THE NEW INDIA ASSURANCE CO. LTD.

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

NEW INDIA FLOATER MEDICLAIM POLICY- PROSPECTUS

We welcome You as Our Customer. This document explains how the NEW INDIA FLOATER MEDICLAIM 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 Floater Mediclaim is a Policy designed to cover Hospitalisation expenses.

1. WHO CAN TAKE THIS POLICY?

This insurance is available to persons between the age of 18 years and 65 years. Children from 3 months up to 25 years can be covered provided they are financially dependent on the parents and one or both parents are covered simultaneously. The upper age limit will not apply to a mentally challenged children and an unmarried daughter(s). The persons beyond 65 years can continue their insurance provided they are insured under the Policy with us without any break.

Midterm inclusion is allowed for newly married spouse and child (after completing 3 months) by charging pro-rata Premium for the remaining period of the Policy.

A New Born Baby, born during the Policy period to an Insured mother who is covered for a continuous period of 24 months, will be covered from date of birth till the expiry of the Policy, without any additional Premium. No coverage for the New Born Baby would be available during subsequent Renewals unless the child is declared for Insurance and covered as an Insured Person.

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

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

- **a)** Proposer
- **b)** Proposer's Spouse
- **c)** Proposer's Dependent Children
- **d)** Proposer's Parents (parents less than equal to 60 years of age will be covered only if they are dependent on the proposer)
- **e)** Proposer's Brother/Sister
- **f)** Proposer's Ward
- **g)** Employers can cover their Employees

Minimum two members are required in this policy. This policy cannot be given to a single person. Maximum six members can be covered in a single policy.

Note:

i. Brother/Sister can only be covered when they are financially dependent on the proposer.
ii. For the relations Employer-Employee/Brother/Sister/Ward 80D certificate shall not be given.

3. WHAT IS NEW BORN BABY COVER?

A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy. Any expense incurred towards post-natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered.

Congenital External Anomaly of the New Born Baby is covered only after 48 months Waiting Period.

Waiting Period for Congenital Internal Disease 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.

Any Illness or Disease will be covered within the Sum Insured of the mother till the expiry of the Policy and No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for insurance and covered as an Insured Person.

Note: New Born Baby means a baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us..

4. WHAT DOES THE POLICY COVER?

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

5. WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?

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

(a)	Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of the Sum Insured per day.
(b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the Sum Insured per day.

(c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
(d)	Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.
(e)	Pre-Hospitalization Medical Expenses, not exceeding thirty days
(f)	Post-Hospitalization Medical Expenses, not exceeding sixty days
(g)	Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on **1.** Cost of Pharmacy and Consumables **2.** Cost of Implants and Medical Devices **3.** Cost of Diagnostics. Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

- **MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:**

  If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

- **MEDICAL EXPENSES FOR ORGAN TRANSPLANT:**

  If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ) incurred on the donor, provided Our liability towards expenses incurred on the donor and the insured recipient shall not exceed the aggregate of the Sum Insured, if any, of the Insured Person receiving the organ.

- **Dental Treatment (Inpatient):** We will cover for medical expenses incurred towards dental treatment done under anaesthesia necessitated due to an accident/injury/illness requiring Hospitalization as Inpatient treatment.

- **LIMIT ON PAYMENT FOR CATARACT**

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

  The limit mentioned above shall be applicable per event for all the Policies of Our Company including Group Policies. Even if two or more Policies of New India are invoked, sublimit of the Policy chosen by Insured shall prevail and our liability is restricted to stated sublimit.

- **NEW BORN BABY COVERAGE**

  A New Born Baby is covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the terms of this Policy. Any expense incurred towards post-natal care, pre-term or pre-mature care or any such expense incurred in connection with delivery of such New Born Baby would not be covered.

  Congenital External Anomaly of the New Born Baby is covered only after 48 months Waiting Period.

  Waiting Period for Congenital Internal Disease 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.

  Any Illness or Disease will be covered within the Sum Insured of the mother till the expiry of the Policy and No coverage for the New Born Baby would be available during subsequent renewals unless the child is declared for insurance and covered as an Insured Person.

