National Insurance Company Limited

CIN - U10200WB1906GOI001713 IRDAI Regn. No. - 58

Arogya Sanjeevani Policy - National

PROSPECTUS

1. PRODUCT

Arogya Sanjeevani Policy - National is a standard individual indemnity health insurance product. The Policy covers Hospitalisation Expenses for In-Patient Care or Day Care Treatment incurred for treatment of an Illness contracted/Injury sustained during the Policy Period, Pre Hospitalisation (30 days) and Post Hospitalisation (60 days) expenses, Ambulance Charges.

Any amount payable under the Policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

2. SALIENT FEATURES

2.1Hospitalisation Options

The Policy provides for Cashless Facility and/ or reimbursement of Hospitalisation expenses for treatment of Illness or Injury. Cashless Facility is available only in Network Providers, subject to pre authorization by TPA.

2.2 Type of Policy

Policy can be issued, as opted by the Proposer, on

i. Individual Basis (i.e., Sum Insured and Cumulative Bonus shall apply separately on each Insured Person)
ii. Floater Basis (i.e., Sum Insured and Cumulative Bonus shall apply cumulatively to cover all Insured Persons)

2.3Eligibility

i. **Entry age of Proposer** should be between **eighteen (18) years and sixty five (65) years**.
ii. If the **Proposer is above sixty five (65) years** old, he/ she can **obtain policy for family without covering self**.
iii. **Maximum entry age** of any family member is **sixty five (65) years**.
iv. **Dependent children** (natural or legally adopted) between the entry age of **three (03) months and twenty five (25) years** may be covered, provided parent(s) is/are covered at the same time.
v. **Family** consisting of Proposer and any one or more of the Family members are allowed under same policy.
    a. Legally wedded spouse
    b. Dependent natural or legally adopted children
    c. Parents and Parents-in-law
vi. **Midterm inclusion** of family members at pro-rata premium is allowed only in case of
    a. Newborn between the age of three (03) months and six (06) months
    b. Spouse within sixty (60) days of marriage

(Members other than above may be included only at renewal. On inclusion of a new member, Waiting Periods specified in Section 6 shall apply for the new member.)

No other relation even within the eligible age band can be covered under the Policy.

2.4 Policy Period

The Policy can only be issued for a period of one (01) year (i.e., 12 calendar months).

2.5 Sum Insured (SI)

The Policy is available with options of SI of **INR1L to 5L, in multiple of INR 50,000.**

i. Individual Basis, different SI may be selected for different Insured Person. SI applicable to the Proposer shall be highest.
ii. Floater Basis, single SI shall apply cumulatively to all Insured Persons.

2.5.1Change of Sum Insured

i. Sum Insured can be changed (increased/ decreased) only at the time of Renewal or any time, subject to discretion of the Company.
ii. Midterm increase in SI to be allowed only in case of midterm inclusion (as explained above in Section 2.3.vi).
iii. For the incremental portion of the SI, the Waiting Periods specified in Section 6 shall start afresh. Coverage on increased SI shall be available after the completion of Waiting Periods.
iv. Increase in SI shall be allowed by one slab at a time.

2.6 Instalment Facility

i. Premium for the Policy may be paid in instalments of **Monthly**, **Quarterly**, **Half Yearly** as well as **Yearly**, as opted in the Proposal Form.
ii. Premium paying frequency other than Yearly shall be allowed, subject to each instalment being at least INR 1,000/-.
iii. Change of Premium Paying Frequency can be opted only at the time of renewal.
iv. Policy with premium paying frequency other than Yearly, shall be issued/ renewed only at the Office and not through Customer Portal.
v. Grace Period of **15 days** shall be allowed for payment of Installment Premium. If premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed.

2.7 Discount for Online Sale

Discount of 10% shall apply on new policy issued through **Customer Portal** or renewal of policy through **Customer Portal** only, provided the policy is with **Yearly premium payment frequency** and **no intermediary is involved**.

