This document provides key information about your policy. You are also advised to go through your policy document.

S. No.	Title	Description	Policy Clause Number
1.	Name of the Insurance Policy	Arogya Sanjeevani Policy, TATA AIG General Insurance Company Ltd.	
2.	Policy Number	<< Policy No. >>	
3.	Type of Insurance Policy	Indemnity- Where insured losses are covered up to the Sum Insured under the policy	
4.	Sum Insured (Basis) (Along with amount)	<<Sum Insured Amount>> As per Sum Insured mentioned in Policy Schedule Sum Insured represents Our maximum, total and cumulative liability under the Policy, for all the Insured Person(s) covered in aggregate, for the respective Policy Year	
5.	Policy Coverage (What the policy covers?)	1. **Hospitalization:** Expenses incurred on hospitalization for minimum period of 24 hours. 2. **AYUSH Treatment:** We will cover Medical Expenses incurred for treatment as In-Patient or Day Care Treatment in an AYUSH Hospital/ AYUSH day care centre. This benefit shall also cover Pre-Hospitalization medical expenses for a period of upto 30 days before the date of admission to the AYUSH hospital/ AYUSH day care centre and Post-Hospitalization Medical Expenses for a period upto 60 days, subject to AYUSH In-Patient hospitalization or AYUSH day care treatment claim being admissible under this benefit. Claims under this section shall be assessed as per the insurance guidelines related to AYUSH and benchmark rates as available on Ministry of AYUSH website (https://ayushnext.ayush.gov.in/site/insurance-guidelines-related-to-ayush). 3. **Cataract Treatment:** Expenses incurred on treatment of cataract.	Section (2)

		4. **Pre Hospitalization:** Expenses incurred on pre hospitalization for a fixed period of 30 days prior to the date of admissible hospitalization. 5. **Post Hospitalisation:** Expenses incurred on post hospitalization for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization. 6. **Modern treatments:** 12 listed Modern treatment procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital. 8. **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.	
6.	Exclusions	**Standard Exclusions** **1. Medical Exclusions** I. Investigation and evaluation (Code-Excl 04) II. Rest cure, rehabilitation and respite care (Code-Excl 05) III. Obesity/ Weight Control (Code-Excl 06) IV. Change-of-Gender treatments (Code-Excl07) V. Cosmetic or Plastic Surgery (Code-Excl 08) VI. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code-Excl 12) VII. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13) VIII. 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) IX. Refractive error (Code-Excl 15)	Section (3)

		X. Unproven treatments (Code-Excl 16) XI. Sterility and Infertility (Code-Excl 17) XII. Maternity (Code-Excl 18) **2. Non-Medical Exclusions** I. Hazardous or Adventure Sports (Code - Excl 09) II. Breach of law (Code- Excl 10) III. Excluded Providers: (Code - Excl 11) **Specific Exclusions (Exclusions other than as those mentioned above)** **1. Medical Exclusions** I. Any expenses incurred on Domiciliary Hospitalization and OPD treatment II. Treatment taken outside the geographical limits of India III. 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. **2. Non-Medical Exclusions** I. 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. II. Nuclear, chemical or biological attack or weapons This is summary of exclusions. For detailed exclusions, please refer Policy wordings (Section 3)	
7.	Waiting period	I. Initial waiting period of 30 days for all illnesses (not applicable for accidents or on renewals) II. Specified Waiting periods (Not applicable for claims arising due to an accident): • 24 months for 20 listed Diseases/procedure • 48 months for 2 listed Diseases/procedure III. Pre-existing disease covered after 48 months	Section (3)

