THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA ASHA KIRAN POLICY

PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA ASHA KIRAN POLICY could provide value to You. In the document the word 'You', 'Your' means the all the members covered under the Policy. 'We', 'Our', 'Us' means The New India Assurance Co. Ltd.

New India Asha Kiran is a Policy designed to cover Hospitalisation expenses of the family and Personal Accident for Parents.

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

   THIS POLICY IS DESIGNED TO THE PARENTS 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.

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

   Yes. You and Your entire family will be covered 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 DOES THE POLICY COVER?**

   This Policy is designed to give You and Your family, protection against unforeseen Hospitalisation expenses and Accident cover to Proposer and Spouse.

4. **WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?**

   A. Policy covers following Hospitalisation Expenses:

i. Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), actually incurred or 1% of the Sum Insured per day, whichever is less.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses actually incurred or 2% of Sum Insured per day, whichever is less.

iii. Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

iv. Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

v. All Hospitalisation Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant.

vi. For cataract claims, the liability of the company will be restricted to 10% of Sum Insured or Rs. 50000 whichever less, for each eye.

vii. **SPECIFIC COVERAGES**:

a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period, subject to it arising during treatment of covered illness.

b) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

c) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** We shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured.

The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions- aggressive/violent behavior or hallucinations, incoherent talking or agitation.
3. Schizophrenia- esp. Psychotic episodes.
4. Bipolar disorder- manic phase.

Treatment of any Injury due to Suicidality shall not be covered.

Condition

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.

Exclusions

Any kind of Psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

d) 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.

e) Age Related Macular Degeneration (ARMD) is covered after 48 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 upto Rs. 75,000 per policy period.

f) Behavioural and Neuro developmental Disorders: Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period.

g) Genetic diseases or disorders are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

Note: For the coverages defined in 3.1.11, waiting periods, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

viii. **COVERAGE FOR MODERN TREATMENTS OR PROCEDURES**: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
1.	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
2.	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 1 Lakh
3.	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh
4.	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
5.	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 1 Lakh.
6.	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.30,000.
7.	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 2 Lakh.
8.	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
9.	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
10.	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.
11.	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 25,000.
12.	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 1.5 Lakh.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centers.

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.

B. Policy also covers the Personal Accident as per the table below:

S NO	COVERAGE		COMPENSATION
1	Accidental Death of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
2	Permanent Total Disablement of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
3	Loss of one limb and one eye or loss of both eyes and/or loss of both limbs of	Proposer or Spouse	100% of Sum Insured
		Proposer and Spouse	200% of Sum Insured
4	Loss of one limb / sight in one eye of	Proposer or Spouse	50% of Sum Insured
		Proposer and Spouse	100% of Sum Insured

5. 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.

6. WHAT IS CRITICAL CARE BENEFIT?

If during the Period of Insurance any Insured Person is diagnosed to be suffering from any Critical Illness as listed below, we will pay flat 10% of Sum Insured as additional benefit i.e. other than the admissible claim:

1. Cancer
2. First Heart attack of specified severity
3. Open chest CABG
4. Open Heart replacement or repair of Heart valves
5. Coma of specified severity

6. Kidney failure requiring regular dialysis
7. Stroke resulting in permanent symptoms
8. Major organ / bone marrow transplant
9. Permanent paralysis of limbs
10. Motor neurone disease with permanent symptoms
11. Multiple sclerosis with persisting symptoms

This will be paid only if the Hospitalisation is more than 24 hours. Any payment under this clause would be in addition to the Sum Insured and shall not deplete the Sum Insured. This benefit will be paid once in lifetime of any Insured Person. This benefit is not applicable for those Insured Persons for whom it is a pre-existing disease.

7. 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 also 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.

8. DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does NOT cover ALL cases of Hospitalisation.

The exclusions under the policies are:

1. **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 48 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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. **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 / 48 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 pre-existing 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. Behavioural and Neuro-Developmental Disorders:
    a. Disorders of adult personality
    b. Disorders of speech and language including stammering, dyslexia
20. Internal Congenital Diseases

(iii) 48 Months waiting period

1. Joint Replacement due to Degenerative Condition
2. Age-related Osteoarthritis & Osteoporosis
3. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
4. Age Related Macular Degeneration (ARMD)
5. Genetic diseases or disorders
6. External Congenital Diseases

3. 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.

4. 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:

4.1 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

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

4.2 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.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

4.3 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 co-morbidities 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

4.4 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.

4.5 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.

4.6 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.

However, Treatment *related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.*

4.7 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.

4.8 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.

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

4.10 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)**

4.11 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)**

4.12 REFRACTIVE ERROR (Code- Excl15)

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

4.13 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.

4.14 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

4.15 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.

4.16 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.

4.17 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.

