THE NEW INDIA ASSURANCE CO. LTD.

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

MEDICLAIM 2012 POLICY- PROSPECTUS

We welcome you as Our Customer. This document explains how the MEDICLAIM 2012 could provide value to you. In the document the word 'You', 'Your' means you, the Insured under the Policy. 'We', 'Our', 'Us' means New India Assurance Co. Ltd.

MEDICLAIM 2012 is a Policy designed to cover Hospitalization expenses.

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

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

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

   Yes. You can cover your family members in one policy, with separate Sum Insured for each Insured Person and you will get a Family Discount of 10% on the total premium payable.

   The members of the family who could be covered under the Policy are:

   a) Proposer
   b) Proposer's Spouse
   c) Proposer's Children
   d) Proposer's Parents

You may also cover the entire family as defined above, under a Single Sum Insured . If You cover the other family members **under a single Sum Insured,** discounts at the following rates are admissible:

	SUM INSURED	
NUMBER OF PERSONS	**% DISCOUNT ON TOTAL PREMIUM**	
	UPTO 300000	**300000 AND MORE**
TWO	**11**	**13**
BETWEEN 3 AND 4	**13**	**15**
MORE THAN 4	**16**	**18**

3. WHAT DOES THE POLICY COVER?

This Policy is designed to give You, the Insured, protection against unforeseen Hospitalization expenses.

4. DOES IT COVER ALL CASES OF HOSPITALIZATION?

No. This Policy does NOT cover ALL cases of Hospitalization. Any Hospitalization expense relating to a Pre Existing Disease is not payable. Similarly, a Hospitalization expense for pregnancy is not covered under the Policy. There are other such instances, where the claim is not payable.

Some of the exclusions are:

- **Diseases contracted within 30 days of insurance**
- **Debility and General Run down Conditions.**
- **Sexually transmitted diseases and HIV (AIDS)**
- **Circumcision, Cosmetic surgery, Plastic surgery unless required to treat injury or illness**
- **Vaccination and Inoculation**
- **Pregnancy, ailments related thereto and child birth**
- **War, Act of foreign enemy, ionising radiation and nuclear weapon.**
- **Treatment outside India**
- **Naturopathy**
- **Domiciliary Treatment**
- **Experimental or unproven treatment**
- **All external equipments such as contact lenses, cochlear implants etc.**

Payments made to the Hospital like Service Charges, Surcharge, cost of external or durable medical equipments, non medical expenses, etc. are not payable.The exclusions stated above are not exhaustive. **The exclusions are mentioned in the Policy under the Section "What are excluded under this Policy".** You may go through the list of Exclusions to get to know what is NOT covered under the Policy.

5. WHAT IS A PRE EXISTING DISEASE?

The term Pre existing condition/disease is defined in the Policy. It is defined as: "Any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or was diagnosed, and/or received medical advice/ treatment, within 48 months prior to the date of commencement of his/her first Policy with Us."

If You had:

a) Signs or symptoms, or

b) Been diagnosed or received Medical Advice, or

c) Been Treated for any condition or disease within forty eight months prior to the commencement of the first policy with us,

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.

6. IS HOSPITALIZATION ALWAYS NECESSARY TO GET A CLAIM?

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

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

The Policy pays only where the Hospitalization is for more than twenty four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty four hours. Please refer to Clause 2.6 of the Policy for details.

8. WHAT DO I NEED TO DO AFTER I GET HOSPITALISED?

Immediately on Hospitalization or within twenty four hours of such Hospitalization, please intimate the TPA of this fact, with details of Your Policy Number, Name of the Hospital and treatment undertaken. This is an important condition of the Policy that you need to comply with.

9. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALIZATION?

Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of Hospitalization are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is hospitalized.

10. IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALIZATION?

Yes. Relevant medical expenses incurred after Discharge from the Hospital for a period of SIXTY days after the date of discharge are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is hospitalized.

