Summary of Terms and Conditions applicable to Arogya Raksha

Scope of Cover:

1. All medical/surgical treatments under this policy shall have to be taken in India and admissible claims are payable in Indian Currency.
2. Indian Bank A/c Holder and his family members (spouse, two dependent Children from the age of 3 months and dependent Parents) can be covered. Son can be covered up to his getting employment or completing 25 years of age, whichever is earlier. Daughter can be covered up to marriage or employment whichever is earlier. No medical check-up is required and policy issued based on declaration of Good Health.
3. Expenses on hospitalization for minimum period of 24 consecutive hours of inpatient care are admissible. However this time limit is not applicable to specific treatments as detailed in policy terms and conditions.
4. Maternity Expenses are eligible only after 9 months – up to 5% of Sum Insured (SI).
5. Expenses in respect of the following specified illnesses will be restricted as detailed below:

Hospitalization Benefits	**Limits for each hospitalization**
a. Cataract	a. 10% of the Sum Insured subject to a maximum of Rs.25,000/-
b. Hernia	b. 15% of the Sum Insured subject to a Maximum of Rs.30,000/-
c. Hysterectomy	c. 20% of the SI subject to a maximum of Rs.50,000/-
d. Major Surgeries*	d. Actual expenses incurred or 80% of the Sum Insured whichever is less
Pre & Post Hospitalization	Actual expenses incurred subject to a Maximum 10% of the Sum Insured
Room, Board and Nursing Expenses	Maximum 1.5% of the Sum Insured per day or actual amount whichever is less
ICU	Maximum of 3% of the Sum Insured per day or actual amount whichever is less
Deductible for persons above 65 years of age	10% deductible will be applied on all admissible claims

*Major surgeries include Cardiac surgeries, Brain Tumor surgeries, Pacemaker implantation for sick sinus syndrome, Cancer surgeries, Hip, Knee, joint replacement surgery, Organ Transplant. The limits specified are applicable per hospitalization / surgery.

6. For Ayurvedic treatment hospitalization expenses are admissible only when the treatment has been undergone in a Government Hospital or in any Institute recognized by the Government and / or accredited by Quality Council of India/NABH.
7. Expenses on major illness charged as a total package to be settled with co-pay on 80:20 basis. The co-pay of 20% will be applicable on the admissible claim amount.
8. The Insured may enhance the Sum Insured (SI) at the time of renewal to the next slab. However, notwithstanding enhancement, for claims arising in respect of ailment, diseases or Injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of Sum Insured under the policy in force at the time when it was contracted or suffered.

Summary of Exclusions:

1. Any disease contracted by the Insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however apply in the case of the insured person having been covered for a continuous period of previous 12 months without any break.
2. All pre-existing diseases/injuries will get covered only after 36 months of continuous coverage.
3. Expenses on treatment of certain diseases such as Cataract, Benign, Prostatic, Hypertrophy, Hysterectomy for Menorrhagia, or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone Removal, Gout & Rheumatism, Calculus Diseases are payable only after the first renewal of Arogya Raksha Policy without break.
4. Charges incurred at Hospital/Nursing Home primarily for Diagnosis not consistent with or incidental to the diagnosis and treatment are excluded. OPD treatment and Domiciliary Hospitalization are excluded.
5. Expenses in connection with convalescence, general debility, run down or rest cure, congenital external disease or defects or anomalies, Sterility, venereal diseases, intentional self-injury and use of intoxication drugs/alcohol.

Claim Procedure:

1. For Cashless Treatment: The TPA provides a List of Approved Network Hospitals. The Insured person should approach any approved Network Hospital for Pre Authorization. Once approval is given by the TPA, the Insured can go ahead with the treatment and need to pay the Hospital only the excess, if any, over the amount approved.
2. Wherever Cashless Treatment is not possible due to emergency etc., the insured person can get the treatment, pay the bills and then submit a Claim to TPA, for reimbursement of eligible amount as per policy terms and conditions.
3. In case of Reimbursement Claim, intimation to TPA shall be made within 24 hours of hospitalization and obtain Discharge Summary, prescriptions, Investigation / LAB Reports and bills, receipts and all other relevant documents and furnish them in **original** to the TPA within 15 days from the date of discharge.