related Osteoarthritis & Osteoporosis

- **36 Months waiting period**
  - Treatment for joint replacement unless arising from accident
  - Age-related Osteoarthritis& Osteoporosis

- **First Thirty Days Waiting Period (Code- Excl03)**
  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.
- This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- 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)**
  - Expenses related to any admission primarily for diagnostics and evaluation purposes.
  - 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:
  - 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.
  - 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:
  - Surgery to be conducted is upon the advice of the Doctor
  - The surgery/Procedure conducted should be supported by clinical protocols

- The member has to be 18 years of age or older and
- Body Mass Index (BMI);
    - greater than or equal to 40 or
    - greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- 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:
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy

- Reversal of sterilization

- **Maternity Expenses (Code - Excl18):**
  - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
  - Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
- **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.
- **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:
  - 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.
  - 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.
  - 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.
- Any expenses incurred on Domiciliary Hospitalization and OPD treatment
- Treatment taken outside the geographical limits of India
- In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

PREMIUM TABLE (Without GST/-).

Premium chart is same for both Individual Sum Insured and Floater Sum Insured.

Annual Premium										
Age	**50000**	**100000**	**150000**	**200000**	**250000**	**300000**	**350000**	**400000**	**450000**	**500000**
<=35	2238	3626	4342	5007	5470	5746	6008	6250	6470	6665
36-45	2351	3805	4557	5257	5743	6034	6309	6563	6794	7000
46-50	4041	6494	7798	9011	9853	10357	10833	11275	11675	12032
51-55	5247	8409	10108	11688	12785	13442	14062	14637	15159	15623
56-60	6807	10893	13102	15155	16581	17436	18241	18989	19667	20271
61-65	9064	14480	17426	20165	22068	23207	24282	25279	26184	26990
66-70	11061	17658	21257	24603	26927	28318	29631	30849	31954	32938
71-75	13501	21541	25936	30023	32861	34561	36165	37652	39002	40203
>=76	16481	26283	31651	36642	40110	42185	44144	45961	47609	49077

Half yearly premium										
Age	**50000**	**100000**	**150000**	**200000**	**250000**	**300000**	**350000**	**400000**	**450000**	**500000**
<=35	1165	1884	2254	2599	2839	2982	3118	3243	3357	3458
36-45	1223	1976	2366	2729	2980	3131	3273	3405	3525	3632
46-50	2098	3369	4045	4673	5110	5371	5618	5846	6054	6239
51-55	2723	4362	5242	6060	6629	6969	7291	7588	7859	8099
56-60	3532	5648	6793	7857	8596	9038	9456	9843	10195	10507
61-65	4701	7507	9033	10453	11438	12029	12586	13102	13571	13988
66-70	5736	9154	11018	12752	13956	14677	15357	15988	16560	17070
71-75	7000	11165	13443	15560	17030	17911	18742	19512	20212	20834
>=76	8544	13622	16404	18989	20786	21861	22876	23817	24671	25432

Quarterly premium										
Age	**50000**	**100000**	**150000**	**200000**	**250000**	**300000**	**350000**	**400000**	**450000**	**500000**
<=35	596	962	1151	1327	1449	1522	1591	1655	1713	1765
36-45	626	1009	1208	1393	1521	1598	1670	1738	1799	1853
46-50	1072	1719	2064	2384	2606	2739	2865	2982	3087	3181
51-55	1390	2225	2674	3091	3380	3554	3717	3869	4007	4130
56-60	1802	2881	3464	4006	4383	4608	4821	5018	5197	5357
61-65	2398	3828	4606	5329	5831	6132	6416	6679	6918	7130
66-70	2925	4667	5617	6500	7114	7481	7828	8149	8441	8701
71-75	3569	5692	6852	7931	8680	9129	9552	9945	10301	10619
>=76	4356	6944	8361	9679	10594	11142	11659	12139	12574	12961

Monthly premium										
Age	**50000**	**100000**	**150000**	**200000**	**250000**	**300000**	**350000**	**400000**	**450000**	**500000**
<=35	209	333	397	456	497	522	545	567	586	604
36-45	219	349	416	478	522	548	572	595	615	634
46-50	370	589	705	813	888	933	975	1015	1050	1082
51-55	477	759	911	1051	1149	1208	1263	1314	1361	1402
56-60	617	981	1177	1360	1487	1564	1635	1702	1762	1816
61-65	818	1300	1563	1807	1976	2078	2174	2262	2343	2415
66-70	996	1583	1904	2202	2409	2533	2650	2759	2857	2945
71-75	1213	1929	2321	2685	2938	3089	3232	3365	3485	3592
>=76	1478	2352	2830	3275	3584	3769	3943	4105	4252	4383