11. CAN I GET TREATED ANYWHERE?

The Policy covers treatment only in India. Even within India, if you had paid the premium applicable to Zone IV and take treatment in any of the Hospitals located in Zone I, II or III, then only 80% of the admissible claim amount will be paid. If premium is paid for Zone III, claims in Zone I or II will be paid only to the extent of 80%. If premium is paid for Zone II, claims in Zone I will be paid only for 80%.

EACH ZONE IS CLASSIFIED AS BELOW: (The Cities mentioned below would include their Urban Agglomeration)	
Zone- I	**Greater Mumbai**
Zone-II	**Delhi and Delhi NCR ,Bangalore, Chennai, Hyderabad and Secunderabad, Ahmedabad and Kolkatta, Vadodara**
Zone-III	**Rest of India (other than those areas specified in Zone I,II and IV)**
Zone-IV	**The States of Bihar, Orissa, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Jharkhand, Sikkim, Chhattisgarh, Uttarakhand, Jammu and Kashmir**

It is therefore in your interest to choose the appropriate Zone and pay the necessary premium depending upon your preference for coverage.

If in respect of any Insured Person the deductible as per Clause 3.2 of the Policy (See Para 32 of this document) and 3.3 (deduction for treatment outside area of coverage) are applicable, both would operate in sequence. To illustrate, for a claim where both conditions are admissible, if admissible claim amount is 10000, 20% would be deducted for application of Clause 3.2 (Deductible for those who enter the policy at over 55 years of age) and on this admissible claim amount of 8000, another 20% on 8000 would be deducted for application of Clause 3.3 (Treatment outside area of coverage) and the amount payable would only be 6400.

12. IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALIZATION?

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

a) for all cases of Hospitalization,
b) expenses paid for medical expenses prior to Hospitalization,
c) expenses paid for medical expenses after discharge from hospital, and
d) any other payment made under the Policy

shall not exceed the Sum Insured.

For Mediclaim 2012 Policies, each Insured Person has a separate Sum Insured. For Family Mediclaim 2012 Policies, the Sum Insured is for **all** persons covered. In Family Mediclaim 2012 policies, any payment made to one Insured Person would make the Sum Insured reduced for **all Insured Persons.** The total payments under a Family Mediclaim 2012 Policy for all Insured Persons for all claims during the Policy period shall not exceed the Sum Insured.

13. WHAT SUM INSURED SHOULD I CHOOSE?

You are free to choose any Sum Insured ranging from Rs. One Lakh to Rs. Eight Lakhs. For those aged over 55, the Sum Insured at entry into Mediclaim 2012 could range from Rs. One Lakh to Rs. Three Lakhs. The Premium You pay depends upon Your Age, the Sum Insured chosen, the Area of Coverage chosen. You are free to choose any Sum Insured available in the range specified above. But it is in your own interest to choose the Sum Insured which could satisfy your present as well as future needs, as explained in Clause 22.

14. 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.

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

Yes. You can and to get all Continuity benefits under the Policy, you should renew the Policy **before** the expiry of the present policy. For instance, if Your Policy commences from 2nd October, 2011 date of expiry is usually on 1st October, 2012. You should renew Your Policy by paying the Renewal Premium on or before 1st October 2012.

16. 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 insurance. If an Insured took a Policy in October, 2008, does not renew it on time and takes a Policy only in December 2009, and renewed it on time in December 2010, any claim for Cataract would not become payable, because the Insured person was not continuously covered for twenty four months. If, he had renewed the Policy in time in October 2009 and then in October 2010, then he would have been continuously covered for twenty four months and therefore his claim for Cataract in the Policy beginning from October 2010 would be payable. For other benefits under the Policy such as cost of health check up and No Claim Bonus, continuous Insurance is necessary. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires. Moreover,

benefits like No Claim Discount or Cumulative Bonus Buffer will be available only when you renew the Policy in time.

17. What is Cumulative Bonus Buffer

The Cumulative Bonus that is available to your credit in Mediclaim 2007, on migration to Mediclaim 2012 is protected, and the amount of such Bonus is stated as Cumulative Bonus Buffer. But for claim free renewal after migration to Mediclaim 2012 only No Claim Discount is admissible and no addition would be made to the Cumulative Bonus Buffer. This buffer will be carried forward until the buffer is completely used after exhausting the basic Sum Insured.