2.8 Tax Rebate

The Proposer can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

2.9 Completion of Proposal Form

i. The Proposal Form is to be completed in all respects (including personal details, medical history of Insured Person) and to be submitted to the Company's office or to Company's intermediary.
ii. Any existing condition, ailment, injury or disease should be specifically declared in the Proposal Form, and accepted by the Company for coverage
    a. If Pre-existing diseases (PED), shall be covered after waiting period.
    b. If existing illness falls under the List of Permanently Excluded Illness (Annexure), shall never be covered for specified ICD codes.
iii. Identity and address of the Proposer must be supported by documentary proofs, as detailed in Proposal Form Annexure C.
iv. If a person is insured under any other health insurance policy of the Company and wants to migrate to **Arogya Sanjeevani Policy - National**, the Proposal Form will have to be completed and submitted to the Company's office or to Company's intermediary.
v. If a person is insured under health insurance policy of any other Non-Life Insurance Company and wants to port to **Arogya Sanjeevani Policy - National**, the Portability Form and Proposal Form will have to be completed and submitted to the Company's office or to Company's intermediary.

2.10Pre Policy Checkup

i. Pre policy checkup is required for persons aged **fifty five (55) years and above**, and availing the Policy for the first time with the Company.
ii. The Company shall reimburse **50%** of the expenses incurred for pre policy checkup, if the proposal is accepted.
iii. The Pre Policy checkup reports required are –
    a) Physical examination (report to be signed by the Doctor with minimum MD (Medicine) qualification), as per Annexure A of Proposal Form
    b) Blood sugar: fasting/ post prandial/ HBA1C
    c) Lipid profile
    d) Serum creatinine
    e) Urine routine and microscopic examination
    f) ECG
    g) Eye checkup (including retinoscopy)
    h) Any other investigation required by the Company

Note:

The date of medical reports should not exceed thirty (30)days prior to the date of proposal.

2.11 Payment of Premium

i. In case of Individual Policy, premium for each individual shall depend on the SI and age from the 'Premium Table for all Individuals'.
ii. In case of Floater Policy, premium for senior most member shall depend on the SI and age from the 'Premium Table for only Senior Most Member' and premium for other Family Members shall depend on age for same SI from 'Premium Table for Family Members (other than Senior Most Member)', in decreasing order of their age.
iii. Base premium of the policy shall be total premium for all individuals, calculated as mentioned above.
iv. Claims shall be serviced by TPA, and both Cashless Facility and Reimbursement Facility will be available.
v. Discounts, if any, shall apply on the Individual/ Family Base Premium (as specified) for Yearly premium payment frequency only.
vi. Installment premium shall be payable as per the table provided, with frequency of payment wise percentage of the total premium payable in each installment.
vii. Full premium/ first instalment of premium shall be paid before the commencement of the Policy.
viii. Yearly premium can be paid online for Renewals without break, provided there is no material change in the Policy.
ix. PAN details must be submitted by the Proposer.
x. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted

2.12 Renewal of Policy

i. The Policy can be renewed without break throughout the lifetime of the Insured Persons except for children above eighteen (18) years of age, if financially independent.
ii. The Policy may be renewed by mutual consent, before the expiry of the Policy or a within the Grace Period after expiry of the Policy. Coverage is not available during the Grace Period
iii. The Company is not bound to send Renewal Notice.
iv. Renewal of Policy can be denied on grounds of fraud, moral hazard, misrepresentation or noncooperation.
v. In case of non-continuance of the Policy by the Insured (due to death or any other valid and acceptable reason)
    - The Policy may be renewed by any Insured Person above eighteen (18) years of age, as the Insured
    - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the Policy period. The legal guardian may be allowed to renew the Policy as Insured, covering the children.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where , the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

3.1 **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

3.3 **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4 **AYUSH Treatment** refers to hospitalisation treatments given Ayurveda, Unani, Sidha and Homeopathy systems (covered under the Policy).

