THE NEW INDIA ASSURANCE CO. LTD.

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

ATMANIRBHAR HEALTH POLICY, NEW INDIA ASSURANCE CO LTD
(UIN: NIAHLIP23207V012223)

PROSPECTUS

We welcome You as Our Customer. This document explains how the ATMANIRBHAR HEALTH 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.

Atmanirbhar Health Policy, New India Assurance Co Ltd is specially designed for Persons with Disability, Mental Illness and Persons with HIV/AIDS 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 and Children from newborn to 17 years.

Insured must have certificate of 40% or more disability as certified by the competent authority as per the Disability Act 2016.

Note: The cover under this policy is available for persons with the following disability/disabilities as defined under the Rights of Persons with Disabilities Act, 2016 and any subsequent additions / modifications to the list in the Act.

1. Blindness	2. Muscular Dystrophy
3. Low vision	4. Chronic Neurological conditions
5. Leprosy Cured persons	6. Specific Learning Disabilities
7. Hearing Impairment (deaf and hard of hearing)	8. Multiple Sclerosis
9. Locomotor Disability	10. Speech and Language disability
11. Dwarfism	12. Thalassemia
13. Intellectual Disability	14. Haemophilia
15. Mental Illness	16. Sickle Cell disease
17. Autism spectrum disorder	18. Multiple Disabilities including deaf/ blindness
19. Cerebral Palsy	20. Acid Attack victim
21. Parkinson's disease	

2. WHAT DOES THE POLICY COVER?

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

3. WHAT ARE THE EXPENSES COVERED UNDER THIS POLCY?

Our liability for all claims admitted during the Period of Insurance in respect of Insured Person shall not exceed the aggregate of the Sum Insured. 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, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day
(b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses maximum upto 2% of the Sum Insured per day.
(c)	Surgeon, Anaesthetist , Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the hospital
(d)	Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses

Other Expenses:

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment necessitated due to disease or injury (for inpatient care only).
iii. Plastic surgery necessitated due to disease or injury.
iv. All day care treatments

Note:

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

2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.

- **LIMIT ON PAYMENT FOR CATARACT**

  The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000 /-, per each eye in one policy year

- **TREATMENTS UNDER AYUSH**

  The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 50% of sum insured as specified in the policy schedule in any AYUSH Hospital.

- **PAYMENT OF EMERGENCY GROUND AMBULANCE CHARGES**

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization up to Rs. 2000 as per the terms and conditions mentioned in the Policy Clause.

- **Pre-Hospitalization Medical Expenses:**

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the policy period.

Conditions:

1. The claim is accepted under Inpatient Care or AYUSH Treatment or Modern Treatments in respect of that Insured Person.
2. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only

- **Post-Hospitalization Medical Expenses:**

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

1. The claim is accepted under Inpatient Care or AYUSH Treatment or Modern Treatments in respect of that Insured Person.
2. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

- **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 50% of the Sum Insured specified in the policy during the policy period.

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy- Monoclonal Antibody to be given as injection.
f. Intra Vitreal injections
g. Robotic surgeries
h. Stereotactic radio Surgeries
i. Bronchial Thermoplasty

j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM- (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4. IS PRE-ACCEPTANCE MEDICAL CERTIFICATE IS REQUIRED?

No it is not required.

- However, Insured must have certificate of 40% or more disability as certified by the competent authority as per the Disability Act 2016.
- Also, For persons suffering with HIV/AIDS, a recent certificate of the current CD4 count (within past 30 days) needs to be submitted.

5. WHAT ARE THE SPECIAL CONDITIONS APPLICABLE FOR PERSONS WITH DISABILITY?

The Company will indemnify reasonable and customary charges for medical expenses incurred towards Inpatient Hospitalisation arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons With Disabilities Act, 2016 subject to the terms and limits mentioned below.

i. Any treatment for the pre-existing disability covered, will have a waiting period of 24 months from the first policy inception date.
ii. Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

6. WHAT ARE THE SPECIAL CONDITIONS APPLICABLE FOR PERSONS WITH HIV/AIDS?

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Conditions

i. This cover will exclude cost for any Anti-Retroviral Treatment.

