National Insurance Company Limited

CIN - U10200WB1906GOI001713

IRDAI Regn. No. - 58

Arogya Sanjeevani Policy - National

1. PREAMBLE

This Policy is a contract of insurance issued by National Insurance Co. Ltd. (hereinafter called the 'Company') to the Proposer mentioned in the Schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the Policy Period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a

Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary, expenses towards the Coverage mentioned hereunder.
Provided further that, 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 Period shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

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 / Aged means completed years of the Insured person on last birthday as on date of commencement of the Policy.

3.3. AIDS means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.

3.4. 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.

3.5. 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.

3.6. 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;

3.7. AYUSH Treatment refers to the medical and/ or Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

3.8. Break in policy means the period of gap that occurs at the end of the existing Policy Period / Instalment Premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

3.9. Cashless Facility means a facility extended by the Company to the Insured where the payments of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider or a Non Network Provider, to the extent pre-authorization approved.

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

3.11. 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.

3.12. Contract means Prospectus, Proposal, Policy and the policy schedule. Any alteration with the mutual consent of the insured person and the insurer can be made only by a duly signed and sealed endorsement on the Policy.

3.13. 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.

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

3.15. 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.

3.16. 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.

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

3.18. Diagnosis means diagnosis by a medical practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

3.19. 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.

3.20. 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.

3.21. 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 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

3.22. Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. The Grace Period for payment of the premium shall be thirty days.
In case of Premium payment in instalments, if the due instalment premium is paid within Grace Period during the Policy Period, coverage shall be available during the Grace Period.
In case of Renewal, Coverage shall not be available during the period for which no premium is received.

3.23. 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.

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

3.25. I D card means the card issued to the Insured person by the TPA for availing Cashless Facility.

3.26. 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

3.27. 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.

3.28. 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.

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

3.30. 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.

3.31. 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.

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

3.33. 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.

3.34. 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.

3.35. 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.

3.36. Migration means a facility provided to 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, from one health insurance policy to another with the same insurer.

3.37. New Born Baby means baby born during the policy period and is aged upto 90 days.

3.38. Network Provider means Hospitals or Day Care Centers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.

3.39. Non- Network Provider means any Hospital, Day Care Centre that is not part of the network.

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

3.41. 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.

3.42. Pre Existing Disease means any condition, ailment, injury or disease
a.
That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the policy or its reinstatement.

3.43. 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.

3.44. 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.

3.45. 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

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

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

3.48. Portability means a facility provided to the policyholders (including all members under family cover), to transfer the credits

gained for, Pre-Existing Diseases and Specific Waiting Periods from one insurer to another insurer.

3.49. 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.

3.50. 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.

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

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

3.53. 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 Period.

3.54. 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.

3.55. Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.
Note: If opted for TPA service, TPA details are mentioned in the Policy Schedule.

3.56. 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 Period, 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 at rates exceeding the aforesaid limits, the reimbursement/payment of Associated Medical Expenses incurred at the Hospital, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. Proportionate deduction shall not apply if admitted to ICU/ ICCU.
Associated Medical Expenses shall include all related expenses except the following expenses,
a. Cost of pharmacy and consumables;
b. Cost of implants and medical devices
c. Cost of diagnostics

3. Sub limits as mentioned above, will not apply in case of treatment undergone as a package for a listed procedure in a Preferred Provider Network (PPN).
4. Listed procedures and Preferred Provider Network list are dynamic in nature, and will be updated in the Company’s website from time to time

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 Period 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 Period.

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. Modern Treatment
The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital subject to the limit of 50% of the Sum Insured for the related modern procedure/ component/ medicine of each Modern

Treatment during the Policy Period:
Modern Treatment
Coverage
UAE & HIFU
Limit is for Procedure cost only

Balloon Sinuplasty
Limit is for Balloon cost only
Deep Brain Stimulation
Limit is for implants including batteries only
Oral Chemotherapy
Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.
Immunotherapy
Limit is for cost of injections only.
Intravitreal injections
Limit is for complete treatment, including Pre & Post Hospitalization
Robotic Surgery
Limit is for robotic component only.
Stereotactic Radio surgeries
Limit is for radiation procedure.
Bronchial Thermoplasty
Limit is for complete treatment, including Pre & Post Hospitalization
Vaporization of the prostrate
Limit is for LASER component only.
IONM
Limit is for IONM procedure only.
Stem cell therapy
Limit is for complete treatment, including Pre & Post Hospitalization

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 Period (where no claims are reported and admitted), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current Policy Period.