4.18 Vaccination and/or inoculation

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

4.20 Dental treatment or Surgery of any kind unless necessitated by accident and requiring Hospitalisation.

4.21 Convalescence, general debility, Venereal disease.

4.22 Bodily Injury or Illness or Death or Disability due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury, attempted suicide.
However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

4.23 Treatment of any Injury or Illness or Disablement or Death, sustained whilst or as a result of participating in any criminal act.

4.24 Naturopathy Treatment.

4.25 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP (Continuous Positive Airway Pressure), Sleep Apnoea Syndrome**,** CPAD (Continuous Peritoneal Ambulatory Dialysis), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump etc. Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Stockings, Elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home.

4.26 Stem cell implantation / Surgery for other than those treatments mentioned in clause 3.1.12.12.

4.27 Domiciliary Hospitalisation

4.28 Acupressure, acupuncture, magnetic therapies

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

4.30 Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

4.31 Circumcision unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an accident.

4.32 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.

9. WHAT IS A PRE EXISTING DISEASE?

PRE-EXISTING DISEASE (PED) means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 48 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 48 months prior to the effective date of the Policy or its reinstatement.

10. 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.

11. HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED FOR MEDICLAIM PURPOSES?

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. The 24 hours treatments are according to the table given in Point 12 below.

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

Following are the day-care treatments covered under this policy (treatments done within 24 hours).

1	Adenoidectomy
2	Appendectomy
3	Anti-Rabies Vaccination
4	Coronary angiography
5	Coronary angioplasty
6	Dilatation & Curettage
7	ERCP (Endoscopic Retrograde Cholangiopancreatography)
8	ESWL (Extracorporeal Shock Wave Lithotripsy)
9	Excision of Cyst/granuloma/lump
10	**FOLLOWING EYE SURGERIES:**
A	Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
B	Corrective surgery for blepharoptosis when not congenital/cosmetic
C	Corrective Surgery for entropion/ectropion
D	Dacryocystorhinostomy [DCR]
E	Excision involving one-fourth or more of lid margin, full-thickness
F	Excision of lacrimal sac and passage
G	Excision of major lesion of eyelid, full-thickness
H	Manipulation of lacrimal passage
I	Operations for pterygium
J	Operations of canthus and epicanthus when done for adhesions due to chronic Infections
K	Removal of a deeply embedded foreign body from the conjunctiva with incision
L	Removal of a deeply embedded foreign body from the cornea with incision
M	Removal of a foreign body from the lens of the eye
N	Removal of a foreign body from the posterior chamber of the eye
O	Repair of canaliculus and punctum
P	Repair of corneal laceration or wound with conjunctival flap
Q	Repair of post-operative wound dehiscence of cornea

R	Penetrating or Non-Penetrating Surgery for treatment of Glaucoma
11	Pacemaker insertion
12	Turbinectomy/turbinoplasty
13	Excision of pilonidal sinus
14	Therapeutic endoscopic surgeries
15	Conisation of the uterine cervix
16	Medically necessary Circumcision
17	Excision or other destruction of Bartholin's gland (cyst)
18	Nephrotomy
19	Oopherectomy
20	Urethrotomy
21	PCNL(percutaneous nephrolithotomy)
22	Reduction of dislocation under General Anaesthesia
23	Transcatherter Placement of Intravascular Shunts
24	Incision Of The Breast, lump excision
25	Vitrectomy
26	Thyriodectomy
27	Vocal cord surgery
28	Stapedotomy
29	Tympanoplasty& revision tympanoplasty
30	Arthroscopic Knee Aspiration if Proved Therapeutic
31	Perianal abscess Incision & Drainage
32	DJ stent insertion
33	FESS (Functional Endoscopic Sinus Surgery)
34	Fissurectomy / Fistulectomy
35	Fracture/dislocation excluding hairline fracture
36	Haemo dialysis
37	Hydrocelectomy
38	Hysterectomy
39	Inguinal/ventral/ umbilical/femoral hernia repair
40	Laparoscopic Cholecystectomy
41	Lithotripsy
42	Liver aspiration
43	Mastoidectomy
44	Parenteral chemotherapy
45	Haemorrhoidectomy
46	Polypectomy
47	**FOLLOWING PROSTATE SURGERIES**
A	TUMT(Transurethral Microwave Thermotherapy)
B	TUNA(Transurethral Needle Ablation)
C	Laser Prostatectomy
D	TURP(transurethral Resection of Prostate)
E	Transurethral Electro-Vaporization of the Prostate(TUEVAP)
48	Radiotherapy
49	Sclerotherapy

50	Septoplasty
51	Surgery for Sinusitis
52	Varicose Vein Ligation
53	Tonsillectomy
54	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
55	Retinal Surgeries
56	Ossiculoplasty
57	Ascitic/pleural therapeutic tapping
58	therapeutic Arthroscopy
59	Mastectomy
60	Surgery for Carpal Tunnel Syndrome
61	Cystoscopic removal of urinary stones / DJ stents
62	AV Malformations (Non cosmetic only)
63	Orchidectomy
64	Cystoscopic fulguration of tumour
65	Amputation of penis
66	Creation of Lumbar Subarachnoid Shunt
67	Radical Prostatectomy
68	Lasik surgery (non-cosmetic)
69	Orchidopexy (non-congenital)
70	Nephrectomy
71	Palatal surgery
72	Stapedectomy& revision of stapedectomy
73	Myringotomy
74	Or any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalisation and for which prior approval from TPA is mandatory.

