

SBIG HEALTH SUPER TOP-UP

POLICY WORDING

Section 1: Preamble

In Consideration Of Payment Of Premium By You And Realized By Us, We will provide insurance cover to the Insured Person(s) under this Policy up to Sum Insured and/or limits as specified in the Policy Schedule subject to all terms, condition and exclusion as mentioned under the Policy and declaration, medical reports as provided by You. This Policy is subject to your statements in respect of all the Insured Person(s) in Proposal form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy.

Section 2: 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.

2.1 Standard Definitions

- 1) **Accident/ Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 2) **Anyone Illness** means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home centre where treatment was taken.
- 3) **AYUSH Treatment** means the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- 4) **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.
- 5) **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment and procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - i. Central or State Government AYUSH Hospital; or
 - ii. Teaching Hospital attached to AYUSH colleges recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - iii. 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:
 - Having at-least 05 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedure are to be carried out;
 - Maintaining daily records of the patients and making them accessible to the Insurance Company's authorized representative.
- 6) **Break in Policy** means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
- 7) **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 network provider by the Company to the extent pre-authorization is approved.
- 8) **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.
- 9) **Complainant** means a Policyholder or prospect or Nominee or assignee or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer and /or distribution channel.
- 10) **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
- 11) **Congenital Anomaly** means a condition which is present since birth and which is abnormal with reference to form, structure or position.
 - i. **Internal Congenital Anomaly**
Congenital Anomaly which is not in the visible and accessible parts of the body.
 - ii. **External Congenital Anomaly**
Congenital Anomaly which is in the visible and accessible parts of the body.
- 12) **Cumulative Bonus** means any increase or addition in Sum Insured granted by the Insurer without an associated increase in premium.
- 13) **Day Care Centre** means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under 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 will make these accessible to the Insurance company's authorized personnel.
- 14) **Day Care Treatment** means medical treatment, and/ or surgical procedure which is:

- i. undertaken under general or local anesthesia in a Hospital/ Day Care Center in less than 24 hours because of technological advancement, and
 - ii. which would have otherwise required Hospitalization of more than 24 consecutive hours.
 - iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
- 15) **Deductible** means a cost sharing requirement under a health insurance Policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A Deductible does not reduce the Sum Insured.
- i. **Deductible** applicable under this Policy for Plus plan is Annual Aggregate Deductible. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Year has to exceed the Aggregate Deductible as mentioned in the Policy Schedule.
 - ii. **Deductible** applicable under this Policy for Pro plan is Long Term Aggregate Deductible. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Period has to exceed the Aggregate Deductible as mentioned in the Policy Schedule.
- 16) **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
- 17) **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.
- 18) **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
- i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
 - ii. the patient takes treatment at home on account of non-availability of room in a hospital.
- 19) **Emergency/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.
- 20) **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. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
- Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
- 21) **Hospital** means any institution established for In-patient care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities, under the Clinical Establishments (Registration & Regulation) Act, 2010 or under enactments specified under the schedule of section 56(1) of the said Act or complies with all with all minimum criteria as under :
- i. has qualified nursing staff under its employment round the clock;
 - ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient 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 makes these accessible to the Insurance company's authorized personnel.
- 22) **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours (Day Care Treatment).
- 23) **Illness** means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
- i. **Acute condition** - Acute condition is a disease, Illness or Injury that is likely to respond 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** - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
 - It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - it continues indefinitely
 - it recurs or is likely to recur
- 24) **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible, and evident means which is verified and certified by a Medical Practitioner.
- 25) **In-Patient Care/ In-Patient Treatment** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
- 26) **Intensive / Critical Care Unit (ICU/CCU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of 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.
- 27) **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses 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.

28) **Maternity Expenses** means

- i. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
- ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

29) **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

30) **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.

31) **Medically Necessary Treatment** means any treatment, tests, medication or stay in Hospital or part of a stay in Hospital which

- i. Is required for the medical management of the illness/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.

32) **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 its scope and jurisdiction of license.

Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017.

The registered practitioner should not be the Policyholder/Insured or their close family member.

33) **Migration** means a facility provided to Policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

34) **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility

35) **Newborn baby** means baby born during the Policy Period and is aged upto 90 days

36) **Non-Network Provider/Hospital** means any Hospital, Day Care center or other provider that is not part of the Network.

37) **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

38) **OPD/Out patient Treatment** means the one 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.

39) **Post Hospitalization Medical Expenses** means Medical

Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

- i. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalization was required and
- ii. The In-patient hospitalization claim for such Hospitalization is admissible by the Company

40) **Portability** means a facility provided to the health insurance 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.

41) **Pre-existing Disease** means any condition, ailment, Injury or disease:

- i. that is/are diagnosed by a physician not more than 24 months prior to the date of commencement of the policy issued by the insurer; or
- ii. for which medical advice or treatment was recommended by, or received from, a physician, not more than 24 months prior to the date of commencement of the policy.

42) **Pre-hospitalization Medical Expenses** means Medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

43) **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

Explanation:

- (i) "Material Information" for the purpose of these regulations shall mean all important, essential and relevant information and documents explicitly sought by insurer in the proposal form.
- (ii) The requirements of "disclosure of material information" regarding a proposal or policy, apply both to the insurer and the prospect, under these regulations.

44) **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.

45) **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved

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

47) **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

- 48) **Senior Citizen** means any person, who has attained the Age of sixty years or above.
- 49) **Solicitation** means the act of approaching a prospect or a Policyholder by an Insurer or by a distribution channel with a view to persuading the prospect or a Policyholder to purchase or to renew an insurance Policy.
- 50) **Specific Waiting Period** means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
- 51) **Surgery / Surgical Procedure / Surgical Operation** 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 or prolongation of life, performed in a Hospital or Day Care centre by a Medical Practitioner.
- 52) **Unproven/ Experimental Treatments** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.2 Specific Definitions