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 Period.

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 Period.

viii. If a claim is made in the expiring Policy Period, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

ix. The Cumulative Bonus will not be accumulated in excess of 50% of the Sum Insured under the current Policy with Us under any circumstances.

x. Any Cumulative Bonus that has accrued for a Policy Period will be credited at the end of that Policy Period if the policy is

renewed with us within grace period and will be available for any claims made in the subsequent Policy Period.

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 (Excl 01)
a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 (thirty six) 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 36 (thirty six) 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 (Excl 03)
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 (Excl 02)
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.
24 Months 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 of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal
Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and
Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies
ii.
36 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 – Excl 04)
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- Excl 05)
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- Excl 06)
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 – Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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7.5. Cosmetic or plastic Surgery (Code – Excl 08)
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 – Excl 09)

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 – Excl 10)
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 – Excl 11)
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. Drug/Alcohol Abuse (Excl 12)
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Excl 12)

7.10. Non Medical Admissions (Excl 13)
Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Excl 13)

7.11. Vitamins, Tonics (Excl 14)
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 practitioners part of hospitalization claim or day care procedure

7.12. Refractive Error (Code – Excl 15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13. Unproven Treatments (Code – Excl 16)
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 – Excl 17)
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 – Excl 18)
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

8. Moratorium Period:
After completion of sixty continuous months of coverage (including Portability and Migration), no claim shall be contestable by the

Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as Moratorium Period. The moratorium would be applicable for the Basic Sums Insured of the first policy. Wherever, the Basic Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Basic Sums Insured only on the enhanced limits.

9. CLAIM PROCEDURE

9.1.1 Procedure for Cashless claims:

(i)

Cashless Facility can be availed, if TPA service is opted.

(ii) Treatment may be taken in a Network Provider / PPN or Non Network Provider and is subject to preauthorization by the Company or its authorized TPA.

(iii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

(iv) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter within an hour to the hospital after verification.

(v) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

(vi) The TPA shall grant the final authorization within three hours of the receipt of discharge authorization request from the Hospital.

(vii) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

(viii) 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 processing.

9.1.2 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. Co-payment
Each and every claim under the Policy shall be subject to a Co-payment as mentioned below, 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 co-payment.
•

Co-payment of 5% on all claims for Insured Person aged less than equal to 75 years on policy inception
•
Co-payment of 15% on all claims for Insured Person aged greater than 75 years on policy inception

9.4. Claim Settlement
i.
The Company shall settle or reject a claim, as the case may be, within 15 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 to the policyholder 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 any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject 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 to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

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 by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

10.2. Condition Precedent to Admission of Liability
The terms and conditions of the policy must be fulfilled by the insured person for 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

Any payment to the policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of then amount for the particular claim.

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

i.

In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person 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 chosen by the insured person 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.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment 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 and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer 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 claim and / or forfeit the policy benefits 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

10.10. Cancellation
i. The Company may cancel the policy at any time, on grounds of misrepresentation, non-disclosure of material facts or

established 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.
ii. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall refund proportionate premium for unexpired policy period, if there is no claim(s) made during the policy period. 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 under the Policy.

10.11. 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.

10.12. 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.

10.13. Migration
The Insured Person will have the option to migrate the Policy to an alternative health insurance product offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,
i. The Insured Person will get all the accrued continuity benefits for credits gained to the extent of the specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person.
ii. Migration benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Migration benefit shall not apply to any other additional increased Sum Insured.
The Proposal may be subject to fresh Underwriting as per terms of conditions of the migrated product, if the insured is not continuously covered for at least 36 months under the previous product

10.14. Portability
The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 15 days before, but not earlier than 60 days from the policy renewal date, as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,
i. The proposed Insured Person will get all the accrued continuity benefits for specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Portability benefit shall not apply to any other additional increased Sum Insured.

10.15. Renewal of Policy
i.
The policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate

to other similar health insurance products/plans offered by the Company.
ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
vi. No loading shall apply on renewals based on individual claims experience.
vii. 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 Proposer, covering the children.

