THE NEW INDIA ASSURANCE CO. LTD

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400001

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY

ICAI TOP-UP MEDICLAIM POLICY PROSPECTUS

Attached to and forming part of master policy No. _____

SALIENT FEATURES OF THE POLICY

- This Policy covers In-Patient Hospitalization Expenses incurred in India.
- This policy will respond only when the aggregate of all Hospitalization expenses (except Pre / Post hospitalization expenses) of one or all members of the policy, exceeds the "Threshold" stated in the policy.
- This Policy will respond for each and every Hospitalization after the Threshold has been exceeded by previous Hospitalization expenses subject only to the Sum Insured stated in the Policy.
- The Sum Insured is the maximum liability of the company for all members of the policy.
- Thus, this Policy offers protection in excess of any Primary Health Policy/Benefit scheme that the Insured may have.
- If there is any expense in excess of Threshold, receivable from any other entity, the Insured Person has an option to recover it from either that entity or this policy, but not both.
- However, the Sum Insured under the policy will be available over and above any reimbursement received from any other entity if such amounts exceed the Threshold.

WHO CAN TAKE THE POLICY Any person fulfilling the eligibility norms given below in addition to base policy taken under ICAI Program with New India Assurance Co. Ltd.

ELIGIBILITY

The policy can be issued on Floater Sum Insured basis covering the family members. Family comprises of Self, Legal Spouse and dependent children.

Age of Entry:

Proposer: 18 to 65 Years
Other Members: 3 Months to 65 Years.

There is no cover ceasing age in case of renewal.

Dependent Children between the age of 3 months and 25 years can be covered provided parents are covered simultaneously.

PROCEDURE FOR TAKING A POLICY

- LOGIN into the portal(www.icai.newindia.co.in):-
- USERID- membership no. of institute
- PASSWORD- Mentioned under Customer Registration

- Select the product and click on “BUY NOW".
- Proposal form has to be filled and the premium will be paid online using “PAY NOW".
- Policy no. will be generated and soft copy of the policy schedule, premium receipt and premium certificate will be forwarded to user dashboard.

TENURE OF THE POLICY This policy will be valid for a period of one year from the date of inception.

SUM INSURED The Sum Insured available are: 20,25,30,35,40,45,50

THRESHOLDS: 20 lacs Sum insured

The following Hospitalization expenses incurred in respect of all the Insured members shall be considered for determining the Threshold under the Policy:

- The admission in the Hospital should have happened during the policy period.
- The Insured should have been admitted as an inpatient (outpatient treatments are not to be considered).
- The Hospitalization should be for an Injury or Illness.
- Pre-Hospitalization and Post-Hospitalization expenses will not be considered.

ENHANCEMENT OF SUM INSURED AND THRESHOLD

- Enhancement of Sum Insured and Threshold will not be considered during the currency of the Policy.
- Enhancement of Sum Insured and Threshold is available only at the time of renewal.
- Sum Insured can be enhanced only to next band.
- If the policy is to be renewed for enhanced sum insured then the restrictions of pre-existing diseases, waiting period for specified diseases/ailments/conditions and first 30 days waiting period will apply to additional sum insured as if it is a new policy.
- Enhancement of Sum Insured will not be considered for the policy in which any of the member had undergone Hospitalization in the preceding one year.

PAYMENT OF PREMIUM: As per top up premium chart.

DETAILS OF COVERAGE

Hospitalization Expenses,

1. Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), actually incurred subject to a capping. (1.5 % of sum insured, restricted to a maximum capping of Rs.30,000/- per day)
2. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, actually incurred subject to a capping. (3% of sum insured, restricted to a maximum capping of Rs.30,000/- per day))
3. Associate Medical Expenses; such as Professional fees of Surgeon, Anesthetist, Consultant, Specialist; Anesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
4. Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

Note: Proportionate Deduction Clause 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 Clause 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.

5. Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Company's liability towards expenses incurred on the donor and the insured recipient shall not exceed the Sum Insured of the insured person receiving the organ.
6. Ambulance service expenses actually incurred subject to capping. Ambulance charges will be paid once for Any One Illness for each Insured. (1.0 % of the sum insured or actual, whichever is less, subject to maximum of Rs. 2,500/-)
7. The Company will pay Hospital Cash at the rate of 0.1% of the Sum Insured, for each day of Hospitalization, 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.
8. Payment of any claim relating to Cataract for each eye shall not exceed Rs.50,000/-.
9. COVERAGE UNDER AYUSH TREATMENT : Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines are covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule. AYUSH Treatments are payable provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

10. <u>SPECIFIC COVERAGES</u>:

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 neuro degenerative disorders:** Our shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization 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 per policy period. The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalization 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 exhibiting 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 Hospitalization 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 10 (a to g), 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.

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

Expenses on Hospitalization for minimum period of 24 hours are admissible. However, this time limit is not applied for some specific treatments like Dialysis, Chemotherapy, Radiotherapy, Eye surgery, Dental Surgery, Lithotripsy (Kidney Stone removal), D & C, Tonsillectomy or where treatment involves technological advances necessitating hospitalization for less than 24 hours.

No payment shall be made for any Hospitalization expenses incurred, unless they form part of the Hospital Bill. However, the bills raised by Surgeon, Anesthetist 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. 10,000/-, where such payment is made in cash and for an amount not exceeding Rs. 20,000/-, where such payment is made by cheque.

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.

PRE-EXISTING DISEASES

a) Treatment of any Pre existing Condition/Disease, until 24 months of Continuous coverage of such Insured Person have elapsed. For Continuous coverage of less than 24 months, the amount payable shall be restricted to a specified % of the admissible claim amount SUBJECT TO A MAXIMUM OF % OF THE SUM INSURED, as per Table below

AMOUNT PAYABLE IS % OF ADMISSIBLE CLAIM AMOUNT SUBJECT TO A MAXIMUM OF % OF THE SUM INSURED, FOR CONTINUOUS COVERAGE	
OF LESS THAN 12 MONTHS	25%
EXCEEDING 12 MONTHS BUT LESS THAN 24 MONTHS	50%

a) In case of enhancement of Sum Insured the waiting period shall apply afresh to the extent of Sum Insured increase.

b) If the Insured Person is continuously covered without any break as defined under the portability norms of the extent IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

c) Coverage under the policy for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

Waiting period for specified diseases/ailments/conditions:

a) For those Insured Persons with less than twenty-four months of Continuous Coverage, the policy will cover the following diseases/ailments/conditions only up to the limits specified below.

Sr. No.	Name of Disease / Ailment / Surgery	CONTINUOUS COVERAGE	
		OF LESS THAN 12 MONTHS	EXCEEDING 12 MONTHS BUT LESS THAN 24 MONTHS
1	Any Skin disorder	25%	50%
2	All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps	25%	50%
3	Benign Ear, Nose, Throat disorders	25%	50%
4	Benign Prostate Hypertrophy	25%	50%
5	Cataract & age related eye ailments	25%	50%
6	Diabetes mellitus	25%	50%
7	Gastric/ Duodenal Ulcer	25%	50%
8	Gout & Rheumatism	25%	50%
9	Hernia of all types	25%	50%
10	Hydrocele	25%	50%
11	Hypertension	25%	50%
12	Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of	25%	50%

	uterus.		
13	Non Infective Arthritis	25%	50%
14	Piles, Fissure and Fistula in Anus	25%	50%
15	Pilonidal Sinus, Sinusitis and related disorders	25%	50%
16	Prolapse Inter Vertebral Disc unless arising from accident	25%	50%
17	Stone in Gall Bladder & Bile duct	25%	50%
18	Stones in Urinary Systems	25%	50%
19	Unknown Congenital internal disease/defects	25%	50%
20	Varicose Veins and Varicose Ulcers	25%	50%

b) For those Insured Persons with less than thirty-six months of Continuous Coverage, the policy will cover the following diseases/ailments/conditions only up to the limits specified below.

Sr. No	Name of Disease/Ailment/Surgery	CONTINUOUS COVERAGE		
		OF LESS THAN 12 MONTHS	EXCEEDING 12 MONTHS BUT LESS THAN 24 MONTHS	EXCEEDING 24 MONTHS BUT LESS THAN 36 MONTHS
1.	Age related Osteoarthritis & Osteoporosis	25%	50%	75%
2.	Joint Replacements due to Degenerative Condition	25%	50%	75%

AMOUNT PAYABLE IS % OF ADMISSIBLE CLAIM AMOUNT SUBJECT TO A MAXIMUM OF % OF THE SUM INSURED, AS SPECIFIED AT (A) AND (B) ABOVE

EXCLUSIONS:

- **FIRST THIRTY DAYS WAITING PERIOD (Code- Excl01)**
  - **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.