- 1) **Age** means "Age as on last birthday" as determined on the date of first Policy issuance or at Renewal. In case of change in Age during the proposal stage then "Age" shall be determined on the date of Proposal Form submission would be considered for premium calculation.
- 2) **Ambulance** means a road vehicle or an aircraft operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
- 3) **Annexure** means document attached and marked as Annexure to this Policy.
- 4) **Child** means Insured Person's biological or legally adopted son or daughter, whose completed age is between 3 months to 25 years as on Policy Period Start Date, and who is financially dependent on the Insured Person and does not have an independent source of income.
- 5) **Claim** means a demand made by the Policyholder or on his behalf, for payment of Medical Expenses under any other benefit, as covered under the Policy.
- 6) **Dependent** means only the family members listed below:
 - i. Your legally married spouse as long as she continues to be married to You
 - ii. Your children (natural or legally adopted), aged between 91 days maximum up to Age of 25 years and financially dependent on You
 - iii. Your natural parents or parents that have legally adopted You,
 - iv. Your parent-in-law as long as Your Spouse continues to be married to You
- 7) **Family** means one or more of the following family members of the Insured Person
 - i. legally wedded spouse
 - ii. Parents and/or Parents- in law
 - iii. Dependent Children (i.e. natural or legally adopted) between the Age 91 days to Age 25 years. If the child above 18 years of Age is financially independent, he or she shall be ineligible for coverage under this Policy in the subsequent renewals.
- 8) **Insured Person/Insured/You/Your** means persons named in the Policy Schedule who are insured under the Policy and are Citizen of India in respect of whom the applicable premium has been received.
- 9) **Life Threatening Medical Condition** means a medical condition suffered by the Insured Person which has any of the following characteristics:
 - i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or
 - ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or
 - iii. Critical care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or
 - iv. Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department; and
 - v. is certified by the attending Medical Practitioner as a Life Threatening Medical Condition.
- 10) **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.
- 11) **Medical Practitioner for Mental Illnesses** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;
- 12) **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

- 13) **Nominee** means the person whose name specifically appears as such in the Policy Schedule and is the person to whom the proceeds under this Policy, if any, shall become payable in the event of the death of the Policyholder. Nominee for all other Insured Person(s) shall be the Policyholder himself.
- 14) **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.
- 15) **Policy Schedule/Schedule** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
- 16) **Policyholder** means the person who has Proposed the Policy and in whose name, Policy is issued.
- 17) **Policy Period/Period of Insurance** means the period commencing from the Policy Period Start Date as specified in Policy Schedule and ending on the Policy Period End Date as specifically appearing in the Policy Schedule or on the date of cancellation of the Policy, whichever is earlier.
- 18) **Policy Year** means a period of 12 consecutive months starting from the Policy Period Start Date and ending on the last day of such 12 month period. For the purpose of subsequent years, Policy Year shall mean a period of 12 months commencing from the end of previous Policy Year and lapsing on the last day of such 12month period, till the Policy Period End Date, as mentioned in the Policy Schedule.
- 19) **E-Opinion** means a procedure whereby upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history. Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner
- 20) **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. The Sub- limit as applicable under the Policy is specified in the Policy Schedule against the relevant benefit in force under the Policy.
- 21) **Sum Insured** means the maximum, total and cumulative liability of the Company, excluding Cumulative Bonus, to pay the claims made under the Policy in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
- 22) **Telemedicine** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.
- 23) **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

- 24) **We/Our/Us/Company/Insurer** means the SBI General Insurance Company Limited

Section 3: Scope of Cover

We hereby agree subject to the terms, conditions and exclusions contained or expressed herein, to compensate the Insured Person as per the covers and limits specified in the Policy Schedule.

We will pay under below listed Covers on Medically Necessary Treatment of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured in excess of Deductible (wherever applicable) and limits including Cumulative Bonus (if applicable), as specified in the Policy Schedule. Subject to otherwise terms and conditions of the Policy.

3A. Hospitalization Covers

3.1 In Patient Treatment

If any of the Insured Person, during the Policy Year, is diagnosed with any Illness or suffers any Injury that requires Inpatient Treatment on the written advice of a Medical Practitioner, then We will indemnify the below Medical Expenses incurred by the Insured in excess of Deductible amount and up to the Sum Insured as specified in the Policy Schedule.

- Room rent and boarding expenses as provided by the Hospital/Nursing home up to the Room Rent limit as specific in the Policy Schedule.
- Intensive Care Unit Expenses/ Intensive Cardiac Care Unit (ICCU) expenses.
- Nursing Expenses as provided by the Hospital
- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees
- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Consultation fees including Telemedicine by Medical Practitioner
- Medicines, drugs, and consumables
- Diagnostic procedures
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

3.1.1 Pre-Hospitalization

We will indemnify the Insured for the Medical Expenses incurred in 60 days immediately before the Insured was Hospitalized, provided that:

- Such Medical Expenses are incurred in respect of the same condition for which Insured has taken Hospitalization, and
- We have accepted the Claim under Benefit-3.1 In Patient Treatment, Benefit-3.2 Day Care Treatment, Benefit-3.4 Modern Treatment, Benefit-3.5 AYUSH Treatment or Benefit-3.6 Domiciliary Hospitalization

3.1.2 Post-Hospitalization

We will indemnify the Insured for the Medical Expenses incurred in 90/180 days (as specified in the Policy Schedule) immediately after the Insured Person was discharged from Hospital provided that:

- Such costs are incurred in respect of the same condition for which the Insured has taken Hospitalization, and
- We have accepted the Claim under Benefit-3.1 In Patient Treatment, Benefit-3.2 Day Care Treatment, Benefit-3.4 Modern Treatment, Benefit-3.5 AYUSH Treatment or

Benefit-3.6 Domiciliary Hospitalization

3.2 Day Care Treatment

We will indemnify the Insured for the Medical Expenses on the written advice of the Medical Practitioner, if during the Policy Year, any of the Insured Person undergoes a Day Care Treatment as defined under this Policy.

Specific Condition applicable to Benefit-3.2 Day Care Treatment

- i. The Day Care Treatment would be covered if the Insured is admitted for more than 2 hours.
- ii. The Day Care Treatment would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer.
- iii. Our maximum liability under this benefit is limited to Sum Insured, in excess of Deductible as specified in the Policy Schedule.

3.3 Organ Donor

We will indemnify the Insured for the Medical Expenses incurred during In Patient Treatment, in respect of donor for any organ transplant Surgery conducted on the Insured Person during the Policy Year, provided that:

- i. The organ donated is for the Insured Person's use
- ii. We have accepted the claim under Benefit-3.1 In Patient Treatment.
- iii. We shall not pay the donor's Pre and Post Hospitalization Expenses
- iv. Our maximum liability under this benefit is limited to Sum Insured, in excess of Deductible as specified in the Policy Schedule.

An organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended).

3.4 Modern Treatments

We will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Medical Expenses incurred during the Policy Year on Inpatient Treatment or Day Care Treatment or **Domiciliary Treatment** of Modern Treatments and not limited to the following:

- i. Uterine Artery Embolization and HIFU
- ii. Balloon Sinuplasty
- iii. Deep Brain Stimulation
- iv. Oral Chemotherapy
- v. Immunotherapy-Monoclonal Antibody to be given as injection
- vi. Intra Vitreal injections
- vii. Robot surgeries
- viii. Stereotactic radio surgeries
- ix. Bronchial Thermoplasty
- x. Vaporization of the prostate (Green laser treatment or holmium laser treatment)
- xi. IONM- (Intra Operative Neutro Monitoring)
- xii. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

3.5 AYUSH Treatment

We will indemnify the Insured Person for the Medical Expenses which are incurred on treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy up to the Sum Insured in excess of Deductible as specified in the Policy Schedule. The AYUSH Treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.

3.6 Domiciliary Hospitalization

We will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Reasonable and Customary Charges for Medical Expenses incurred towards the Domiciliary Hospitalization during the Policy Year, provided that the condition for which the medical treatment is required for at least twenty-four hours.

The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

3.7 Road Ambulance

We will indemnify the Insured up to an amount specified in the Policy Schedule, per Hospitalization for expenses incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider

- i. We have accepted a Claim under Benefit 3.1 In Patient Treatment or Benefit 3.2 Day Care Treatment.
- ii. Such life-threatening emergency condition is certified by the Medical Practitioner.
- iii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital or from one Hospital to another Hospital, which is prepared to admit the Insured Person and provide the necessary medical services, provided that transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

3.8 Home Health Care

We will indemnify the Reasonable and Customary charges towards Medical Expenses incurred by the Insured for Home Health Care Services during the Policy Year, up to the Sum Insured in excess of Deductible, provided that

- i. The treatment in normal course would require In Patient Treatment at a Hospital and be admissible under Benefit-3.1 In Patient Treatment but is actually taken while confined at home.
- ii. The benefit shall not be available for any emergency treatment/care.
- iii. The treatment is availed from Our empanelled service provider on Cashless basis
- iv. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.

3B. Optional Covers

The covers listed below are optional covers and are available to the Insured Persons, on payment of additional premium, subject to below mentioned terms, conditions, and exclusions.

3.9 Maternity Expenses

We will indemnify towards the Maternity Expenses of female Insured Person incurred on Inpatient Treatment, to the extent of Sum Insured, subject to Deductible, provided:

- i. This benefit is available only to female members between the age group of 18 years to 45 years.

- ii. The benefit also covers expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner
- iii. This benefit shall become available only after the expiry of 36 months from the date of inception of the first Policy with Us.
- iv. The payment under this cover is limited to maximum two deliveries or termination for the female Insured Person covered under this Policy. Those female Insured Persons who are already having two or more children will not be eligible for this benefit.

3.10 New-born Baby Cover

We will indemnify up to the extent of Sum Insured in excess of Deductible specified in the Policy Schedule towards the Medical Expenses incurred in respect of a Newborn Baby subject to Mother being covered under the Policy. Provided that,

- i. The claim under this benefit shall be payable, if We have accepted the claim under Benefit-3.9 Maternity Expenses
- ii. The coverage will be available in respect of a New born Baby for 90 days from the date of delivery.
- iii. The Baby born during the Policy Year, will be covered from day one up to 90 days of age.
- iv. New Born Baby older than 90 days and less than 1 year can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the additional premium
- v. Sum Insured available under this benefit shall be up to Mother's Sum Insured in case of an individual policy and up to family floater Sum Insured in case of family floater Policy.

3.11 Hospital Daily Cash

If We have accepted a claim under Benefit-3.1 In-Patient Treatment, then We will pay the Insured an amount equal to the Hospital Daily Cash amount specified in the Policy Schedule per day of Hospitalization, provided

- i. A deductible of 24 hours shall apply under this Benefit; thus, the benefits shall become payable only after the completion of the first 24 hours of Hospitalization of the Insured Person.
- ii. In a given Policy Year, the amount under this benefit shall be payable for a maximum of no. of days (as specified in the Policy Schedule) in a Policy Year.
- iii. In case of ICU hospitalization, We will pay per day Hospital Daily Cash amount maximum of 2 times of Hospital Cash Limit as specified in the Policy Schedule
- iv. Irrespective of Policy type, this benefit shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule.
- v. The payment under this benefit shall not reduce the Sum Insured.

3.12 Consumables

If We have accepted a Hospitalization claim, then the items which are not payable as per List I- 'Expenses not covered' under Annexure II related to that particular claim will become payable, provided

- i. Such Non-Medical/Consumables items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In Patient Treatment or Day Care Treatment and
- ii. We have accepted a claim under Benefit 3.1 to Benefit-3.6 and Benefit 3.8 Home Health Care.

3.13 Global Cover

We will indemnify the Medical Expenses incurred towards the Insured Person's In Patient Treatment or Day Care Treatment taken outside India during the Policy Year for below listed procedures that occurs or manifests itself during the Policy Year.

Listed Illness and Definitions:

Sno	Name of Illness	Definition
1	Cancer Treatment Surgery	We will be covering expenses incurred in Surgery for Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. I. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high-grade dysplasia or severe dysplasia.
2	Heart Valve Replacement	I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.
3	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).
4	Pulmonary Artery Graft Surgery	We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

5	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: - Surgery performed using only minimally invasive or intra-arterial techniques. - Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. The following are excluded: Angioplasty and/or any other intra-arterial procedures.
7	Surgical Treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II. We will be covering surgical treatment of Stroke limited to: - Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy; - Stenting of Intra cranial blood vessels, needed for the treatment of Stroke.

		III. The following are excluded: - Transient ischemic attacks (TIA); - Traumatic injury of the brain; - Vascular disease affecting only the eye or optic nerve or vestibular functions.
8	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases: - End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: - FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and - Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and - Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO₂ < 55mmHg); and - Dyspnea at rest.
9	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases: I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
10	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to: - Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy - A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: - no response to external stimuli continuously for at least 96 hours; - life support measures are necessary to sustain life; and - permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. - The condition has to be confirmed by a specialist medical practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.