18. WHAT IS A NO CLAIM DISCOUNT?

If You had insured with Us in the previous year and no claim has been reported during the previous year, at the time of renewal of the Policy, We offer a Discount on the Premium payable. This Discount is called No Claim Discount. **This Discount is available only for the years of claim free experience in Mediclaim 2012. Claim free experience under Mediclaim 2007 shall not be reckoned for No Claim Discount.** The details of No Claim Discount are:

	AGE<=60		AGE>60	
	% Discount per year	MAX. DISCOUNT%	% Discount per year	MAX. DISCOUNT%
SUM INSURED <300000	2	10	3	15
SUM INSURED=>300000	3	15	3	15

No Claim Discount is available only when no claims have been made in the expiring Policy and only when the Policy is renewed before its expiry.

19. WHAT WILL HAPPEN TO NO CLAIM DISCOUNT IF THERE IS A CLAIM?

If there is claim during the current year, next year, **there will be no No Claim Discount.** Even if the claim is for a smaller amount, the No Claim Discount will be withdrawn in the next year.

20. WHEN CAN THE CUMULATIVE BONUS BUFFER BE USED?

If the total amount of claims in a year, either a single claim or multiple claims, exceeds Sum Insured, then the payment could be considered beyond Sum Insured, but upto the limit of Cumulative Bonus Buffer. For example, a person has a Sum Insured of Rs. 100000 and Cumulative Bonus Buffer of Rs 30000. During this year, if the total payments exceed the Sum Insured, then we will pay him the admissible

claims upto Rs 130000 though he has insured only for Rs 100000. CUMULATIVE BONUS BUFFER shall not be treated as part of the Sum Insured for the purposes of reckoning any limit specified in the Policy.

21. 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 disease contracted or injuries sustained or Hospitalization 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.

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

We may agree for a request for increase in Sum Insured at the time of renewal. But we are not obliged to agree to this request, if we feel the Person is not in good health. Moreover, for persons aged over 45, such a request could entail subjecting the Person for Medical Examination and other Medical tests, which could mean spending your money and time. (In case the risk is accepted, 50% of the reasonable cost of Medical Examination would be reimbursed). Moreover, no enhancement in Sum Insured would be considered for any person who had undergone a Hospitalization in the preceding two years, regardless of whether any claim was lodged in respect of such Hospitalization or not. No enhancement in Sum Insured would be considered for persons over 65 years of age. It is therefore in Your interest to take insurance for a Sum Insured that could take care of not only your present needs, but also future needs. All requests for increase in Sum Insured should be accompanied by a proposal form with all details filled in.

A onetime option of increase in Sum Insured is available at the time of migration from Mediclaim 2007 to Mediclaim 2012, as per details in Annexure I.

23. WHAT IS ENTRY LOAD?

Any person above the age of 45 entering the Mediclaim 2012 or Family Mediclaim 2012 for the first time would be charged an entry load, as per details below:

SUM ASSURED	Upto 45	45-50	51-55	56-60	61-65
Upto 3 Lakhs	Nil	Nil	1000	1500	2000
3 lakhs to Rs.5 lakhs	Nil	1000	2000	NOT ELIGIBLE	NOT ELIGIBLE
Over 5 lakh	Nil	2000	4000	NOT ELIGIBLE	NOT ELIGIBLE

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

No. Your Policy can be renewed, as long as you pay the Renewal Premium before the date of expiry of the Policy. There is an age limit for taking a fresh Policy, but there is no age limit for renewal. However, if you do not renew Your Policy before the date of expiry or within thirty days of the date of expiry, the Policy may not be renewed, and only a fresh Policy could be issued, subject to our underwriting rules. In such cases, it is possible that a fresh Policy could not be issued by us. It is therefore in your interest to ensure that Your Policy is renewed before **expiry.**

25. 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 suppression 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.