3.5 An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative; and

3.6 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable, and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7 **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

3.8 **Cashless Facility** means a facility extended by the Company to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the Company to the extent pre-authorization is approved.

3.9 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.10 **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

3.11 **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

3.12 **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium.

3.13 **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.14 Day Care Treatment means medical treatment, and/or surgical procedure which is:
i. undertaken under general or local anesthesia in a hospital/ day care centre in less than twenty four (24) hrs because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.15 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.16 Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

3.17 Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

3.18 Family means the Family that consists of the proposer and anyone or more of the family members as mentioned below:
i. Legally wedded spouse.
ii. Parents and Parents-in-law.
iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18yearsofage is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

3.19 Grace Period means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

3.20 Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least ten (10) inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.21 Hospitalisation means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

3.22 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
i. **Acute Condition** means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b) it needs ongoing or long-term control or relief of symptoms
c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

3.23 Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

3.24 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than twenty four (24) hours for a covered event.

3.25 Insured Person means person(s) named in the schedule of the Policy.

3.26 Intensive Care Unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients

who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.27 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

3.28 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.29 Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.30 Medical Practitioner means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

3.31 Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of illness or injury suffered by the insured ;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32 Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.33 Network Provider means hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an insured by a cashless facility.

3.34 Non- Network Provider means any hospital that is not part of the network.

3.35 Notification of Claim means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

3.36 Out-Patient (OPD) Treatment means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

3.37 Pre existing Disease 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 the Company 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.

3.38 Pre-hospitalisation Medical Expenses means medical expenses incurred during the period of 30 days preceding the hospitalisation of the Insured Person, provided that:

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

3.39 Post-hospitalisation Medical Expenses means medical expenses incurred during the period of 60 days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

3.40 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person

3.41 Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.42 Policy Schedule means the Policy Schedule attached to and forming part of Policy.

3.43 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

3.44 Portability means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

3.45 Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.46 Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.47 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.48 Sub-limit means a cost sharing requirement under a health insurance policy in which the Company would not be liable to pay any amount in excess of the pre-defined limit.

3.49 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

3.50 Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

3.51 Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by the Company, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.

3.52 Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1. Hospitalization

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs. 5,000/- per day
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of the sum insured subject to maximum of Rs. 10,000/- per day
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1. Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs 2,000 per hospitalization.

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. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2. AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or INR 40,000 per eye, whichever is lower, per each eye in one policy year.

4.4. Pre Hospitalisation

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.

4.5. Post Hospitalisation

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.

4.6. 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 Sum Insured, specified in the policy schedule, 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. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) K. IONM - (Intra Operative Neuro Monitoring)
K. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.7. The expenses that are not covered in this policy are placed under List-l of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

5. CUMULATIVE BONUS (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for each Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

6. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1. Pre-Existing Diseases (Excl01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 (forty eight) months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 (forty eight) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. First 30 days waiting period (Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than 12 (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.

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6.3. Specified disease/procedure waiting period (Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 (twenty four) months 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
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

i. 24Months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia ofall types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula inanus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi inurinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

7. 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:

7.1. Investigation & Evaluation (Code - Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7.2. Rest Cure, rehabilitation and respite care (Code - Excl05)

a) 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.

7.3. 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 has to 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 Apnea
      iv. Uncontrolled Type2 Diabetes

7.4. 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.

7.5. Cosmetic or plastic Surgery (Code - Excl08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7.6. 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.

7.7. 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.

7.8. Excluded Providers (Code - Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Company and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

7.9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code - Excl12)**

7.10. Treatments received in heath 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)**

7.11. 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)**

7.12. Refractive Error (Code – Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13. 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.

7.14. Sterility and Infertility (Code - Excl17)
Expenses related to sterility and infertility. This includes:
i. Any type of sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

7.15. Maternity Expenses (Code - Excl18)
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.16. 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.

7.17. 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.