11	Surgery for Pheochromocytoma	I. We will be covering the actual undergoing of surgery to remove the tumour. II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.
12	Liver Transplant Surgery in case of End Stage Liver Disease	In case of End Stage Liver Disease We will be covering the actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following: i. Permanent jaundice; and ii. Ascites; and iii. Hepatic Encephalopathy. iv. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. Liver failure secondary to drug or alcohol abuse is excluded
13	Pneumonectomy - Removal of an entire lung	The undergoing of surgery to remove an entire lung for disease or trauma. The following is not covered: i. Partial removal of a lung (lobectomy) or lung resection or incision. The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
14	Surgical removal of an eyeball	Surgical removal of a complete eyeball as a result of injury or disease. For the above definition the following is not covered: i. Self- inflicted injuries The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
15	Heart transplant surgery	Covers the actual undergoing of a transplant of human heart due to irreversible end- stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
16	Craniotomy for Cerebral Aneurysm	We will be covering the actual undergoing of Craniotomy for treatment of Cerebral aneurysm diagnosed by appropriate medical consultant supported with evidence of cerebral angiogram and/or magnetic resonance angiography and/or CT scan. For the above definition the following are not covered:

		i. Cerebral arteriovenous malformation.
--	--	---

Provided that,

- The above listed Illness must be diagnosed in India.
- The symptoms of the listed Illness first occur or manifest itself during the Policy Year and after completion of the applicable Waiting Period as specified in the Policy Schedule.
- This benefit is available on Reimbursement basis
- Our maximum liability under this benefit shall be limited to Sum Insured in excess of Deductible as specified in the Policy Schedule.
- The treating Medical Practitioner must recommend the necessity of treatment abroad, considering the medical condition and availability of treatment at an international center of excellence which is best in class.
- The Hospitalization is towards Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.
- For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and/or regulations applicable to the country where the treatment is taken.
- The claim payment under this benefit shall be payable in Indian Rupees.

3.14 Radio Cab

We shall indemnify the Insured up to the amount specified in the Policy Schedule, per Hospitalization, for the expenses incurred on availing registered Radio cab operator services, provided that:

- We have accepted the claim under Benefit- 3.1 In Patient Treatment and Benefit-3.2 Day Care Treatment
- The coverage includes the cost of the transportation of the Insured for whom claim has been accepted under under Benefit 3.1 In Patient Treatment or Benefit 3.2 Day Care Treatment to the nearest Hospital and/or from Hospital to home.

3.15 Air Ambulance

We will indemnify the Insured to the extent of Sum Insured specified in the Policy Schedule for expenses incurred on availing Air Ambulance services during the Policy Year, provided

- The medical condition of the Insured requires immediate ambulance services from the place where the Insured is injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing.
- The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
- We have accepted a claim under Benefit 3.1 In Patient Treatment or Benefit 3.2 Day Care Treatment.
- Expenses under this benefit shall be payable on reimbursement basis subject to the original Ambulance bills and payment receipt submitted to Us.
- The Origin and Destination of Air Ambulance Service are within the geographical boundaries of Republic of India.
- Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.

- vii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.

3.16 Recovery Benefit

We shall pay a lump sum amount as specified in the Policy Schedule to the Insured for the Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, during the Policy Year, provided

- i. We have accepted a claim under Benefit-3.1 Inpatient Hospitalization Treatment or Benefit 3.5 AYUSH Treatment.
- ii. This benefit is over and above the Sum Insured
- iii. This benefit is available once for each Insured Person in a Policy Year.
- iv. The Deductible shall not be applicable on this benefit.

3.17 Personal Accident Cover

3.17.1 Accidental Death

If the Primary Insured Person, sustains an injury, from an Accident, during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the Insured, then we shall be liable to pay 100% of Sum Insured to Nominee/ Legal Heir/ Assignee as mentioned in the Policy Schedule.

3.17.2 Permanent Total Disability

If the Primary Insured Person, sustains an injury, from an Accident, during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of Permanent Total Disablement of the nature specified below, then we shall be liable to pay 100% of Sum Insured to the Insured Person as specified in the Policy Schedule.

- a. Total and irrecoverable loss of sight of both eyes or
- b. Physical separation or loss of use of both hands or feet or
- c. Physical separation or loss of use of one hand and one foot or
- d. loss of sight of one eye and Physical separation or loss of use of hand or foot
- e. If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever

Note:

1. Disappearance: In the event of Insured Disappearance, If such claim payment has been made and if after the payment of claim, it is found that the Insured Person has survived the Accident, then the Insured Person has to refund the payment back to Us in consideration of the obligatory guarantee as provided during the claim.
2. The claim under this benefit shall be payable either under Accidental Death or Permanent Total Disablement.
3. If we become liable to make payment under Accidental Death / Permanent Total Disability due to Accidental bodily injury, then this insurance will cease as far as the Insured is concerned.
4. Our maximum liability to pay the claim under this benefit is limited to Sum Insured as specified in the Policy Schedule.

- 5. The Deductible shall not be applicable on this benefit.

For the purpose of this cover, Primary Insured Person shall mean the Insured Person who has paid the premium for this Policy.

3.18 Unlimited Restore Benefit

We shall restore the Base Sum Insured unlimited times during the Policy Year after occurrence and payment of claim amount under the Policy, provided:

- i. the Sum Insured shall be restored to full extent immediately after settlement of a claim under Benefits 3.1 (In Patient Treatment), 3.1.1 (Pre- Hospitalization), 3.1.2 (Post Hospitalization), 3.2 (Day Care Treatment), 3.3 (Organ Donor), 3.4 (Modern Treatments), 3.5 (AYUSH Treatment), 3.6 (Domiciliary Hospitalization) and 3.8 (Home Health Care).
- ii. The Restored Sum Insured shall be available only for all subsequent claims.
- iii. The Restored Sum Insured can be utilized unlimited times for subsequent claims for related or unrelated illness/ injury.
- iv. The Unlimited Restore benefit shall be available at each Policy Year and the Restored Sum Insured at given time shall not exceed the Sum Insured specified in the Policy Schedule.
- v. Restored Sum Insured will be available on individual basis for individual policies and on floater basis for Family Floater Policies during a Policy Year.
- vi. If the Unlimited Restore Benefit is not utilized in a Policy Year it shall not be carried forward to any subsequent Policy Year.
- vii. Under the Policy, this benefit can be utilized in following sequence:
 - a. Sum Insured
 - b. Cumulative Bonus
 - c. Unlimited Restored Benefit (if opted)

3.19 Reduction in Room Rent

If you avail this option, the Insured shall be allowed to opt the Room Rent category Actuals to Single Private A.C Room or Twin Sharing Room for hospitalizations allowable under Section 3A of this Policy, if so, requested by the Insured and accepted by Us. The agreed Room Rent category shall be expressly specified in the Policy Schedule.