8.	Financial limits of coverage i. Sub-limit (it is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) ii. Co-payment (it is a specified amount/percentage of the admissible claim amount to be paid by policy holder /insured) iii. Deductible (it is a specified amount: - Up to which an insurance company will not pay any claim, and - Which will be deducted from total claim amount (if claim amount is more than the specified amount) Any other limit (as applicable)	The policy will pay only up to the limits specified hereunder for the following diseases/procedures: **Sub-limit** <u>Benefit Specific Sub-limit:</u> • Room Rent, Boarding, Nursing Expenses- Up to 2% of the sum insured subject to maximum of Rs.5000/-, per day • Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses - Up to 5% of sum insured subject to maximum of ₹10,000/- per day • Road Ambulance- Upto ₹2,000 per hospitalization • Cataract Treatment- Up to 25% of Sum Insured or ₹40,000/- whichever is lower • Modern treatment methods and Advancements in technology Up to 50% of the Sum insured **Co-payment:** Co-payment of 5% on each and every claim under the Policy **Any Other limit:** • Hospitalization – Upto Sum Insured • AYUSH Treatment – Upto Sum Insured • Pre Hospitalization – Upto 30 days, Upto Sum Insured • Post Hospitalisation – Upto 60 days, Upto Sum Insured • Dental treatment necessitated due to injury – upto Sum Insured • Plastic surgery necessitated due to disease or injury – upto Sum Insured • Day care treatments – Upto Sum Insured	Section (2) & Section (4)
9.	Claims/Claims Procedure	**Claim procedure:** **Notification of Claim:** Notice with full particulars shall be sent to the Company/TPA (if applicable) as under: i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.	Section (5)

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

- **For Cashless Service:**

1. Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
2. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/ TPA for authorization.
3. 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.
4. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
5. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
6. 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.

- **For Reimbursement of Claim:**

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable) /Company within the prescribed time limit as specified hereunder.

i. Reimbursement of hospitalization, day care and pre hospitalization expenses- Within thirty days of date of discharge from hospital.

ii. Reimbursement of post hospitalization expenses- Within fifteen days from completion of post hospitalization treatment.

Turn Around Time (TAT) for claims settlement:

i. TAT for preauthorization of cashless facility: 2 hours

ii. TAT for cashless final bill authorization: 4 hours

		Assistance: 1. Please refer to our website www.tataaig.com or call us on our toll free number at 1800-266-7780 to get details on our empanelled hospitals and list of Excluded providers/ Blacklisted Hospitals. 2. Helpline number: Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) 3. Please refer our website www.tataaig.com to download claim form	
10.	Policy Servicing	Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)	Section (4)
11.	Grievances/ Complaints	**Redressal of Grievance** In case of any grievance the insured person may submit in writing to the Policy issuing office or regional office for redressal. if the Insured Person is not satisfied with The Company's services and wish to lodge a complaint, please feel free to contact us through below channels: Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders) Email: customersupport@tataaig.com Courier: Customer Support, TATA AIG General Insurance Company Limited, 7th and 8th Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 40006 **Escalation level 1:** For lack of a response or if the resolution still does not meet your expectations, you can write to manager.customersupport@tataaig.com. **Escalation level 2:** For lack of a response or if the resolution still does not meet expectations, the Insured Person can write to the Head - Customer Services at head.customerservices@tataaig.com **Escalation to Insurance Ombudsman** Within 30 days of lodging a complaint with us, if the Insured Person does not get a satisfactory response from us and wish to pursue other avenues for redressal of grievances, the Insured Person may approach Insurance Ombudsman appointed by IRDAI under the Insurance Ombudsman Scheme.	Section (4)

		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 Annexure -B of policy wordings.	
12.	Things to remember	**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 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. i. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to 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; **Policy renewal** 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 without 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.	Section (4)

v. A Grace Period of 30 days for renewing the Policy is provided under this Policy (For cases other than Premium payment in instalments.)

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

For Detailed Guidelines on Migration, kindly refer Guidelines on Migration and Portability of Health Insurance policies – Ref: IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020

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

For Detailed Guidelines on Portability, kindly refer Guidelines on Migration and Portability of Health Insurance policies – Ref: IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020

Change in Sum Insured
Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company.

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.

13.	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and termination of Your policy.	

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