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

For Mediclaim:

Upon the happening of any event which may give rise to a claim under the policy, please immediately intimate the TPA or underwriting office or nearest office of "The New India Assurance Co. Ltd.", whichever is applicable, 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 or underwriting office, whichever applicable, within 24 hours from the time of Hospitalisation.

For Personal Accident:

In case of death claim:

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

In case of Injury claim:

1. Notify the policy issuing office immediately.
2. Submit Police report if any.
3. Submit claim form along with medical certificate certifying the disablement.
   This is an important condition that you need to comply with.

14. 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.

15. IN CASE OF AYURVEDIC TREATMENT, WILL THE ENTIRE AMOUNT BE PAID?

The liability of the company in case of Ayurvedic/Homoeopathic/ Unani treatment will be 25% of the Sum Insured provided the treatment is taken in a government Hospital or in any institute recognized by government or accredited by Quality Council of India or National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures.

16. 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 cover will be as described in point 4(B).

19. CAN I GET TREATED ANYWHERE?

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

a) 80% of admissible claim amount
b) Sum Insured

Whichever is less.

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.

EACH ZONE IS CLASSIFIED AS BELOW:(The Cities mentioned below would include their Urban Agglomeration)	
Zone- I	**Greater Mumbai (**includes Mira-Bhayandar, Thane, Navi Mumbai, Kalyan-Dombivli, Ulhasnagar, Ambarnath, Badlapur) **andstate 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 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 lakhs, 3 lakhs, 5 lakhs, and8 Lakhs. The premium payable is determined on the following criteria:

1. The premium for the eldest member of the family. (Premium from Primary Member Premium Table)
2. Premium for All additional members to be covered in this policy. (Premium from Additional Member Premium Table)
3. Premium for the daughter(s) shall be 50% of her premium from Additional Member Premium Table.
4. Sum Insured
5. Zone (As per point 19 above)

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, 2011 date of expiry is usually on 1st October, 2012. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2012.

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, 2008, does not renew it on time and takes a Policy only in December 2009, and renewed it on time in December 2010, any claim for Cataract would not become payable, because the Insured Person was not continuously covered for twenty four months. If, he had renewed the Policy in time in October 2009 and then in October 2010, then he would have been continuously covered for twenty four months and therefore his claim for Cataract in the Policy beginning from October 2010 would be payable. 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.

Sum Insured can be enhanced to the next Sum Insured band only.

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:
    a) Diabetes
    b) Hypertension
    c) Any chronic Illness/ Ailment
    d) Any recurring Illness/ Ailment
    e) Any Critical Illness

In respect of any increase in Sum Insured, exclusion 4.1, 4.2, 4.3.1 and 4.3.2as mentioned in point 8 would apply to the additional Sum Insured from the date of such increase.

26. 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**.**

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

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation ornon-disclosureof 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.

28. 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 two years or four years.

29. WHO WILL SETTLE THE CLAIM?

Health claims are generally processed by Third Party Administrator (TPA). 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 processes reimbursement claims within the scope of the Policy.

The person can also opt for servicing through underwriting office. In such event the insured cannot avail cashless facility. No discount will be offered for not opting TPA.

Personal Accident claims will only be processed by the underwriting office.

30. 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 ata 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.
Note: This facility is available only for Mediclaim purposes.

31. 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.

32. 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, 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. Claim Form duly filled and signed by the claimant.
b. Discharge Certificate from the hospital.
c. All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history.
d. Bills, Receipts, Cash Memos from hospital supported by proper prescription.
e. Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
f. Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt.
g. Attending doctor’s / consultant’s / specialist’s / anesthetist's bill and receipt, and certificate regarding diagnosis.
h. Details of previous policies, if the details are not already with TPA or any other information needed by the TPA for considering the claim.

For Personal Accident cases, the Insured Person needs to submit the following documents:

- Claim form duly filled and signed.
- Police report
- Death Certificate and post mortem report (only in case of death)

- Proof of disablement

33. 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 7 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.

34. 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 in Point 4(B) 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.

35. 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 You are not satisfied by the reasons for rejection, You can represent to Us within 15 days of such denial. If You do not receive a response to Your representation or if You are not satisfied with the response, You may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/Content.aspx?pageid=73. You may also call our Call Centre at the Toll free number **1800-209-1415**, which is available 24x7.