3.20 Change in Pre-Existing Waiting Period

If you avail this option, the Insured shall be allowed to change the 24 months Waiting Period for Pre-Existing Diseases as specified in Section 4 to 36 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Policy Schedule.

3.21 Change in Maternity Waiting Period

If you avail this option, the Insured shall be allowed to change the 36 months Waiting Period for Maternity Expenses as specified in Section 4 to 48 months, 24 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Policy Schedule.

3.22 Reduction in Specific Disease Waiting Period

If you avail this option, then We shall reduce the 24 months Waiting Period for Specific Diseases as specified in the Section 4 to 12 months. Such reduction, if allowed, shall be expressly specified in the Policy Schedule.

3C. Value Added Services

3.23 E-Opinion

Under this benefit, the Insured Person may avail E-Opinion on his/her medical condition occurring during the Policy Year from a Medical Practitioner from our empanelled network.

Provided,

It is agreed and understood that the E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

- i. The Insured Person may have an option to choose E-Opinion from the list of Specialist as provided by Us on Our Website/App
- ii. It is agreed and understood that Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
- iii. Appointments to avail this benefit shall be requested through Our Website/App or by calling Our call center on the toll-free number specified in the Policy Schedule
- iv. Under this benefit, we are only providing Insured with access to an E-opinion and We shall not be deemed to substitute Insured's visit or consultation to an independent Medical Practitioner
- v. The E-Opinion provided under this benefit is not for emergency care and shall not be valid for any medico legal purposes.
- vi. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
- vii. The Deductible shall not be applicable on this benefit.

3.24 Stay Fit Health Check Up

The Insured may avail a health check-up, only for Preventive Test, up to a limit specified in the Policy Schedule, provided

- i. This benefit is available only once in a Policy Year and all tests must have been done on the same date subject to the conditions mentioned in the Policy Schedule.
- ii. The list of tests covered under this benefit will be Complete Blood Count (CBC), Urine Routine, Erythrocyte Sedimentation Rate (ESR), Fasting Blood Glucose, Electrocardiogram, S Cholesterol, Complete Physical Examination by Physician, Post prandial / lunch blood sugar (PPBS / PLBS), Uric Acid, Lipid Profile, Kidney function test, Serum Vitamin D, Serum Electrolytes, HbA1C, Thyroid profile (TSH), Liver Function Test (LFT), Treadmill test (TMT) and Ultrasound test.
- iii. Irrespective of Individual or Family Floater, this benefit is available to all adult members above 18 years of age on individual basis.
- iv. The benefit shall be available on Cashless basis and arranged with Our Network Provider. Where the test(s) cannot be arranged by Network Provider, We may provide Reimbursement facility on approval basis.
- v. Availing of Claim under this benefit will not impact the Sum Insured or the Cumulative Bonus.
- vi. The Deductible shall not be applicable on this benefit.
- vii. This benefit is over and above the Sum Insured.

3D. Renewal Benefits

3.25 Cumulative Bonus

At the end of each completed and continuous claim free Policy Year, We will provide Cumulative Bonus which will increase 10% of the Sum Insured of immediate preceding Policy Year provided the Policy is renewed with Us without a break, subject to maximum cap of 100% of the Sum Insured under the current Policy Year. If a claim is made in any particular Policy Year, the Cumulative Bonus accrued shall not be reduced and no Cumulative Bonus will be earned on the Policy Renewal.

Specific Condition Applicable to Benefit-3.25 Cumulative Bonus

- i. In case where the Policy is on individual basis as specified in the Policy Schedule, the Cumulative Bonus shall be added and available individually to the Insured Person and in case where the Policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis.
- ii. Cumulative Bonus shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- iii. 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 Cumulative Bonus for such Insured Persons under the expiring policy, and such expiring Policy has been renewed on a floater policy basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
- iv. In case of floater policies where the 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 Cumulative Bonus of the expiring policy shall be apportioned to such renewed Policies in the proportion of the Sum Insured of each renewed Policy.
- v. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured in current Policy.
- vi. If the Sum Insured under the Policy has been increased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
- vii. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.
- viii. In case of mid-term addition in floater policies, the accumulated Cumulative Bonus will be available among all the Insured Persons including the newly added member on floater basis.
- ix. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit 3.1 to 3.8 and 3.13.

Section 4: Waiting Period

We are not 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:

4.1 First Thirty Days Waiting Period (Code-Excl 03):

- i. Expenses related to the treatment of any Illness within 30 days from the first Policy Commencement Date shall be excluded excepts claims arising due to an accident, provided the same are covered.

- ii. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than 24 months.
- iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Note: The above waiting period shall not be applicable for claims arising due to Critical Illness Cover, Hypertension, Diabetes and Cardiac Condition.

4.2 Specified diseases and Procedures Waiting Period (Code-Excl 02):

- i. Expenses related to the treatment of listed Conditions; Surgeries/treatments shall be excluded until the expiry of 24 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.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. If any of the specified disease / procedures falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.
- iv. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- v. If the Insured Person is continuously covered without any break as defined under the applicable norms of Portability stipulated by IRDAI, then waiting period for the same would be

1. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. Kidney stone, Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/Fistula in anus, Hemorrhoids including
Pilonidal sinus	Gout and Rheumatism
Benign tumors, Cysts, Nodules, Polyps including breast lumps	Osteoarthritis and Osteoporosis
Polycystic ovarian diseases	Fibroids (Fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate
Genetic Disorder	

2. Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy
Dilatation and curettage (D&C)	Nasal concha resection
Myomectomy for fibroids	Surgery of Genito urinary system
Surgery on prostate	Cholecystectomy
Hernia	Hydrocele/Rectocele
Surgery for prolapsed inter vertebral disc	Joint replacement surgeries

Surgery for varicose veins and varicose ulcers	Surgery for Nasal septum deviation
Surgery for Perianal Abscesses	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries

4.3 Pre-Existing Diseases (Code-Excl01):

- i. Expenses related to the treatment of a Pre-Existing Diseases (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. Coverage under the Policy after expiry of 24 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Us.