26. 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 Hospitalization due to accidents occurring during the first thirty days are payable. There are certain treatments where the waiting period is two years or four years. Please see Conditions 4.3.1, 4.3.2 and 4.4.6.2 of the Policy.

27. 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 hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

28. WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is 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 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.asp. 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.

29. 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.

30. 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. Within twenty four hours of Hospitalization the TPA should be intimated. The following documents in original should be submitted to the TPA within seven days from the date of Discharge from the Hospital:

- 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 or any other information needed by the TPA for considering the claim.

31. 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. 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 your TPA. The bills must be sent to the TPA within 7 days from the date of completion of treatment. You must also provide the TPA with additional information and assistance as may be required by the company/TPA in dealing with the claim.

32. 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 Hospitalization as per Policy conditions and is supported by proper documents, except the expenses which are excluded. For persons aged over 55 entering the Mediclaim 2012 policy without Continuous Coverage, We will pay only 80% of the claim amount until he has four years of claim free continuous coverage.

33. CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. 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/public.asp. You may also call our Call Centre at the Toll free number **1800-209-1415**, which is available 24x7.

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

34. CAN I CANCEL THE POLICY?

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

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

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

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

35. 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.

ANNEXURE I

AT THE TIME OF MIGRATION FROM MEDICLAIM 2007 TO MEDICLAIM 2012				
AGE	**UPTO 45**	**46-55**	**56-65**	**OVER 65**
PRESENT SUM INSURED	**WITHOUT CLAIM OR HOSPITALIZATION IN THE TWO PRECEDING YEARS**			
500000	YES. UPTO EIGHT LAKHS	YES. UPTO EIGHT LAKHS WITHOUT MEDICAL EXAMINATION	YES. UPTO EIGHT LAKHS WITHOUT MEDICAL EXAMINATION	YES. UPTO EIGHT LAKHS WITHOUT MEDICAL EXAMINATION
LESS THAN 500000 BUT MORE THAN OR EQUAL TO 300000	YES. UPTO EIGHT LAKHS	YES. UPTO EIGHT LAKHS WITHOUT MEDICAL EXAMINATION	UPTO **5** LAKHS, WITHOUT MEDICAL EXAMINATION **AND** UPTO **8** LAKKHS WITH MEDICAL EXAMINATION	YES. UPTO FIVE LAKHS, WITHOUT MEDICAL EXAMINATION
LESS THAN 300000	YES. UPTO EIGHT LAKHS	YES. UPTO FIVE LAKHS , WITHOUT MEDICAL EXAMINATION	UPTO **3** LAKHS, WITHOUT MEDICAL EXAMINATION **AND** UPTO **5** LAKHS WITH MEDICAL EXAMINATION	YES. UPTO THREE LAKHS, WITHOUT MEDICAL EXAMINATION

AT SUBSEQUENT RENEWALS UNDER MEDICLAIM 2012				
AGE	**UPTO 45**	**46-55**	**56-65**	**OVER 65**
PRESENT SUM INSURED	**WITHOUT CLAIM OR HOSPITALIZATION IN THE TWO PRECEDING YEARS**			
500000	YES. UPTO EIGHT LAKHS	YES. UPTO EIGHT LAKHS, WITHOUT MEDICAL EXAMINATION,	YES. UPTO EIGHT LAKHS, **WITH MEDICAL EXAMINATION**	NO ENHANCEMENT
LESS THAN 500000 BUT MORE THAN OR EQUAL TO300000	YES. UPTO EIGHT LAKHS	YES. UPTO FIVE LAKHS, WITHOUT MEDICAL EXAMINATION	YES. UPTO FIVE LAKHS, **WITH MEDICAL EXAMINATION**	NO ENHANCEMENT
LESS THAN 300000	YES. UPTO EIGHT LAKHS	YES. UPTO THREE LAKHS, WITHOUT MEDICAL EXAMINATION.	YES. UPTO THREE LAKHS, **WITH MEDICAL EXAMINATION**	NO ENHANCEMENT

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