7. DOES IT COVER ALL CASES OF HOSPITALISATION ?

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

- **PRE-EXISTING DISEASES (Code- Excl01)**
  - Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for pre-existing disability /48 months for all pre-existing condition other than HIV/AIDS and Disability (as mentioned in the policy schedule of continuous coverage after the date of inception of the first policy with the insurer.
  - In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

- If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- Coverage under the policy after the expiry of 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)**
  - Expenses related to the treatment of the listed conditions, surgeries / treatments shall be excluded until the expiry of 24 months as (mentioned in policy schedule) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
  - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
  - If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
  - The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
  - If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
    - **24 Months waiting period**
      - Benign ENT disorders
      - Tonsillectomy
      - Adenoidectomy
      - Mastoidectomy
      - Tympanoplasty
      - Hysterectomy
      - All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.
      - Benign prostate hypertrophy
      - Cataract and age-related eye ailments
      - Gastric/ Duodenal Ulcer
      - Gout and Rheumatism
      - Hernia of all types
      - Hydrocele
      - Non-Infective Arthritis

- Piles, Fissures and Fistula in anus
- Pilonidal sinus, Sinusitis and related disorders
- Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
- Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
- Varicose Veins and Varicose Ulcers

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

- **SPECIFIC CONDITION APPLICABLE FOR PERSONS WITH HIV-AIDS**

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Conditions:

1. This cover will exclude cost for any Anti-Retroviral Treatment

- **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:

i. 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.

ii. 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:**

1. Surgery to be conducted is upon the advice of the Doctor.
2. The surgery/Procedure conducted should be supported by clinical protocols.
3. The member must be 18 years of age or older and
4. Body Mass Index (BMI).

   a. greater than or equal to 40 or
   b. 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 Apnoea
   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, Burns 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:
  1. Any type of contraception, sterilization
  2. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
  3. Gestational Surrogacy
  4. Reversal of sterilization
- **MATERNITY (Code - Excl18)**
  1. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
  2. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

- **Specific Exclusions:**
  - Any medical treatment taken outside India
  - Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs

- Nuclear damage caused by, contributed to, by or arising from ionising radiation or contaminated by the radioactivity from
- Any nuclear fuel or from any nuclear waste; or
- From the combustion of nuclear fuel (including any self-sustaining picture of nuclear fission);
- Nuclear weapons material
- Nuclear equipement or any part of that equipment
- War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority
- Injury or Disease caused by or contributed to by nuclear weapons/materials
- Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident
- Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy
- Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
- Vaccination or inoculation except as post bite treatment for animal bite
- Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect
- Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered
- Dental treatment or surgery of any kind unless requiring Hospitalistion as a result of accidental bodily injury.
- Venereal/ Sexually Transmitted disease
- Stem cell storage
- Any kind of service charge, surcharge levied by the hospital
- Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies
- Non-payable items: The expenses that are not covered in this policy are placed under list-I Annexure II of the Policy Clause
- Any medical procedure or treatment, which is not medically necessary or not performed by the medical practitioners

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 disease

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.

9. 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.

10. 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 day treatments specified in the Policy, period of stay at the Hospital could be less than twenty-four hours.

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

Day Care Procedures are as per Annexure III of the Policy Clause.

12. 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 Hospitalisation, this information needs to be given to the TPA or underwriting office, whichever applicable, within 24 hours from the time of Hospitalisation. This is an important condition that you need to comply with.

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

Company will pay ambulance charges up to Rs. 2000 per Hospitalisation. These charges are available in case of emergency extraction from anywhere to Hospital or Hospital to Hospital.

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

Yes, there is a mandatory co-payment of 20% under the policy. However, on payment of additional premium of 30%, co-payment shall be waived.

15. WHETHER I CAN PAY THE PREMIUM THROUGH INSTALMENTS?

You may opt for Payment of Premium on an instalments basis i.e. Half Yearly, Quarterly or Monthly, the following Conditions shall apply (notwithstanding any terms contrary else where in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
iii. The Benefits provided under — "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

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

The company shall imdemnify medical expenses incurred for inpatient care treatment under Ayurveda,Yoga and Naturopathy ,Unani and Siddha and Homeopathy systems of medicine during each policy year up to 50% of the sum insured as specified in the policy schedule in any AYUSH hospital.

17. 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:

- The claim is accepted as Inpatient Care or AYUSH Treatment or Modern Treatments in respect of that Insured Person.
- Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

18. 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:

- The claim is accepted as Inpatient Care or AYUSH Treatment or Modern Treatments in respect of that Insured Person.
- Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

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

Yes. We will pay Hospitalisation expenses upto a limit, known as **Sum Insured**. In cases where the Insured Person was Hospitalised more than once, the **total of all amounts** paid

a) for all cases of Hospitalisation,
b) expenses paid for medical expenses prior to Hospitalisation, and
c) expenses paid for medical expenses after discharge from Hospital

Shall not exceed the Sum Insured and 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. (check)

20. CAN I GET TREATED ANYWHERE?

The Policy covers treatments rendered only in India.

21. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured of Rs. 4 Lakhs and 5 Lakhs.

22. WHAT ARE PREMIUM AFFECTING PARAMETERS?

The premium payable is determined on the respective Age of the member for the respective Sum Insured and the Category of Disability or Illness.

Category of Disability or Illness is defined as below:

Category 1	Category 2	Category 3
Blindness	Low vision	Muscular Dystrophy
Leprosy Cured persons	Specific Learning Disabilities	Chronic Neurological conditions
Hearing Impairment (deaf and hard of hearing)	Intellectual Disability	Multiple Sclerosis
Speech and Language disability	Haemophilia	Locomotor Disability
Dwarfism	Autism spectrum disorder	Thalassemia
	Acid Attack victim	Mental Illness
	Parkinson's disease	Sickle Cell disease
		Multiple Disabilities including deaf/ blindness
		Cerebral Palsy
		HIV/AIDS

23. 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.

24. 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, 2020 date of expiry is usually on 1st October, 2021. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2021.

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 of Health Insurance Policies, as amended from time to time.

25. 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. For other benefits under the Policy such as cost of health checkup, Continuous Coverage is necessary. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires.

26. 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.

27. 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 as per our Underwriting guidelines.

28. 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 which is 65 Years, but there is no age limit for renewal.

29. 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.

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

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. However, claims for Hospitalisation due to accidents occurring even during the first thirty days are payable. There are certain treatments where the waiting period is two years or four years.

31. 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.

32. 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.

33. 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.

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

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

- Duly Completed claim form.
- Photo Identity proof of the patient
- Medical practitioner's prescription advising admission.
- Original bills with itemized break-up
- Payment receipts
- Discharge summary including complete medical history of the patient along with other details. vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
- Sticker/invoices of the Implants, wherever applicable.
- MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
- NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
- KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
- Legal heir/succession certificate, wherever applicable
- Any other relevant document required by Company/TPA for assessment of the claim.

35. 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.

36. 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.

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

You may also call our Call Centre at the Toll free number **1800-209-1415**, which is available 24x7.

You also have the right to represent Your case to the Insurance Ombudsman.

38. CAN I CANCEL THE POLICY?

Yes, You can. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below

Refund % To the Insured	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to to 30 days	75.00%
31 to 90 days	50.00%
91 days to 180 days	25.00%
181 days to 365 days	0.00%

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 You under this Policy.

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.

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.

39. WHAT IS FREE LOOK PERIOD?

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of 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.

lf the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

40. 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.

41. 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.

Premium for Atmanirbhar Health Policy, New India Assurance Co Ltd.									
(Excluding GST)									
Category	**Sum Insured**	**0 to 17 years**	**18 to 35 years**	**36 to 45 years**	**46 to 50 years**	**51 to 55 years**	**56 to 60 years**	**61 to 65 years**	**66 years & above**
Category I	**4 Lakhs**	6,710	7,975	8,785	11,665	14,290	21,755	30,760	39,160
	5 Lakhs	7,895	9,380	10,335	13,725	16,810	25,595	36,190	46,070
Category II	**4 Lakhs**	13,725	16,305	17,970	21,695	26,570	40,450	57,200	72,815
	5 Lakhs	16,150	19,180	21,140	25,520	31,260	47,590	67,295	85,665
Category III	**4 Lakhs**	24,400	28,985	31,945	38,565	47,235	71,910	95,300	1,10,260
	5 Lakhs	28,705	34,100	37,580	45,365	55,565	84,600	1,12,115	1,29,715

Optional Cover for Waiver of Co-Pay of 20%: Copayment of 20% shall be waived on payment of Addition Premium of 30%

Category of Disability & Illness

Category 1	Category 2	Category 3
Blindness	Low vision	Muscular Dystrophy
Leprosy Cured persons	Specific Learning Disabilities	Chronic Neurological conditions
Hearing Impairment (deaf and hard of hearing)	Intellectual Disability	Multiple Sclerosis
Speech and Language disability	Haemophilia	Locomotor Disability
Dwarfism	Autism spectrum disorder	Thalassemia
	Acid Attack victim	Mental Illness
	Parkinson's disease	Sickle Cell disease
		Multiple Disabilities including deaf/ blindness
		Cerebral Palsy
		HIV/AIDS