4.4 Hypertension, Diabetes, Cardiac Condition:

A waiting period of 90 days shall apply for all claims of Hypertension, Diabetes, Cardiac Condition except if these diseases are pre-existing and disclosed at the time of Policy.

4.5 Global Treatment:

Expenses related to the treatment taken abroad for any listed Illness under this benefit within 36 months from the first Policy Period Start Date shall be excluded.

Section 5: Exclusions (Applicable to all benefits under the Policy)

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy.

5.1 Standard Exclusions

1) Investigation & Evaluation (Code: Excl04)

- a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment, except under the Benefit 3.24- Stay Fit Health Check Up

2) Rest Cure, rehabilitation and respite care (Code: Excl05)

- a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - 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.
 - Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3) Obesity/ Weight Control (Code: Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- a. Surgery to be conducted is upon the advice of the Doctor
- b. The surgery/Procedure conducted should be supported by clinical protocols

- c. The member has to be 18 years of age or older and
- d. Body Mass Index (BMI);
 - greater than or equal to 40 or
 - 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:
 - Obesity-related cardiomyopathy
 - Coronary heart disease
 - Severe Sleep Apnea
 - Uncontrolled Type2 Diabetes
- 4) Change-of-Gender treatments (Code: Excl07):** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.
- 5) Cosmetic or Plastic Surgery (Code: Excl08):** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- 6) Hazardous or Adventure sports (Code: Excl09):** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- 7) Breach of law (Code: Excl10):** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- 8) Excluded Providers (Code: Excl11):** Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim (For updated and detailed list of Excluded Providers refer website- <https://www.sbigeneral.in/>)
- 9) Substance Abuse and Alcohol (Code: Excl12):** Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
- 10) Wellness and Rejuvenation (Code: Excl13):** Treatments received in health spas, 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.
- 11) Dietary Supplements & Substances (Code: Excl14):** 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
- 12) Refractive Error (Code: Excl15):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
- 13) Unproven Treatments-Code (Code: Excl16):** Expenses related to any unproven treatment, services and supplies for or in

connection with any treatment. Unproven treatments are

treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14) Sterility and Infertility (Code: Excl17): Expenses related to sterility and infertility. This includes:

- a. Any type of contraception, sterilization
- b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- c. Gestational Surrogacy
- d. Reversal of sterilization

15) Maternity (Code-Excl 18) (Not Applicable to Benefit-3.9 Maternity Expenses (if opted))

- i. Medical treatment expenses traceable to child-birth (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.

5.2 Specific Exclusions

- 1) 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.
- 2) 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.
- 3) Treatment taken outside India, except for Benefit-3.13-Global Cover.
- 4) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident
- 5) Convalescence, general debility, "run-down" condition, rest cure, external congenital anomaly.
- 6) Vaccination or inoculation except as part of post-bite treatment for animal bite.
- 7) Medical Practitioner's home visit expenses during Pre and Post hospitalization period, attendant nursing expenses.
- 8) Non-payable items: Expenses against items mentioned in "List I" shall not be payable. This exclusion shall be waived off, if

Optional Benefit-3.12(Consumables) has been opted under the Policy.

- 9) An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self-Injury, or attempted suicide while sane or insane.
- 10) 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 such specified ICD codes. If as per any or all of the medical references herein below containing guidelines and protocols for evidence-based medicines, the Hospitalization for treatment under claim is not necessary or the stay at the Hospital is found unduly long:
 - a) Medical text books,
 - b) Standard treatment guidelines as stated in clinical establishment act of Government of India,
 - c) World Health Organization (WHO) protocols,
 - d) Published guidelines by healthcare providers,
 - e) Guidelines set by medical societies like cardiological society of India, neurological society of India etc
- 11) Any Permanent Exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

Section 6: General Terms and Clauses (Applicable to All Benefits under the Policy)

6.1 Standard Terms and Conditions

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).

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.

3) Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest 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 means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due)

4) 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 maybe, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5) Multiple Policies

a. Indemnity Policies:

A Policyholder can file for Claim settlement as per his/her choice under any Policy. The Insurer of that chosen Policy shall be treated as the primary Insurer.

In case the available coverage under the said Policy is less than the admissible Claim amount, the primary Insurer shall seek the details of other available policies of the Policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the Policy conditions, without causing any hassles to the Policyholder.

b. Benefit based Policies:

On occurrence of the Insured event, the Policyholders can Claim from all Insurers under all policies.

6) 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:

- i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- iii. any other act fitted to deceive; and
- iv. 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.

7) Cancellation

a) Cancellation by you:

The Policyholder may cancel his/her Policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

- i. refund proportionate premium for unexpired Policy Period, if the term of Policy up to one year and there is no Claim (s) made during the Policy Period.
- ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

b) Cancellation by Us

We may cancel the Policy at any time on grounds of misrepresentation non-disclosure of material facts, 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.

8) Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on 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, the Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period etc. in the previous Policy to the Migrated Policy.

For Detailed Guidelines on Migration, kindly refer the link-
<https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf>

9) 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 45 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 any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.

For Detailed Guidelines on Portability, kindly refer the link-
<https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf>

10) Renewal of Policy

- i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.
- 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 the 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.

11) Withdrawal of Policy

- 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.

12) Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance Policy, no Policy and claim shall be contestable by the insurer 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 Sums Insured of the first Policy. Wherever, the Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Sums Insured only on the enhanced limits.