10.16. Premium Payment in Installments
If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly, 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 (as defined) would be given to pay the instalment premium due for the policy.
ii. If Installment Premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed. However, if the premium is paid in instalments within the Grace Period, coverage shall be available during the Grace Period.
iii. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
iv. In case of a claim being admissible under the Policy, all the remaining installments for the Policy Period shall become due and payable immediately.
v. Change of Premium Paying Frequency can be opted only at the time of renewal.
vi. In case of installment premium due not received within the grace Period, the Policy will get cancelled ab-initio.

10.17. Withdrawal of Product
i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90

days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

10.18. 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 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 person shall be allowed free look period of thirty (30) days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact: Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in
For more information on grievance mechanism, and to download grievance form, visit our website https://nationalinsurance.nic.co.in
Bima Bharosa (an Integrated Grievance Management System earlier known as IGMS) - https://bimabharosa.irdai.gov.in/
Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as listed in Annexure-B. The updated list of Office of Insurance Ombudsman are available on IRDAI website: https://irdai.gov.in/ and on the website of Council for Insurance Ombudsman: https://www.cioins.co.in/
Helpline Number: 1800 345 0330
Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.in

12. TABLE OF BENEFITS

Name

Arogya Sanjeevani Policy - National

Product Type

Individual/ Floater

Category of Cover

Indemnity
Sum insured
₹ 50,000 to ₹ 10L, in multiple of ₹ 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 aged of 18 years and 65 years above, 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
The grace period of thirty days (where premium is paid in quarterly/half yearly/annual instalments) is available on the premium due date, to pay the premium.
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 3 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 for age less than equal to 75 years
15% Co-pay on all claims for age greater than 75 years
Add-Ons Available
National Home
Care Treatment
Add-On

INR 10,000/ 15,000/ 20,000/ 25,000/ 30,000/ 35,000/ 40,000/ 45,000/ 50,000, subject to 10% of Basic SI under base Policy.

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

Arogya Sanjeevani Policy - National
UIN: NICHLIP25041V022425

Annexure-A
List I – List of which coverage is not available in the policy

Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	

LAUNDRY CHARGES
12
MINERAL WATER
13
SANITARY PAD
14
TELEPHONE CHARGES
15
GUEST SERVICES
16
CREPE BANDAGE
17
DIAPER OF ANY TYPE
18
EYELET COLLAR
19
SLINGS
20
BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21
SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22
Television Charges
23
SURCHARGES
24
ATTENDANT CHARGES
25
EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS

PART OF BED CHARGE)
26
BIRTH CERTIFICATE
27
CERTIFICATE CHARGES
28
COURIER CHARGES
29
CONVEYANCE CHARGES
30
MEDICAL CERTIFICATE
31
MEDICAL RECORDS
32
PHOTOCOPIES CHARGES
33
MORTUARY CHARGES
34
WALKING AIDS CHARGES
35
OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36
SPACER
37
SPIROMETRE
38
NEBULIZER KIT
39
STEAM INHALER

40
ARMSLING
41
THERMOMETER
42
CERVICAL COLLAR
43
SPLINT
44
DIABETIC FOOT WEAR
45
KNEE BRACES (LONG/ SHORT/ HINGED)
46
KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47
LUMBO SACRAL BELT
48
NIMBUS BED OR WATER OR AIR BED CHARGES
49
AMBULANCE COLLAR
50
AMBULANCE EQUIPMENT
51
ABDOMINAL BINDER
52
PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53
SUGAR FREE Tablets
54

CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55
ECG ELECTRODES
56
GLOVES
57
NEBULISATION KIT
58
ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59
KIDNEY TRAY
60
MASK
61
OUNCE GLASS
62
OXYGEN MASK
63
PELVIC TRACTION BELT
64
PAN CAN
65
TROLLY COVER
66
UROMETER, URINE JUG
67
VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH

14
BED PAN
15
FACE MASK
16
FLEXI MASK
17
HAND HOLDER
18
SPUTUM CUP
19
DISINFECTANT LOTIONS
20
LUXURY TAX
21
HVAC
22
HOUSE KEEPING CHARGES
23
AIR CONDITIONER CHARGES
24
IM IV INJECTION CHARGES
25
CLEAN SHEET
26
BLANKET/WARMER BLANKET
27
ADMISSION KIT
28

