THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

PARIPOORNA MEDICLAIM AYUSH BIMA

(HEALTH INSURANCE COVER FOR CGHS BENEFICIARIES)

(UIN : NIAHLIP26073V012526)

POLICY PROSPECTUS AND FAQS

- Paripoorna Mediclaim Ayush Bima is an exclusive health insurance policy designed for serving and retired CGHS beneficiaries and their family members.
- This plan offers comprehensive coverage for up to 6 family members with flexible Sum Insured options of ₹10 Lakh or ₹20 Lakh.

Highlights of the Policy:

1. This policy has flexible co-pay options of 70:30 and 50:50.
2. Pre – Hospitalization Expenses Coverage up to 30 Days, and
   Post – Hospitalization Expenses Coverage up to 60 Days.
3. The policy offers a Cumulative Bonus that increases the Sum Insured by 10% for every claim-free year (up to 100%), ensuring that the family's coverage grows over time under a single Sum Insured.
4. Floater discounts are available: 5% for 2 members, 10% for 3 members and 15% for more than 3 members.

1. Who can take this policy?

This insurance is available to all the CGHS beneficiaries, Serving and Retired (with a valid CGHS membership card of all members) and their dependent family members.

2. Can I cover my family members in one policy?

Yes.

For In-Serving dependent members: CGHS primary member along with CGHS beneficiaries and non-CGHS beneficiaries financially dependent/non-dependent on the proposer.

The proposer with following relationships can be covered as per the above specified conditions:

- Proposer
- Proposer's Spouse
- Proposer's Children
- Proposer's Parents

- Proposer's Parents-in-laws
- Proposer's Brother/Sister (Financially dependent only)

For Retirees, CGHS Primary member along with family members with valid CGHS membership.

Note: This policy can be given to minimum 1 to maximum 6 members per family. **In no condition the total number of members under a single policy shall exceed 6 in number (including the primary member).**

3. Can this policy cover a new born baby and newly wedded spouse?

A New Born Baby or Newly Wedded Spouse or both, who are enrolled under the CGHS can be added on midterm basis under the policy on payment of pro-rata extra premium. The cover shall commence from the date of payment received.

Note:

- Discounts are not applicable for midterm additions of new-born baby and newly wedded spouse.
- Modern Treatment Rider is not available for mid term renewals.
- Any of these will be available on subsequent renewals.

4. What are the expenses covered under this policy?

Policy covers following Hospitalization Expenses:

- Room Rent, boarding and nursing expenses as provided by the Hospital not exceeding 1% of the Sum Insured per day.
- Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2% of the Sum Insured per day
- Surgeon, Anaesthetist, Medical Practitioner, Consultant's Specialist fees.
- Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during Surgery like pacemaker, Relevant Laboratory/Diagnostic test, X-Ray and other medical expenses related to the treatment.
- Hospitalization Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant.
- Pre and Post Hospitalisation expenses for 30 and 60 days respectively.
- Cataract limit Per Eye per Person: Rs.1 Lakh for Sum Insured of Rs. 10 Lakh: Rs. 1.5 Lakhs for Sum Insured Rs. 20 Lakh
- Coverage for AYUSH treatment – up to 100% of Sum insured (in-patient).
- Ambulance charges – up to 0.5 % of Sum Insured or Actuals whichever is less.
- Coverage for Congenital Internal and External diseases after 24 months Waiting Period.
- Coverage for Modern treatments as per list mentioned in policy, maximum up to 25% of Sum Insured.
- Coverage for Modern Treatment can be enhanced up to 100% of Sum Insured by opting for the Modern Treatment Rider for all members covered in the policy at an extra premium. This Rider is for **All or None**.

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.

5. Is pre-acceptance medical check-up required?

Pre-acceptance medical check-up is required from the medical testing centre recommended by the policy issuing office for all the members entering after the age of 60 years for the first time.

The cost of this health Check-up will be borne by the proposer. But if the proposal is accepted, then 50% of the cost of this health check-up will be reimbursed to the proposer.

Note: Irrespective of the above a person needs to undergo this pre-acceptance medical check-up, if he/she has an adverse medical history and or there is increase in Sum Insured at the time of policy renewal only.

Adverse Medical History means a person:

- Who has undergone more than one Hospitalization in previous two years,
- Who is suffering from Critical Illness, Recurring Illness or Chronic Illness.
- Is Suffering from Hypertension / Diabetes.
- Is not in good health and free from Physical and mental diseases or infirmity or medical complaints.

6. Does this policy covers all cases of hospitalization?

Kindly refer to the policy clause for Exclusion from - 4.4.1 to 4.4.3.