13) Premium Payment in Instalments (wherever applicable)

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Single, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

- i. Grace Period would be given to pay the instalment premium due for the Policy.
 In case of monthly instalment option, a grace period of 15 days is applicable. Whereas, in case of Single, Half Yearly, Quarterly instalment options, a grace period of 30 days is applicable.
- ii. During such grace period, coverage will be available from the due date of instalment premium till the date of receipt of premium by Company.
- iii. The Insured Person will get the accrued continuity benefit in respect of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Periods for Pre-existing Diseases, Moratorium Period etc. in the event of payment of premium within the stipulated Grace Period.
- iv. No interest will be charged If the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

14) Possibility of Revision of Terms of the Policy Including the Premium Rates

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

15) Free Look Period

- (1) Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.
- (2) In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any claim, he shall have the option to return the Policy to the insurer for cancellation, stating the reasons for the same.
- (3) Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.
- (4) A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (3) above.

16) 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. 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.

17) Redressal of Grievance**Stage 1**

If you are dissatisfied with the resolution provided above or for lack of response, you may write to head.customercare@sbigeneral.in We will look into the matter and decide the same expeditiously within 14 days from the date of receipt of your complaint.

For Senior Citizens: Senior Citizens can reach us at seniorcitizengrievances@sbigeneral.in; Toll Free - 1800 22 1111 / 1800 102 1111 (24/7).

Stage 2

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may send your Appeal addressed to the Grievance Redressal Officer at : gro@sbigeneral.in or contact at 022- 45138021.

Address: Grievance Redressal Officer, 9th Floor, A & B Wing, Fulcrum Building, Sahar Road, Andheri (East), Mumbai 400 099. List of Grievance Redressal Officers at Branch: <https://content.sbigeneral.in/uploads/0449cac1bcd144bbb160d3f6b714fbdd.pdf>

Stage 3

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may Register your complaint with IRDAI on the below given link

<https://bimabharosa.irdai.gov.in/Home/Home>

Stage 4

If your grievance remains unresolved from the date of filing your first complaint or is partially resolved, you may approach the Insurance Ombudsman falling in your jurisdiction for Redressal of your Grievance. The details of the Insurance Ombudsman can be accessed at (<https://www.cioins.co.in/Ombudsman>)

6.2 Specific Terms and Clauses**1) Change of Sum Insured**

Sum Insured or Deductible or Plan can be changed (increase / decrease) only at the time of Renewal subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

2) Material Change

The Insured Person 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.

3) Notice and Communication

Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.

- i. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- ii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

4) Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to Our liability to make any payment under this Policy.

5) 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 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.

6) Automatic change in Coverage under the policy

- i. The coverage for the Insured Person(s) shall automatically terminate: In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been

made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

- ii. Upon exhaustion of Sum Insured and Cumulative Bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

7) 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.

8) Terms and conditions 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.

9) Alterations in the Policy

The Proposal Form, Certificate, and Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and Us. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Us. All endorsement requests will be made by the Policy Holder and/or the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us.

10) Conditions when a claim arises

On the occurrence of any Claim under this Policy, the claim procedures set out below shall be followed.

Procedures	Cashless Hospitalization	Reimbursement Claims
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website or Our TPAs Website	
Claim Intimation timelines	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for Claim notification	1. Policy Number 2. Name of the Insured Person(s) named in the Policy schedule availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner Hospital 5. Date and time of event if applicable 6. Date of admission	
Particulars to be provided for preauthorization	1. Policy Number 2. Name of the Insured person(s) named in the Policy schedule availing treatment 3. Nature of disease/Illness/Injury	Not Applicable

	4. Name and address of the attending Medical Practitioner/ Hospital 5. Date of admission & probable date of discharge 6. Approximate Claim Expenses 7. Treatment Details 8. Claim Form / Pre-Authorization Request form 9. Any other relevant information as required 10. cKYC Form and KYC Documents	
Process for obtaining Pre-Authorization	I. If the particulars are not provided in full or are insufficient for us to consider the request in Pre-defined Claim Form, We will request additional information or documentation II. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may;• • Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or • Reject the request for preauthorization specifying reasons for the rejection.	Not Applicable
List of Documents	Not Applicable	As listed below

11) List of Documents for Reimbursement Claims:

Covers	List of Claim Documents
Hospitalization Cover: Hospitalization Expenses, Pre and Post Hospitalization, Organ Donor Expenses, Modern Treatment, Road Ambulance, Domiciliary Hospitalization, Reduction in Room Rent, AYUSH Treatment, Home Health Care, Maternity Expenses	1. Duly filled and signed claim form 2. Certified copy of Hospital discharge Summary 3. Certified copy of final hospital bill, pharmacy bills, Investigation labs bills 4. All original reports of Investigations done 5. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form with KYC Form 6. Beneficiary bank account / NEFT

	details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc. 7. Certified copy of Death certificate issued by municipal authority (in case of death of insured) 8. KYC details and Documents
Personal Accident Cover	Accidental Death Cover 1. Duly completed and signed Claim Form, in original 2. Death certificate 3. Post mortem report if available and applicable 4. First Information Report/ Final Police Report, if applicable 5. Identity proof of Nominee or Original Succession Certificate/ Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased. 6. Any other document as required by the Company to assess the Claim Disability 1. Duly completed and signed Claim Form, in original 2. Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel of the related speciality 3. Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any 4. Photographs of the Insured Person highlighting the injury / disability 5. Copy of FIR / MLC (if registered)/ Panchnama, wherever applicable
Global Cover	1. Duly completed and signed Claim Form, in original 2. Passport Copy with Visa Stamp 3. Medical Practitioner's referral letter advising Hospitalization 4. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation 5. Original bills, receipts and discharge card from the Hospital / Medical Practitioner 6. Original bills from pharmacy / chemists 7. Original pathological / diagnostic test reports and payment receipts 8. Indoor case papers 9. First Information Report/ Final Police Report, if applicable 10. Post mortem report, if available

Critical Illness Cover	1. Duly filled and signed claim form 2. Certified copy of first hospital consultation & first diagnostic report 3. Certified copies of hospital treatment records, investigation reports and follow up details with Medical assessment certificate (if applicable) 4. In case of death, certified copy of death certificate, Medical certificate of cause of death 5. Duly filled and signed Central KYC Registry form (applicable for benefit of Rs 1,00,000 & above) 6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable for benefit of Rs 1,00,000 & above) 7. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
Hospital Daily Cash	1. Duly filled and signed claim form 2. Certified copy of Hospital discharge Summary with Pre & Post Hospitalization consultation details (if any) 3. Certified copy of Diagnostic report confirming diagnosis. 4. Certified copy of final hospital bill with detailed break up 5. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable only in case of benefit above Rs 1 Lakh) 6. Beneficiary (Primary Insured) bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
Value Added Covers: E-Opinion, Stay Fit Health Check Up	As per case, if required

Note:

1. Case specific additional documents may be requested if required for justified claim decision & processing.
2. The Company at its discretion may revise the list of documents mentioned above.
3. Certified copies of document meaning documents attested by any vested authority (e.g. Notarized Documents, attested from Gazetted officer, SBI Branch Manager, Special Executive officer, any officer who is having authority of attestation of documents).