- **INVESTIGATION & EVALUATION (Code- Excl02)**
  - **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.

- **REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl03)** 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.

- **OBESITY / WEIGHT CONTROL (Code- Excl04)** 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

- **CHANGE-OF-GENDER TREATMENTS (Code- Excl05)**

  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- Excl06)**

  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- Excl07)**

  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.

- **BREACH OF LAW (Code- Excl08)**

  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-Excl09)**

  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- Excl10)**
- 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- Excl11)**
- 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- Excl12)**
- **REFRACTIVE ERROR (Code- Excl13)**

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

- **UNPROVEN TREATMENTS (Code- Excl14)**

  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- Excl15)**

  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 - Excl16)**
  - **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.

- War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
  - **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.

- Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses.
- Expenses incurred for Naturopathy Treatment, acupressure, acupuncture, magnetic and such other therapies.
- Circumcision unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an accident.
- Vaccination or inoculation.
- 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.
- Dental treatment or Surgery of any kind unless necessitated by Accident and requiring Hospitalization.
- Convalescence, general debility, Venereal disease and intentional self-injury.
- Bodily Injury or sickness 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.

- Treatment of Injury or Illness sustained whilst or as a result of participating in any criminal act.
- stem cell implantation / Surgery for other than those treatments mentioned in clause 4.4.26
- 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, elastocrepe bandages, external orthopedic 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.
- Domiciliary Hospitalization.
- Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.
- Any kind of Service charges, Surcharges, Admission Fees/Registration Charges levied by the Hospital.
- Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- Treatment or Investigation taken outside India.

CLAIM PROCEDURE

All claims will be processed and settled by specified Third Party Administrator (TPA) licensed by IRDA.

Intimation of Hospitalization to be given to the TPA 48 hours before Hospitalization, for planned Hospitalization. For emergency Hospitalization, intimation is to be given within 48 hours from the time of Hospitalization.

To avail Cashless facility - Pre-authorization request to be sent or faxed to TPA immediately on admission.

In Reimbursement cases - Insured to intimate TPA about Hospitalization of Insured Persons immediately on admission. Claim bills to be submitted to TPA within seven days of discharge.

In case of Hospitalization where the expenses are likely to involve the TPAs of both regular Health Policy and New India Top-Up Mediclaim Policy, the intimation/pre-authorization request with regard to a Hospitalization is to be given to both the TPAs of these Policies.

In the case of a covered Hospitalization, the costs of which were not initially estimated to exceed the Threshold but were subsequently found likely to exceed the Threshold, the intimation to the named TPA should be submitted along with a copy of intimation made to

the Primary Health Policy TPA/Reimbursement Provider immediately on knowing that the Threshold is likely to be exceeded.

The payment will be made either to Hospital in case of Cashless treatment or to the Proposer/Insured Person in other cases.

The TPA of the regular Health Insurance Policy/Reimbursement Provider will first process the claims and the TPA for this policy will make the balance admissible payments either to the Hospital in the case of cashless settlement or to Insured in case of reimbursement. The Insured has to submit the details of settlement made by the TPA of regular Health Insurance Policy in the case of cashless settlement. In the case of reimbursement, the above details along with photo-copies of bills attested by Primary TPA/Reimbursement Provider are to be submitted to TPA of New India Top-Up Mediclaim Policy.

The details of claims lodged and settlement details under regular Health Policy since inception of this policy should be furnished to the TPA of New India Top-Up Mediclaim Policy even when the claim is not under the New India Top-Up Mediclaim Policy. These documents are to be submitted to the TPA not later than thirty days from the date of discharge from the Hospital. This will enable faster response by the TPA in case of future Hospitalization requiring the services of this policy.