7. Is there any waiting period for a particular Ailment/disease?

- First 30 days waiting period
- Pre-existing diseases - 24 Months
- Specific waiting period –
    1. 90 Days Waiting Period
        a. Diabetes Mellitus
        b. Hypertension
    2. 24 Months Waiting period
        a. Cataract and age related eye ailments
        b. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
        c. Benign ear, nose, throat disorders
        d. Benign prostate hypertrophy
        e. Gastric/ Duodenal Ulcer
        f. Gout and Rheumatism

g. Hernia of all types
h. Hydrocele
i. Non Infective Arthritis
j. Piles, Fissures and Fistula in anus
k. Pilonidal sinus, Sinusitis and related disorders
l. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
m. Skin Disorders
n. Stone in Gall Bladder and Bile duct, excluding malignancy
o. Stones in Urinary system
p. Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus
q. Varicose Veins and Varicose Ulcers
r. Puberty and Menopause related Disorders
s. Internal Congenital Diseases
t. Joint Replacement due to Degenerative Condition
u. Age-related Osteoarthritis & Osteoporosis
v. Treatment of mental illness
w. Age Related Macular Degeneration (ARMD)
x. Genetic diseases or disorders
y. External Congenital Diseases

8. 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 24 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 24 months prior to the effective date of the Policy or its reinstatement.
c. Such a condition or disease shall be considered as Pre-existing. Any Hospitalization arising out of such pre-existing disease or condition is not covered under the Policy before 24 months of continuous coverage.

9. What is Waiver of PED/ Reduction of Waiting Period?

If the proposer provides a Good Health Certificate with No hospitalisation during the past 24 months from his/her employer/CGHS/previous insurer, then the waiver may be considered.

10. Is hospitalization always necessary to get a claim?

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

Day Care procedures are also covered - Modern procedures requiring less than 24-hour hospitalization are covered for claim. (Annexure I of the Policy Clause).

11. How long does the insured person need to be hospitalised?

The Policy pays only where the Hospitalization is for more than **24** hours. But for day care treatments as specified in the Policy Clause, period of stay at the Hospital could be less than **24** hours.

12. What are the day care treatments covered under this policy?

It refers to medical treatment or Surgery which are:

- Undertaken under General or Local Anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a Hospitalization of more than 24 hours.
- Treatment normally taken on an out-patient basis is not included in the scope of this definition
- Day care treatment list is given in the policy clause. (Annexure I in Policy Clause).

13. 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 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 Hospitalization, this information needs to be given to the TPA or underwriting office, whichever applicable, within 24 hours from the time of Hospitalization.

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 0.5% of SI or actual whichever is less per event. These charges are available in case of emergency extraction from anywhere to Hospital or Hospital to Hospital.

15. In case of AYUSH treatment, will the entire amount be paid?

Expenses incurred for **in-patient** 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.

16. Is payment available for expenses incurred before hospitalization?

Yes. Medical Expenses incurred during the period of 30 days preceding Your Hospitalisation will be paid as pre-hospitalisation expenses, provided that:

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

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

17. Is payment available for expenses incurred after hospitalization?

Yes. Medical Expenses incurred during the period of 60 days immediately after Your discharge from the Hospital provided that:

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

18. Can I get treated anywhere?

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

19. What sum insured should I choose?

You are free to choose Sum Insured of Rs.10 Lakh or Rs.20 Lakh on a Family Floater basis. The premium payable is based on the opted sum insured and the respective Age of the member/s.

20. What are Co-payment options available under the Policy?

Co-payment as opted at the inception of the policy by the insured is applicable for each and every admissible claim as mentioned below:

- 70% by Insurer; 30% by Insured
- 50% by Insurer; 50% by insured

21. What is the premium frequency and Is any discount given on the premium?

The premium is annual and the policy should be renewed annually.

Yes, Floater Discount will be given, based on the number of members covered under the policy as below:

Numbers of Members	Discount
2	5 %
3	10 %
More than 3	15 %

This above discount will be applied on the basic premium of the members covered.

22. What is Cumulative Bonus?

The Sum Insured under Policy shall be increased by 10 % at each renewal in respect of each claim free year of insurance, subject to maximum of 100 %. If a claim is made in any particular year, the Cumulative bonus accrued may be reduced at the same rate at which it is accrued.

Cumulative bonus will be lost if, policy is not renewed within 30 days' grace period.

23. What is discount in lieu of Cumulative Bonus available in the policy?

Insured may opt for a premium discount at the time of renewal in lieu of the accrued Cumulative bonus. The Cumulative bonus in the range of 10% to 100% will have a discount in the base premium as per the below table:

Cumulative Bonus (% of Sum Insured)	**Discount (% of Base Premium)**
10	1.20
20	2.20
30	2.95
40	3.60
50	4.15
60	4.60
70	4.95
80	5.25
90	5.50
100	5.75

Example for Premium calculation:

SUM INSURED	Rs. 10 lacs					
Scenario	Age	70% Co Pay (Base Premium)- **A**	Premium for NIA Modern Treatment Rider- **B** 15%*Base Premium	Accumulated CB during first renewal for a claim free year- 10% of SI Discount CB% as per the chart-1.2 Discount in Lieu of CB- **E** (CB%*Base Premium)	Family Discount Amount- **F** (considering 15% family discount for 6 members covered in the policy) (Family Disocunt % * Base Premium)	Calculated Premium **(Z)**
Person 1 (SELF)	45	13640	2046	163.68	2046	13476.32
Person 2	38	10134	1520.1	121.608	1520.1	10012.392
Person 3	11	7272	1090.8	87.264	1090.8	7184.736
Person 4	15	7345	1101.75	88.14	1101.75	7256.86
Person 5	81	57470	8620.5	689.64	8620.5	56780.36
Person 6	75	50180	7527	602.16	7527	49577.84
Policy Premium	**144288.5**					

24. Is there any GST applicable for this Product?

As this is treated as a Retail Health Product, GST is exempted.

25. How long is the policy valid?

The Policy is valid for a period of one year as mentioned in the policy schedule.

26. Is there any grace period for renewal of the policy?

Yes. A grace period of 30 days is allowed after the expiry of the previous policy. Policy should be renewed within the grace period of 30 days to avail the continuity benefit. The earned Cumulative Bonus under the policy becomes 0, if the policy is not renewed within the grace period of the policy.

27. What if my policy is not renewed within the expiry date/Grace Period?

Continuity benefit can be availed by those insured under a policy for a period of continuous coverage as specified in the policy clause without break in the policy period.

If a policyholder fails to renew his/her policy on time, a **break in insurance** occurs. For instance, if an insured takes coverage in October 2025 but does not renew the same within the due date in October 2026, the continuity is severed. In this scenario, the insured will not be eligible for Cumulative Bonus, which is only available if the Policy is renewed before the expiry of the earlier policy or during the Grace Period of 30 days from the date of expiry of the expiring policy.

Any hospitalisation/any disease is contracted during the break period it is excluded from the policy.

No claim will be entertained during the Break Period.

On the contrary, had the policy been renewed on or before the expiry date in October 2026, the insured would have maintained uninterrupted coverage. Under these circumstances, seamless covers will be available.

28. What if the policy is renewed after the grace period?

Continuity benefit is not allowed. A good health declaration/ doctors certificate is to be submitted. If any adverse health conditions/age of the insured are above 60 years, medical reports to be submitted. Cumulative Bonus is also not allowed after the Grace Period.

29. Can the sum insured be increased/ at the time of renewal?

Yes. You may seek enhancement of Sum Insured in writing at the renewal of the policy. However, enhancement of the Sum Insured is subject to No Claim during the two previous policy periods and following the medical underwriting guidelines of the policy.

30. Is there an age limit up to 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.

31. 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.

32. Can I make a claim immediately after taking a policy?

There is a general waiting period after the issuance of the policy for the first 30 days. However, claims for Hospitalization due to accidents occurring within the first **30 days** of the policy period are payable. Also, there are specified waiting periods (90 days/24 months) for certain diseases/ ailments/ treatments.

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

34. What is cashless hospitalization?

Cashless Hospitalization is the service provided by the TPA on Our behalf whereby you are not required to settle the Hospitalization expenses at the time of discharge from Hospital. The settlement is done directly by the TPA on Our behalf. However, those expenses which are not admissible under the Policy would not be paid and you would have to pay such inadmissible expenses to the Hospital. Cashless facility is available in Networked Hospitals. Prior intimation/approval is required from the TPA before the patient is admitted into the Networked Hospital in case of planned surgeries.

You may visit our Website at **https://newindia.co.in/hospitals-list**. 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.

35. 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.

36. 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 fulfils the conditions of definition of Hospital in the Policy.

The following documents in original should be submitted to the TPA within **7** days from the date of Discharge from the Hospital:

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

37. How to get reimbursement for pre and post hospitalization expenses?

The Policy allows reimbursement of medical expenses incurred before and after admissible Hospitalization up to a certain number of days (30 days' pre-hospitalization expenses and 60 days' post-hospitalization expenses). 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.

38. Will the entire amount of the claimed expenses be paid?

The admissible claim amount is payable based upon the co-pay opted at the inception of the policy. [Option A: 70% by the insurer, 30% by the insured; Option B: 50% by the insurer, 50% by the insured].

39. 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.

40. Can I cancel the policy?

Yes, You can. The Refund will be processed on a pro-rata basis from the date of application for cancellation of policy, subject to no claim under the policy and deduction of administrative charges.

41. 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 **30 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:

- 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;

- 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.

42. 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.

43. Is congenital diseases covered in the policy?

Yes. Congenital Internal Disease or Defects or anomalies shall be covered after **24** 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 **30** days of expiry of the Policy.

Congenital External Disease or Defects or anomalies shall be covered after 24 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 2 years.

44. 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 Hospitalization (including Pre & Post Hospitalization Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

45. 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.