7.18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

7.19. Treatment taken outside the geographical limits of India

7.20. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes (Annexure).

8. Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

9. CLAIM PROCEDURE

1.1 Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA.
(ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
(iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
(v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
(vi) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

1.2 Procedure for Reimbursement of Claims

For reimbursement of claims the Insured Person shall submit the necessary documents to TPA (if claim is processed by TPA)/Company within the prescribed time limit as specified hereunder.

Sl. No.	Type of claim	Prescribed Time limit
1.	Reimbursement of hospitalisation, day care and pre hospitalisation expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

9.1. Notification of Claim

Notice with full particulars shall be sent to the Company/ TPA (if applicable) as under:

i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.2. Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission.
iv. Original bills with itemized break-up
v. Payment receipts
vi. 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

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:
1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

9.3. Copayment
Each and every claim under the Policy shall be subject to a Copayment of 5%, applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

9.4. Claim Settlement (provision for Penal Interest)
i. The Company shall settle or reject a claim, as may be the case, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days the Company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9.5. Services Offered by TPA
Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.
The services offered by a TPA shall not include
i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

9.6. Disclaimer
If the Company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

9.7. Payment of Claim
All claims under the policy shall be payable in Indian currency and through NEFT/ RTGS only.

10. GENERAL TERMS & CONDITIONS

10.1 Disclosure of Information
The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

10.2 Condition Precedent to Admission of Liability
The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

10.3 Material Change
The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

10.4 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

10.5 Complete Discharge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge by the Company.

10.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

10.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

10.8 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

10.9 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.
Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the Company or to induce the Company to issue an insurance Policy:-

a) the suggestion ,as a fact of that which is not true and which the Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the Company. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

10.10 Cancellation

a) 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 %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	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 the Insured person under the Policy.

b) The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material fact, 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.

10.11 Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through anyone of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

10.12 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

10.13 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

10.14 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous bonus/multiplier benefit (as part of the base sum insured), migration sum insured and accrued benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link: https://nationalinsurance.nic.co.in/

10.15 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link: https://nationalinsurance.nic.co.in/

10.16 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the Insured Person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits with Break in Policy. Coverage is not available during the Grace Period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

10.17 Premium Payment in Installments

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere 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.

10.18 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three (03) months before the changes are effected.

10.19 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.
The insured shall be allowed a period of fifteen (15) days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, 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.

10.20 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

10.21 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh for the incremental portion of the sum insured.

10.22 Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

10.23 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy

11. REDRESSAL OF GRIEVANCE

Grievance – In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.
For details of grievance officer, kindly refer the link: https://nationalinsurance.nic.co.in/
IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
Insurance Ombudsman – The insured person may also approach the office of Insurance Ombudsman of the respective area/ region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Appendix III.

12. TABLE OF BENEFITS

Name	**Arogya Sanjeevani Policy - National**
Product Type	**Individual/ Floater**
Category of Cover	**Indemnity**
Sum insured	**INR 1L to 5L, in multiple of INR 50,000** **On Individual basis – SI shall apply to each individual family member** **On Floater basis – SI shall apply to the entire family**
Policy Period	**1 years**
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Children between the age of 91 days and 25 years may be covered, provided parent(s) is/are covered at the same time. Policy can be availed for Self and the following family members a. Legally wedded spouse b. Parents and parents-in-law. c. Dependent children (i.e., natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as Grace Period
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Center
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/doctors fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital/ Nursing Home up to 2% of the Sum Insured subject to maximum of Rs. 5,000/- per day 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital/ Nursing Home up to 5% of the Sum Insured subject to maximum of Rs. 10,000/- per day
Cataract Treatment	Up to 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per eye, under one policy year
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system of medicines shall be covered upto sum insured, during each policy year as specified in the policy schedule
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after a waiting period of 4 years
Cumulative bonus	Increase in the sum insured by 5% of SI in respect of each claim free year of insurance maximum up to 50% of current SI. In the event of claim the cumulative bonus shall be reduced as the same rate.
Co Pay	**5% co pay on all claims**