  Note: New Born Baby means a baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.

- **COVERAGE UNDER 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.

- **HOSPITAL CASH**

  We will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalisation, admissible under the Policy. The payment under this Clause for Any One Illness shall not exceed 1% of the Sum Insured. The payment under this Clause is applicable only where the period of Hospitalization exceeds twenty-four hours.

- **CRITICAL CARE BENEFIT**

  If during the Period of Insurance any Insured Person discovers that he or she is suffering from any Critical Illnesses as defined under 2.8 of the policy clause, which results in a claim admissible under this Policy, 10% of the Sum Insured would be paid as Critical Care Benefit along with the admissible claim amount. Critical Care Benefit is payable only once in the life time of each Insured Person and is not applicable to any Insured Persons for whom it is a Pre- Existing Condition/Disease. Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

- **PAYMENT OF AMBULANCE CHARGES**

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

- **PAYMENTS ONLY IF INCLUDED IN HOSPITAL BILL**

  No payment shall be made for any Hospitalisation expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anaesthetist directly and not included in the Hospital Bill shall be paid provided a numbered Bill is produced in support thereof, for an amount not exceeding Rs. Ten thousand, where such payment is made in cash and for an amount not exceeding Rs. Twenty thousand, where such payment is made by cheque.

- **TREATMENT FOR CONGENITAL DISEASES**

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

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

- **CUMULATIVE BONUS**

  Cumulative Bonus shall be increased by 25% at each renewal in respect of each claim free year of insurance, subject to maximum of 50%. If a claim is made in any particular year; the Cumulative Bonus accrued shall be reduced at the same rate at which it is accrued.

  Cumulative Bonus will be lost if policy is not renewed before or within 30 days from the date of expiry. In case Sum Insured under the policy is reduced at the time of renewal, the applicable Cumulative Bonus percentage shall be applied on the reduced Sum Insured.

  In case You have more than one policy, the Cumulative Bonus shall be reduced from the policy/policies in which claim is made irrespective of number of policies.

  Note 1: Unless otherwise specified, Cumulative Bonus shall not be treated as part of the Sum Insured for the purposes of reckoning any limit specified in the Policy.

  Note 2:

  i. Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported under the policy.

  ii. 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 Cumulative Bonus for each 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 Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the Lowest among all the Insured Persons.

  iii. 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, the same CB of the expiring policy shall be applicable to each Individual of such Renewed Policies.

  iv. If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

  v. 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.

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

  On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Policy Clause 3.1(g) stands deleted for the members covered in the Policy as stated in the Schedule.

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

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

  On the payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Clause 4.4.15 stands deleted for Insured Person as mentioned in the Schedule. Our liability for claim admitted for Maternity shall not exceed 10% of the average Sum Insured of the Insured Person in the preceding three years.

  Special conditions applicable to Maternity Expenses Benefit:

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

  ii A waiting period of thirty-six months is applicable, from the date of opting this cover, for payment of any claim relating to normal delivery or caesarian section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of miscarriage or abortion induced by accident or other medical emergency.

  iii Claim in respect of delivery for only first two children and / or surgeries associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof.

  iv Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

  Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there.

  The maternity limit mentioned above shall be applicable per event for all the Policies of Our Company including Group Policies. Even if two or more Policies of New India are invoked, sublimit of the Policy chosen by Insured shall prevail and our liability is restricted to stated sublimit.

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

  This optional cover, if opted, will be in addition to limit specified in Policy Clause 3.2.

  On payment of additional Premium as mentioned in Schedule, it is declared and agreed that following additional amount for Cataract shall become payable but not exceeding the actual expenses incurred:

Sum Insured	Additional Cataract limit
Rs. 8,00,000	Rs. 80,000
Rs. 10,00,000	Rs. 1,00,000
Rs. 12,00,000	Rs. 1,20,000
Rs. 15,00,000	Rs. 1,50,000

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

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

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

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

- **SPECIFIC COVERAGES**:

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

  b) Puberty and Menopause related Disorders: Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

  c) Age Related Macular Degeneration (ARMD) is covered after 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.

  d) 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 (a) to (d) above, waiting period's, 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.

  e) Treatment of Mental Illness: The Company shall indemnify the Medical Expenses incurred towards treatment of Mental Illness subject to the condition that Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

  The following Mental Illnesses are covered after completion of 48 months of Continuous Coverage with a sub-limit up to 25% of Sum Insured per policy period.