DIABETIC CHART CHARGES
29
DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30
DISCHARGE PROCEDURE CHARGES
31
DAILY CHART CHARGES
32
ENTRANCE PASS / VISITORS PASS CHARGES
33
EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34
FILE OPENING CHARGES
35
INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36
PATIENT IDENTIFICATION BAND / NAME TAG
37
PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges
Sl
Item
1
HAIR REMOVAL CREAM
2
DISPOSABLES RAZORS CHARGES (for site preparations)
3
EYE PAD
4

EYE SHEILD
5
CAMERA COVER
6
DVD, CD CHARGES
7
GAUSE SOFT
8
GAUZE
9
WARD AND THEATRE BOOKING CHARGES
10
ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11
MICROSCOPE COVER
12
SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13
SURGICAL DRILL
14
EYE KIT
15
EYE DRAPE
16
X-RAY FILM
17
BOYLES APPARATUS CHARGES
18
COTTON

19
COTTON BANDAGE
20
SURGICAL TAPE
21
APRON
22
TORNIQUET
23
ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment
Sl
Item
1
ADMISSION/REGISTRATION CHARGES
2
HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3
URINE CONTAINER
4
BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5
BIPAP MACHINE
6
CPAP/ CAPD EQUIPMENTS
7
INFUSION PUMP– COST
8

HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9
NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10
HIV KIT
11
ANTISEPTIC MOUTHWASH
12
LOZENGES
13
MOUTH PAINT
14
VACCINATION CHARGES
15
ALCOHOL SWABES
16
SCRUB SOLUTION/STERILLIUM
17
Glucometer & Strips
18
URINE BAG

Annexure-B

National Insurance Co. Ltd.

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction
Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar
Haveli, Daman and Diu
Office of the Insurance Ombudsman,
Jeevan Prakash Building, 6th Floor, Tilak
Marg, Relief Road, Ahmedabad-380001
Tel: 079 -25501201/ 02/ 05/ 06
Email:
bimalokpal.ahmedabad@cioins.co.in
Karnataka
Office of the Insurance Ombudsman,
Jeevan Soudha Building, PID No. 57-27-N-
19, Ground Floor, 19/19, 24th Main Road,
JP Nagar, Ist Phase, Bengaluru – 560 078.
Tel.: 080 - 26652048 / 26652049
Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh,
Chhattisgarh
Office of the Insurance Ombudsman,
1st floor,"Jeevan Shikha", 60-B,
Hoshangabad Road, Opp. Gayatri Mandir,

Bhopal – 462 011.
Tel.: 0755 - 2769201 / 2769202
Email: bimalokpal.bhopal@cioins.co.in

Odisha
Office of the Insurance Ombudsman,
62, Forest park, Bhubneshwar – 751 009.
Tel.: 0674 - 2596461 /2596455
Fax: 0674 - 2596429
Email:
bimalokpal.bhubaneswar@cioins.co.in

Punjab, Haryana
(excluding Gurugram,
Faridabad, Sonepat and
Bahadurgarh), Himachal
Pradesh, Union
Territories of Jammu &
Kashmir, Ladakh &
Chandigarh
Office of the Insurance Ombudsman,
S.C.O. No. 101, 102 & 103, 2nd Floor,
Batra Building, Sector 17 – D,
Chandigarh – 160 017.
Tel.: 0172 - 4646394 / 2706468
Email:
bimalokpal.chandigarh@cioins.co.in

Tamil Nadu, Puducherry
Town and Karaikal
(which are part of
Puducherry)

Office of the Insurance Ombudsman,
Fatima Akhtar Court, 4th Floor, 453,
Anna Salai, Teynampet,
CHENNAI – 600 018.
Tel.: 044 - 24333668 / 24333678
Email: bimalokpal.chennai@cioins.co.in
Delhi & following
Districts of Haryana -
Gurugram, Faridabad,
Sonepat & Bahadurgarh
Office of the Insurance Ombudsman,
2/2 A, Universal Insurance Building,
Asaf Ali Road,
New Delhi – 110 002.
Tel.: 011 - 23237539
Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya,
Manipur, Mizoram,
Arunachal Pradesh,
Nagaland and Tripura
Office of the Insurance Ombudsman,
Jeevan Nivesh, 5th Floor,
Nr. Panbazar over bridge, S.S. Road,
Guwahati – 781001(ASSAM).
Tel.: 0361 - 2632204 / 2602205
Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh,
Telangana, Yanam and
part of Union Territory

of Puducherry
Office of the Insurance Ombudsman,
6-2-46, 1st floor, "Moin Court",
Lane Opp. Saleem Function Palace,
A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.
Tel.: 040 - 23312122
Email: bimalokpal.hyderabad@cioins.co.in