You also have the right to represent Your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

36. CAN I CANCEL THE POLICY?

Yes, You can. But the Refund that would be made in case the Policy is cancelled would not be proportionate to the unexpired term of the Policy. Such Refund would be made **only if no claim has been made or paid under the Policy,** and the Refund would be at our Short Period rate table given below:

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

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

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

Mid-term Deletion of members will be on short scale basis.

37. WHAT IS FREE LOOK PERIOD?

The free look period shall be applicable at the inception of first policy.

You will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

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

1) A refund of the premium paid less any expenses incurred by Us on medical examination of the insured persons and the stamp duty charges or;

2) Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover.

38. 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 taxableincome asper Section 80 D of the Income Tax Act, 1961. For details, please refer to the relevant Section of the Income Tax Act.

39. IS CONGENITAL DISEASES COVERED IN THE POLICY?

Yes. **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.**

40. IF THE CLAIM EVENT FALLS WITHIN TWO POLICY PERIODS, HOW MUCH WILL BE PAID?

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of Premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

41. HOW MUCH WILL BE REIMBURSED IF THE PERSON HAS MORE THAN ONE POLICY?

If the Insured Person is covered by more than one policy issued by Us or by any other insurer, where such policies indemnify treatment cost, the Insured Person shall have the right to require a settlement of his claim in terms of any of his policies, provided the admissible claim is within the limits of and according to the terms of the chosen policy.

If the amount to be claimed exceeds the Sum Insured under a single policy after considering Deductibles or Co-Pay, the Insured Person shall have the right to choose insurers by whom the claim is to be settled. In such cases the Company shall not be liable to pay or contribute more than its ratable proportion of the admissible claim.

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

None of the provisions of this Clause shall apply for payments under Personal Accident Section, Hospital cash benefit and Critical care benefit.

42. 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.

PREMIUM CHART

Sum Insured (Rs.)	Zone	PRIMARY MEMBER Premiums applicable at different ages (Rs. per annum excluding GST)								
		0-20	21-30	30-35	36-40	41-45	46-50	50-55	55-60	60-65
200,000	I	1,953	2,657	3,161	3,875	5,030	6,143	8,579	10,500	17,703
300,000	I	2,919	3,854	4,347	5,303	6,888	8,411	12,222	14,931	25,242
500,000	I	4,484	6,090	6,857	8,390	9,744	11,907	17,913	21,903	37,191
800,000	I	5,964	8,096	9,125	11,162	12,968	15,834	23,825	29,589	49,466
200,000	II	1,775	2,415	2,877	3,518	4,568	5,586	7,802	9,545	16,097
300,000	II	2,657	3,507	3,948	4,820	6,258	7,644	11,109	13,577	22,943
500,000	II	4,074	5,534	6,237	7,623	8,862	10,826	16,286	19,908	33,810
800,000	II	5,418	7,361	8,295	10,143	11,792	14,396	21,662	26,901	44,972
200,000	III	1,596	2,174	2,594	3,171	4,116	5,030	7,025	8,589	14,490
300,000	III	2,394	3,161	3,549	4,337	5,628	6,878	9,996	12,222	20,654
500,000	III	3,665	4,977	5,618	6,857	7,980	9,744	14,658	17,913	30,429
800,000	III	4,872	6,626	7,466	9,135	10,616	12,957	19,499	24,213	40,478

Sum Insured (Rs.)	Zone	ADDITIONAL MEMBER Premiums applicable at different ages(Rs. per annum excluding GST)								
		0-20	21-30	30-35	36-40	41-45	46-50	50-55	55-60	60-65
200,000	I	263	378	536	651	1,155	1,407	2,982	3,644	11,508
300,000	I	389	546	714	882	1,586	1,943	4,232	5,177	16,391
500,000	I	599	872	1,145	1,397	2,237	2,741	6,206	7,592	24,161
800,000	I	798	1,155	1,523	1,859	2,982	3,644	8,243	10,091	32,130
200,000	II	242	347	483	588	1,050	1,281	2,709	3,308	10,458
300,000	II	357	494	651	798	1,439	1,764	3,843	4,704	14,900
500,000	II	546	788	1,040	1,271	2,037	2,489	5,639	6,899	21,966
800,000	II	725	1,050	1,386	1,691	2,709	3,308	7,497	9,177	29,211
200,000	III	221	315	431	525	945	1,155	2,436	2,982	9,408
300,000	III	326	441	588	714	1,292	1,586	3,455	4,232	13,409
500,000	III	494	714	935	1,145	1,838	2,237	5,072	6,206	19,772
800,000	III	651	945	1,250	1,523	2,436	2,982	6,752	8,264	26,292

Premium will increase by 2% for every year after the age of 65 years for both primary and additional member.

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