ICD Code	ICD Code Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities

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

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

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 a Maximum upto Rs. 2 Lakh
2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to a Maximum upto Rs. 2 Lakh
3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to a maximum upto Rs. 5 Lakh
4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum upto Rs. 1 Lakh.
5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to a Maximum of Rs 2 Lakh.
6	Intravitreal injections.	Upto 10% of Sum Insured subject to a Maximum of Rs.75,000.
7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum of Rs. 5 Lakh.
8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum of Rs. 2.5 Lakh.
11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum of Rs. 50,000.
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 of Rs. 2.5 Lakh.

6. WHAT IS HOSPITAL CASH BENEFIT?

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

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

7. WHAT IS CRITICAL CARE BENEFIT?

If during the Period of Insurance any Insured Person discovers that he/she is suffering from any Critical Illnesses as listed below, we will pay flat 10% of Sum Insured as additional benefit i.e. other than the admissible claim:

1. Cancer of Specified severity
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

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.

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

i. Pre-acceptance test is required for all the members entering after the age of 50 for the first time.
ii. However, the condition (i) shall be relaxed to 60 year's 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 (i) & (ii) 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.

9. DOES IT COVER ALL CASES OF HOSPITALISATION?

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

STANDARD EXCLUSIONS

- **PRE-EXISTING DISEASES (Code- Excl01)**

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 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.

- **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 preexisting diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i. 90 Days Waiting Period

1. Diabetes Mellitus
2. Hypertension
3. Cardiac Conditions

ii. 24 Months waiting period

1. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
2. Benign ear, nose, throat disorders
3. Benign prostate hypertrophy
4. Cataract and age related eye ailments
5. Gastric/ Duodenal Ulcer
6. Gout and Rheumatism
7. Hernia of all types
8. Hydrocele
9. Non Infective Arthritis
10. Piles, Fissures and Fistula in anus
11. Pilonidal sinus, Sinusitis and related disorders
12. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
13. Skin Disorders

14. Stone in Gall Bladder and Bile duct, excluding malignancy
15. Stones in Urinary system
16. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
17. Varicose Veins and Varicose Ulcers
18. Puberty and Menopause related Disorders
19. Internal Congenital Diseases

iii. 48 Months waiting period

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

- **FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)**
  - **a.** Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
  - **b.** This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
  - **c.** The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

- **EXCLUSIONS**

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

- **INVESTIGATION & EVALUATION (Code- Excl04)**
  - **a.** Expenses related to any admission primarily for diagnostics and evaluation purposes.
  - **b.** Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment
- **REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05)** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
  - **a.** Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
  - **b.** Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- **OBESITY/ WEIGHT CONTROL (Code- Excl06)** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
  - **a.** Surgery to be conducted is upon the advice of the Doctor
  - **b.** The surgery/Procedure conducted should be supported by clinical protocols
  - **c.** The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or

2. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea **iv.** Uncontrolled Type2 Diabetes

- **CHANGE-OF-GENDER TREATMENTS (Code- Excl07)**
  Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- **COSMETIC OR PLASTIC SURGERY (Code- Excl08)**
  Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- **HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)**
  Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- **BREACH OF LAW (Code- Excl10)**
  Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- **EXCLUDED PROVIDERS (Code-Excl11)**
  Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**
- Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**
- Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**
- **REFRACTIVE ERROR (Code- Excl15)**
  Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
- **UNPROVEN TREATMENTS (Code- Excl16)**
  Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- **STERILITY AND INFERTILITY (Code- Excl17)**
  Expenses related to sterility and infertility. This includes:

  a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

- **MATERNITY EXPENSES (Code - Excl18)**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SPECIFIC EXCLUSIONS