All claims under this policy shall be payable in Indian currency. **CLAIMS ADJUDICATION**

Any Claim which goes beyond the Threshold and Insured makes a claim in this policy, will be adjudicated as examples given below:

Claim lodged by the Insured				**Insured having an Individual policy of 8 Lakhs**		**Insured having a Top-Up of 12 Lakhs with Threshold 8 Lakhs**	
	Charges	Days	Amount	**Sum Insured**	**8,00,000**	**Threshold**	**8,00,000**
Room Rent	10,000	20	2,00,000	Room Rent (1% of Sum Insured)	1,60,000	Room Rent (Maximum Rs. 8000 for opted Threshold of Rs. 8 lakhs)	1,60,000
Surgeon Charges			4,00,000	Surgeon Charges (proportionate on SI)	3,20,000	Surgeon Charges (proportionate on SI)	3,20,000
Diagnostics			3,20,000	Diagnostics (proportionate on SI)	2,56,000	Diagnostics (proportionate on SI)	2,56,000
Medicines			2,50,000	Medicines (Actual)	2,50,000	Medicines (Actual)	2,50,000
Total Cost			11,70,000				
				Admissible	9,86,000	Admissible	9,86,000
				Payable under policy	8,00,000	Deductible under Top-Up	8,00,000
				Not Admissible	1,86,00	Payable under Top-Up	1,86,000

		0		
Insured Incurred	Rs. 11,70,000			
Total Paid under the Policy	Rs. 8,00,000		Rs. 1,86,000	
Expense borne by Insured	Rs. 1,84,000			

Claim lodged by the Insured				**Insured having an Individual policy of 5 Lakhs**		**Insured having a Top-Up of 10 Lakhs with Threshold 5 Lakhs**	
	Charges	Days	Amount	**Sum Insured**	**5,00,000**	**Threshold**	**5,00,000**
Room Rent	5,000	20	1,00,000	Room Rent	1,00,000	Room Rent	1,00,000
				(1% of Sum Insured)		(Maximum Rs. 5000 for opted Threshold of Rs. 5 lakhs)	
Surgeon Charges			4,00,000	Surgeon Charges (Actual)	4,00,000	Surgeon Charges (Actual)	4,00,000
Diagnostics			3,20,000	Diagnostics (Actual)	3,20,000	Diagnostics (Actual)	3,20,000
Medicines			2,50,000	Medicines (Actual)	2,50,000	Medicines (Actual)	2,50,000
Total Cost			10,70,000				
				Admissible	10,70,000	Admissible	10,70,000
				Payable under policy	5,00,000	Deductible under Top-Up	5,00,000
				Not Admissible	5,70,000	Payable under Top-Up	5,70,000
Insured Incurred	Rs. 10,70,000						
Total Paid under the Policy	Rs. 5,00,000					Rs. 5,70,000	
Expense borne by Insured	Rs. 0						

Insured is not eligible to receive any amount more than the admissible claim. If he goes to a higher Room Rent category than his eligible Room Rent category, the claimed amount will be proportionately deducted and the deducted amount will not be payable even in Top-Up. But if he goes to his eligible Room Rent category, the claim will be settled in full without any deductions in the admissible amount.

CANCELLATION

The Company may at any time cancel this Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by Insured by sending 15 days' notice by registered letter at the Insured's last known address and in such event the Company shall not refund any premium.

The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given below) provided no claim has occurred up to the date of cancellation however the company shall remain liable

for any claim/ claims arising prior to such cancellation.

SHORT PERIOD REFUND RATE TABLE	
PERIOD ON RISK	**RATE OF PREMIUM TO BE CHARGED (RETAINED)**
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

FREE LOOK PERIOD:

The free look period shall be applicable at the inception of the 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, you shall be entitled to:

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

TAX REBATE

Tax rebate, as per provision of Income Tax rules, under Section 80-D.

RENEWAL

The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof and in any case not later than 30 days from the date of expiry of the current policy.

If, during the grace period of 30 days, any Insured Person incurs any Hospitalization expenses, he shall not be entitled for any claim.

The Company shall not be bound to give notice that such renewal premium is due, provided however that if the Insured shall apply for renewal and remit the requisite premium before the expiry of this policy, renewal shall not be refused, unless the Company has reasonable justification to do so.

A policy that is sought to be renewed after the grace period of 30 days will be underwritten as a Fresh Policy.

Request for increase in Sum Insured at renewals may be considered, after a satisfactory pre-acceptance health check-up.

This Prospectus shall form part of the proposal form.