Rajasthan
Office of the Insurance Ombudsman,
Jeevan Nidhi – II Bldg., Gr. Floor,
Bhawani Singh Marg,
Jaipur - 302 005.
Tel.: 0141- 2740363/2740798
Email: Bimalokpal.jaipur@cioins.co.in

Kerala, Lakshadweep,
Mahe-a part of Union
Territory of Puducherry
Office of the Insurance Ombudsman,
10th Floor, Jeevan Prakash, LIC Building,
Opp to Maharaja's College, M.G. Road,
Kochi - 682 011.
Tel.: 0484 - 2358759
Email: bimalokpal.ernakulam@cioins.co.in

West Bengal, Sikkim,
Andaman & Nicobar
Islands
Office of the Insurance Ombudsman,
Hindustan Bldg. Annexe, 7th Floor,

4, C.R. Avenue, KOLKATA - 700 072.
Tel.: 033 - 22124339 / 22124341
Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar
Pradesh : Lalitpur,
Jhansi, Mahoba,
Hamirpur, Banda,
Chitrakoot, Allahabad,
Mirzapur, Sonbhabdra,
Fatehpur, Pratapgarh,
Jaunpur,Varanasi,
Gazipur, Jalaun, Kanpur,
Lucknow, Unnao,
Sitapur, Lakhimpur,
Bahraich, Barabanki,
Raebareli, Sravasti,
Gonda, Faizabad,
Amethi, Kaushambi,
Balrampur, Basti,
Ambedkarnagar,
Sultanpur, Maharajgang,
Santkabirnagar,
Azamgarh, Kushinagar,
Gorkhpur, Deoria, Mau,
Ghazipur, Chandauli,
Ballia, Sidharathnagar
Office of the Insurance Ombudsman,
6th Floor, Jeevan Bhawan, Phase-II,
Nawal Kishore Road, Hazratganj,

Lucknow - 226 001.
Tel.: 0522 - 4002082 / 3500613
Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai
Metropolitan Region
(excluding Navi Mumbai
& Thane)
Office of the Insurance Ombudsman,
3rd Floor, Jeevan Seva Annexe, S. V.
Road, Santacruz (W), Mumbai - 400 054.
Tel.: 022 - 69038800/27/29/31/32/33
Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and
the following Districts of
Uttar Pradesh: Agra,
Aligarh, Bagpat,
Bareilly, Bijnor,
Budaun, Bulandshehar,
Etah, Kannauj,
Mainpuri, Mathura,
Meerut, Moradabad,
Muzaffarnagar, Oraiyya,
Pilibhit, Etawah,
Farrukhabad, Firozbad,
Gautam Buddh nagar,
Ghaziabad, Hardoi,
Shahjahanpur, Hapur,
Shamli, Rampur,
Kashganj, Sambhal,

Amroha, Hathras,
Kanshiramnagar,
Saharanpur
Office of the Insurance Ombudsman,
Bhagwan Sahai Palace, 4th Floor, Main
Road, Naya Bans, Sector 15,
Distt: Gautam Buddh Nagar, U.P-201301.
Tel.: 0120-2514252 / 2514253
Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand
Office of the Insurance Ombudsman,
2nd Floor, Lalit Bhawan,
Bailey Road, Patna 800 001.
Tel.: 0612-2547068
Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of
Navi Mumbai and Thane
(excluding Mumbai
Metropolitan Region)
Office of the Insurance Ombudsman,
Jeevan Darshan Bldg., 3rd Floor,
C.T.S. No.s. 195 to 198, N.C. Kelkar Road,
Narayan Peth, Pune – 411 030.
Tel.: 020-24471175
Email: bimalokpal.pune@cioins.co.in