- Acupressure, acupuncture, magnetic therapies.
- Any expenses incurred on Domiciliary Hospitalization.
- Service charges, Surcharges, Luxury Tax, Admission fees, Registration fees, Record Charges and Telephone Charges levied by the Hospital.
- Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.
- Circumcision unless Medically Necessary or as may be necessitated due to an Accident.
- Convalescence and General debility.
- Cost of braces, equipment or external prosthetic devices, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants.
- External Medical / Non-medical equipment used for diagnosis and/or treatment including CPAP/BIPAP, Oxygen Concentrator, Infusion pump , Ambulatory devices (walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads) and sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and equipment, which is subsequently used at home and outlives the use and life of the Insured Person.
- Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

- Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.16.12.
- Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- Treatment taken outside the geographical limits of India.
- Vaccination and/or inoculation.

- War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

10. WHAT IS A PRE EXISTING DISEASE?

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

a. That is/are diagnosed by a physician within 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.

11. IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

Yes. Unless the Insured Person is Hospitalised for a condition warranting Hospitalisation, no claim is payable under the Policy. The Policy does not cover outpatient treatments.

12. HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED?

The Policy pays only where the Hospitalisation is for more than twenty-four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty-four hours.

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

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

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

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

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

This is an important condition that you need to comply with.

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

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

16. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

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

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

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

17. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

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

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

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

Yes. We will pay Hospitalisation expenses upto a limit, known as **Sum Insured** and **Cumulative Bonus**. 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 and Cumulative Bonus

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.

19. CAN I GET TREATED ANYWHERE IN INDIA?

Yes, but the Policy covers treatment and/or services rendered only in India.

20. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured from Rs. 2, 3, 5, 8, 10, 12 and 15 Lakhs. The premium payable is determined on the respective Age of the member for the respective Sum Insured. A discount on the number of members will be applied based on the number of members covered, which is as under:

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

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.

A digital discount of 10% is offered to customer taking fresh policy online through Company's Customer online Portal or Customer mobile app, as per directive of the government to promote digital transactions.

21. HOW LONG IS THE POLICY VALID?

The Policy is valid during the Period of Insurance stated in the Schedule attached to the Policy. It is usually valid for a period of one year from the date of beginning of insurance.

22. CAN THE POLICY BE RENEWED WHEN THE PRESENT POLICY EXPIRES?

Yes. You can and to get all Continuity benefits under the Policy, you should renew the Policy **before** the expiry of the present policy. For instance, if Your Policy commences from 2nd October, 2021 date of expiry is usually on 1st October, 2022. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2022.

In case of revision including premium or modification or withdrawal of the Policy a notice will be provided to Insured Person, 90 days before such revision or modification or withdrawal.

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

Please note that:

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
v. No loading shall apply on renewals based on individual claims experience.

23. WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, Cataract is covered only after twenty-four months of Continuous Coverage. If an Insured took a Policy in October, 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.

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

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

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

Yes. You may seek enhancement of Sum Insured in writing before payment of premium for renewal, which may be granted at Our discretion. Before granting such request for enhancement of Sum

Insured, We have the right to have You examined by a Medical Practitioner authorized by Us or the TPA (50% of Medical examination cost will be reimbursed to the Insured Person). Our consent for enhancement of Sum Insured is dependent on the recommendation of the Medical Practitioner.

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

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

Enhancement of Sum Insured will not be considered for:

1) Insured Persons over 65 years of age.
2) Insured Person who had undergone Hospitalization in the preceding two years.
3) Insured Persons suffering from one or more of the following Illnesses/Conditions:
- **i** Any chronic Illness/ Ailment
- **ii** Any recurring Illness/ Ailment
- **iii** Any Critical Illness

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

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

No. Your Policy can be renewed, as long as you pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal.

Children between 18 years to 25 years can be continue to be covered in the Policy provided they are financially dependent on the parents and one or both parents are covered simultaneously. On attaining the age of 18 years or ceasing to be financially dependent on the parents, they can, on renewal take a separate Policy. In such an event the benefits on Continuous Coverage can be ported to the new Policy. The upper age limit will not apply to a mentally challenged children and an unmarried dependent daughter(s).