Annual Premium										
Age/Sum Insured	550000	600000	650000	700000	750000	800000	850000	900000	950000	1000000
<=35	6877	7045	7200	7343	7477	7602	7719	7829	7934	8033
36-45	7222	7399	7561	7712	7852	7983	8106	8223	8332	8437
46-50	12414	12717	12997	13256	13497	13722	13934	14133	14322	14501
51-55	16119	16513	16876	17212	17525	17818	18093	18352	18597	18829
56-60	20914	21426	21897	22333	22739	23118	23475	23811	24129	24431
61-65	27846	28528	29155	29735	30275	30781	31256	31703	32127	32529
66-70	33983	34815	35580	36288	36948	37565	38144	38691	39208	39698
71-75	41479	42494	43428	44293	45098	45851	46558	47225	47856	48454
>=76	50634	51874	53014	54069	55052	55971	56835	57649	58419	59149

Half yearly premium										
Age	550000	600000	650000	700000	750000	800000	850000	900000	950000	1000000
<=35	3568	3655	3735	3810	3879	3943	4004	4061	4116	4167
36-45	3747	3838	3923	4001	4073	4141	4205	4265	4322	4376
46-50	6437	6594	6739	6873	6998	7114	7224	7327	7425	7518
51-55	8356	8561	8749	8923	9085	9236	9379	9513	9640	9761
56-60	10841	11106	11350	11576	11786	11983	12167	12342	12506	12663
61-65	14432	14785	15110	15411	15691	15953	16199	16431	16650	16858
66-70	17612	18043	18439	18806	19148	19467	19768	20051	20318	20572
71-75	21495	22021	22505	22953	23370	23760	24127	24472	24799	25109
>=76	26239	26881	27471	28018	28527	29004	29451	29873	30272	30650

Quarterly premium										
Age	550000	600000	650000	700000	750000	800000	850000	900000	950000	1000000
<=35	1820	1865	1906	1944	1979	2012	2043	2072	2100	2126
36-45	1912	1958	2001	2041	2078	2113	2145	2176	2205	2232
46-50	3282	3362	3436	3505	3568	3628	3683	3736	3786	3833
51-55	4260	4365	4460	4549	4632	4709	4781	4850	4915	4976
56-60	5526	5661	5786	5901	6008	6108	6202	6291	6375	6455
61-65	7356	7536	7702	7855	7998	8131	8257	8375	8487	8593
66-70	8977	9196	9398	9585	9759	9922	10075	10219	10356	10485
71-75	10955	11223	11470	11698	11911	12110	12296	12472	12639	12797
>=76	13372	13700	14001	14279	14539	14781	15009	15224	15428	15620

Monthly premium										
Age	550000	600000	650000	700000	750000	800000	850000	900000	950000	1000000
<=35	623	638	652	664	676	687	698	708	717	726
36-45	653	669	684	697	710	721	732	743	752	762
46-50	1116	1143	1168	1191	1213	1233	1251	1269	1286	1302
51-55	1446	1481	1514	1544	1571	1598	1622	1645	1667	1688
56-60	1873	1919	1961	2000	2036	2070	2102	2132	2160	2187
61-65	2491	2552	2608	2659	2708	2753	2795	2835	2873	2908
66-70	3038		3180	3243	3302	3357			3503	3547
71-75	3706	3796	3879	3956	4028	4095	4158	4218	4274	4327
>=76	4522	4632	4734	4828	4915	4997	5074	5146	5215	5280

Note:

- Floater Discount

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

- Discount of 20% will be applicable for Policyholders residing in places other than Greater Mumbai (includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli, Ulhasnagar, Ambarnath, Badlapur), entire State of Gujarat, Delhi NCR (includes Faridabad, Gurgaon, Mewat, Rohtak, Sonepat, Rewari, Jhajjhar, Panipat and Palwal, Meerut, Ghaziabad, Gautam Budha Nagar, Bulandshahr, and Baghpat, Alwar and NCT of Delhi), and cities namely Bengaluru, Chennai, Hyderabad, Secunderabad, Pune and Kolkata.
- Digital Discount of 10% is applicable for both Fresh and Renewals. This is only applicable in New India Assurance Customer Portals and it is over and above the Discount of 20%.