Rates Chart (in INR)

For Policy on Individual basis – Premium Table for each family Member
For Policy on Floater basis – Premium Table for only Senior Most Member of family

Age band	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
0-5	2,932	3,696	3,969	4,224	4,472	4,684	4,879	5,123	5,323
6-17	2,435	2,892	3,240	3,793	4,305	4,542	4,778	4,987	5,157
18-25	2,752	3,217	3,828	4,236	4,709	5,145	5,473	5,794	6,057
26-30	3,031	3,748	4,358	4,730	5,152	5,698	6,170	6,728	7,185
31-35	3,467	4,210	4,757	5,371	5,728	6,249	6,699	7,243	7,688
36-40	4,137	4,959	5,451	6,094	6,532	6,975	7,378	7,831	8,202
41-45	4,472	5,650	6,413	7,012	7,756	8,316	8,877	9,521	10,048
46-50	5,266	7,414	8,299	9,005	10,329	10,916	11,525	12,639	13,551
51-55	7,260	9,894	11,028	12,671	13,951	14,918	15,878	17,065	18,037
56-60	9,619	12,789	15,022	16,828	18,376	20,006	21,409	23,317	24,877
61-65	12,079	15,685	18,444	20,427	22,436	25,465	28,673	31,311	33,470
66-70	15,552	19,284	23,386	27,430	29,608	32,229	37,746	40,426	42,618
71-75	18,270	22,433	27,994	31,667	33,050	35,643	42,486	46,288	49,398
76-80	20,535	25,746	30,732	35,518	37,812	42,487	48,187	52,721	56,430
81-85	22,100	28,321	33,785	38,166	41,522	46,666	52,913	57,874	61,934
86+	24,295	31,120	37,107	40,975	45,560	51,213	56,782	62,908	67,921

For Policy on Floater basis – Premium Table for family members (other than Senior Most member)

Premium Rate for 2nd Eldest Member									
Age band	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
0-5	2,228	2,809	3,017	3,210	3,399	3,560	3,708	3,894	4,046
6-17	1,850	2,198	2,463	2,883	3,272	3,452	3,632	3,790	3,920
18-25	2,147	2,510	2,986	3,304	3,673	4,013	4,269	4,519	4,724
26-30	2,364	2,924	3,400	3,689	4,018	4,445	4,812	5,248	5,604
31-35	2,774	3,368	3,806	4,297	4,583	4,999	5,360	5,795	6,151
36-40	3,310	3,968	4,361	4,876	5,225	5,580	5,903	6,265	6,562
41-45	3,667	4,633	5,259	5,750	6,360	6,819	7,279	7,807	8,239
46-50	4,318	6,080	6,806	7,384	8,470	8,951	9,450	10,364	11,112
51-55	6,026	8,212	9,153	10,517	11,580	12,382	13,179	14,164	14,970
56-60	7,984	10,614	12,468	13,967	15,252	16,605	17,769	19,353	20,648
61-65	10,026	13,019	15,309	16,954	18,621	21,136	23,798	25,988	27,780
66-70	13,064	16,199	19,644	23,041	24,871	27,072	31,707	33,958	35,799
71-75	15,530	19,068	23,795	26,917	28,092	30,296	36,113	39,344	41,989
76-80	17,455	21,884	26,122	30,190	32,140	36,114	40,959	44,813	47,966
81-85	18,785	24,073	28,717	32,441	35,294	39,666	44,976	49,193	52,644
86+	20,894	26,763	31,912	35,238	39,182	44,043	48,832	54,101	58,412
Premium Rate for 3rd Eldest Member									
Age band	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
0-5	1,862	2,347	2,520	2,682	2,840	2,974	3,098	3,253	3,380
6-17	1,558	1,851	2,074	2,428	2,755	2,907	3,058	3,192	3,301
18-25	1,844	2,156	2,565	2,838	3,155	3,447	3,667	3,882	4,058
26-30	2,031	2,511	2,920	3,169	3,452	3,818	4,134	4,508	4,814
31-35	2,427	2,947	3,330	3,760	4,010	4,374	4,690	5,070	5,382
36-40	2,896	3,472	3,816	4,266	4,572	4,883	5,165	5,482	5,741
41-45	3,287	4,153	4,714	5,154	5,700	6,112	6,525	6,998	7,385
46-50	3,949	5,561	6,225	6,753	7,747	8,187	8,644	9,480	10,163
51-55	5,627	7,668	8,546	9,820	10,812	11,561	12,305	13,225	13,978
56-60	7,599	10,103	11,867	13,294	14,517	15,805	16,913	18,420	19,653
61-65	9,664	12,548	14,755	16,342	17,948	20,372	22,938	25,049	26,776
66-70	12,597	15,620	18,943	22,219	23,983	26,105	30,575	32,745	34,520
71-75	15,073	18,507	23,095	26,125	27,266	29,405	35,051	38,187	40,754
76-80	16,839	21,112	25,200	29,124	31,006	34,839	39,513	43,231	46,273
81-85	18,122	23,224	27,703	31,296	34,048	38,266	43,389	47,457	50,786
86+	20,165	25,830	30,798	34,009	37,815	42,507	47,129	52,214	56,374