If you do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to our underwriting rules. In such cases, it is possible that a fresh Policy could not be issued by us. It is therefore in your interest to ensure that Your Policy is renewed before expiry**.**

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 or non-disclosure of material facts or non-cooperation being committed by You or any one acting on Your behalf in obtaining insurance or subsequently in relation thereto. If we discontinue selling this Policy, it might not be possible to renew this Policy on the same terms and conditions. In such a case you shall, however, have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

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 90 days, two years or four years.

29. WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

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

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 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.

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, 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.

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 15 days from the date of completion of treatment. You must also provide the TPA/underwriting office with additional information and assistance as may be required by the Company/TPA in dealing with the claim.

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.

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 of any grievance the insured person may contact the company through

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

Toll free: 1800-209-1415

E-mail, Fax and Courier: As mentioned in the above address

Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

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

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

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

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

36. CAN I CANCEL THE POLICY?

The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period at Our short period rate detailed below.

Period On Risk	Rate of Premium To Be Charged (Retained By The Insurer)
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

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

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

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

37. WHAT IS FREE LOOK PERIOD?

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If 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;

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 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.

39. 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 of the expiring Policy only. Sum Insured of the Renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

40. WHAT IS A PPN? CAN I GO FOR REIMBURSEMENT IN A PPN?

Preferred provider network (PPN) means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The

list of planned procedures is available with the Company/TPA and subject to amendment from time to time.

Yes, your claim will be admissible but Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

New India Floater Mediclaim Policy - Premium Chart – Per Member (Excluding GST)
(Applicable from 1st May 2023 for Fresh Policies and 1st August 2023 for Renewal Policies)

Age Band / SI	2L	3L	5L	8L	10L	12L	15L
3m-18 Y	2,137	2,492	2,782	3,186	3,362	3,609	3,860
19-30 Y	3,789	4,463	5,013	5,795	6,578	7,113	7,618
31-35 Y	4,156	4,901	5,509	6,356	6,726	7,173	7,691
36-40 Y	5,505	6,510	7,331	8,475	8,974	9,578	10,277
41-45 Y	6,657	7,885	8,887	10,285	10,894	11,632	12,486
46-50 Y	8,841	10,490	11,837	14,027	15,953	17,270	18,510
51-55 Y	11,905	14,146	16,764	20,851	23,724	25,687	27,537
56-60 Y	14,753	17,544	19,824	23,027	26,202	28,371	30,418
61-65 Y	19,305	22,975	25,972	30,150	33,602	36,386	39,014

Sum Insured (Rs.)	OPTIONAL COVER I : NO PROPORTIONATE DEDUCTION						
	<35	**36-45**	**46-50**	**51-55**	**56-60**	**61-65**	**>65**
2,00,000	1,418	1,506	2,483	3,741	4,852	6,419	9,201
3,00,000	980	1,040	1,715	2,584	3,351	4,434	6,355
5,00,000	770	817	1,348	2,031	2,634	3,485	4,995
8,00,000	646	686	1,131	1,704	2,210	2,924	4,191
10,00,000	662	703	1,159	1,747	2,265	2,997	4,296
12,00,000	644	684	1,127	1,699	2,203	2,915	4,178
15,00,000	458	487	802	1,209	1,568	2,075	2,974

OPTIONAL COVER II : MATERNITY EXPENSES BENEFIT					
SI	**5,00,000**	**8,00,000**	**10,00,000**	**12,00,000**	**15,00,000**
(Rs.)	5,000	8,000	10,000	12,000	15,000

Sum Insured (Rs.)	OPTIONAL COVER III : REVISION IN LIMIT OF CATARACT				
	<50	**51-55**	**56-60**	**61-65**	**>65**
8,00,000	444	1,049	2,269	3,645	3,893
10,00,000	555	1,311	2,836	4,556	4,866
12,00,000	666	1,573	3,404	5,467	5,839
15,00,000	832	1,967	4,255	6,834	7,299

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

Once the Insured Person crosses the age of 65 years, the applicable premium on renewal will be loaded by 2.5% per year. This loading is applicable on premium for the age band of 61 years to 65 years.

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