Premium rate for all other members of the family									
Age band	**1,00,000**	**1,50,000**	**2,00,000**	**2,50,000**	**3,00,000**	**3,50,000**	**4,00,000**	**4,50,000**	**5,00,000**
0-5	1,539	1,940	2,084	2,218	2,348	2,459	2,562	2,690	2,795
6-17	1,315	1,562	1,750	2,048	2,325	2,453	2,580	2,693	2,785
18-25	1,569	1,834	2,182	2,415	2,684	2,933	3,120	3,303	3,452
26-30	1,758	2,174	2,528	2,743	2,988	3,305	3,578	3,902	4,167
31-35	2,184	2,652	2,997	3,384	3,609	3,937	4,221	4,563	4,844
36-40	2,689	3,224	3,543	3,961	4,246	4,534	4,796	5,090	5,331
41-45	3,108	3,927	4,457	4,873	5,390	5,780	6,170	6,617	6,983
46-50	3,844	5,412	6,059	6,573	7,540	7,969	8,413	9,227	9,892
51-55	5,482	7,470	8,326	9,567	10,533	11,263	11,988	12,884	13,618
56-60	7,407	9,847	11,567	12,957	14,150	15,405	16,485	17,954	19,156
61-65	9,422	12,234	14,387	15,933	17,500	19,863	22,365	24,423	26,107
66-70	12,286	15,235	18,475	21,670	23,391	25,461	29,820	31,936	33,668
71-75	14,707	18,058	22,535	25,492	26,605	28,692	34,201	37,262	39,766
76-80	16,428	20,597	24,586	28,414	30,249	33,990	38,549	42,176	45,144
81-85	17,680	22,657	27,028	30,533	33,218	37,333	42,330	46,299	49,547
86+	19,679	25,207	30,056	33,190	36,904	41,483	45,993	50,956	55,016

Rates are including TPA charges, but excluding GST

Installment Premium

Percentage of total family premium (Individual or Floater) to be charged in each installment is as shown below.

	Half Yearly	**Quarterly**	**Monthly**
1st Installment	53.50%	30.00%	12.50%
Other(s)	50.00%	25.00%	8.50%
Total	**103.50%**	**105.00%**	**106.00%**

Discounts
Discount for Direct Sale – 10% on total premium

No loading shall apply on renewals based on individual claims experience
Insurance is the subject matter of solicitation

Annexure

Permanently Excluded Illness

Sl	Existing Disease	ICD Code Excluded
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophagealvarices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta-(super) infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9