- **Claim Document Submission Address**

All claim related documents need to be sent to below address.

Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team

SBI General Insurance Company Limited

9th Floor, Westport, Pan Card Club Road, Baner

Pune, Maharashtra – 411 045

- **Conditions for obtaining Cashless Facility:**

- i. Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers and empaneled Service providers are available on Our Website and can be obtained by contacting Our TPA.
- ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim.
- iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.
- iv. We will make payment for the Cashless authorized amount directly to the Network Provider.
- v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

- **Claim documents submission:**

In case of any Claim, the list of documents as mentioned above shall be provided by the Policy Holder/ Insured Person to Company within 30 days of date of discharge from Hospital.

- **Scrutiny and Investigation of Claim:**

We will scrutinize the claim based on submission of above claim documents by you and if any deficiency in document we will intimate You in writing within 7 days from the date of submission of claim documents. We will 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.

- **Claim Assessment**

We will pay fixed amounts as specified in the applicable Sections in accordance with the terms of this Policy. We are not liable to make any payments that are not specified in the Policy.

- **Condonation of delay:**

If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

12) Proportionate Deduction

(In case higher Room Category opted) Subject to the other Terms and Conditions of this Policy, the Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- i. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula.
- ii. (Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges. Proportionate deductions may apply based on the room category.
- iii. The proportionate deductions and relevant Associated Medical Expenses specified above under point (i) and (ii) shall not be applicable for Hospitalization in an ICU.
- iv. The expenses related to or subsumed into room charges / procedure charges / costs of treatment as specified in List II, List III and List IV of Annexure II are not covered, unless otherwise Specified in the Policy Schedule.

13) Payment of Claim

All claims under the Policy shall be payable in Indian currency only.

Section 7: Schedule of Benefits

Policy Period	1/2/3 years		
Plans	There are 2 Plans. Plus and Pro. Plus: Annual Aggregate Deductible Pro: Long Term Aggregate Deductible (applicable to 2 and 3 years policy period)		
Room Rent Category	Actuals		
Covers	Plan 'Plus'- Annual Aggregate Deductible	Plan 'Pro'- Long Term Aggregate Deductible	Sum Insured Applicability
Base Covers			
Inpatient Treatment	Actuals up to Sum Insured		Within Sum Insured
Pre-Hospitalization	60 Days		Within Sum Insured
Post-Hospitalization	90 Days/180 Days		Within Sum Insured
Day Care Treatment	All day care procedures covered		Within Sum Insured
Organ Donor	Covered		Within Sum Insured
Modern Treatments	Covered		Within Sum Insured
AYUSH Treatment	Covered		Within Sum Insured
Domiciliary Hospitalization	Covered		Within Sum Insured
Road Ambulance	Up to INR 5000 per hospitalization		Within Sum Insured
Home Health Care	Covered		Within Sum Insured
Optional Covers			

Maternity Expenses	Upto INR 2 Lacs for deductible 5 L and above		Within Sum Insured
New-born Baby Cover	Covered		Within Sum Insured
Hospital Daily Cash	INR 500 per day upto 10 days maximum ICU- 2 times of Hospital Daily Cash	INR 500/1000 per day upto 10 days maximum ICU- 2 times of Hospital Daily Cash	Over and Above Sum Insured
Consumables	Covered		Within Sum Insured
Global Cover	Covered for deductible options INR 20 Lacs & above.		Within Sum Insured
Radio Cab	Upto INR 3000 per hospitalization		Within Sum Insured
Air Ambulance	up to INR 5 Lacs		Within Sum Insured
Recovery Benefit	INR 5000	INR 5000/ 10000/ 25000	Over and Above Sum Insured
Personal Accident Cover	INR 10 Lacs	INR 10 Lacs/ INR 20 Lacs	Over and Above Sum Insured
Unlimited Restore Benefit	On subsequent claim Unlimited restore up to 100% of Sum Insured, for related and unrelated illness/ injury		Over and Above Sum Insured
Reduction in Room rent	Actuals to Single Private A.C Room or Twin Sharing Room		Within Sum Insured
Change in Pre-existing waiting period	3/ 1 years		Not Applicable
Change in Maternity Waiting period	1/ 2/ 4 years		Not Applicable
Reduction in Specific disease waiting period	1 year		Not Applicable
Value Added Services (Optional Covers)			
E-Opinion	Unlimited		Not Applicable
Stay Fit Health Check Up	Upto INR 5000(Annual). No Deductible applicable		Over and Above Sum Insured
Renewal Benefits (Base Cover)			
Cumulative Bonus	10% increase of Sum Insured up to 100% for each claim free policy year. There will be no reduction in case there is a claim.		Over and Above Sum Insured

Illustration: Application of Deductible

Deductible Working for both the Plans is explained below:

Policy Details	
Sum Insured (INR)	5 lakhs
Deductible (INR)	2 lakhs
Policy Period	3 years
Policy Start Date	1-1-2021
Policy End Date	31-12-2023

Policy Year	No. of Hospitalization Claims	Date of admission	Claim Amount	Payable claim amount	
				Plus: (Annual Aggregate Deductible)	Pro: (Long Term Aggregate Deductible)
Policy Year 1 (1-1-2021 to 31-12-2021)	Claim 1	05-05-2021	1,00,000	-	-
	Claim 2	30-11-2021	3,00,000	2,00,000	2,00,000
End of Policy Year 1				Deductible Reconstituted	No Deductible Reconstituted
Policy Year 2 (1-1-2022 to 31-12-2022)	Claim 3	15-04-2022	2,00,000	-	2,00,000
	Claim 4	27-06-2022	3,00,000	3,00,000	3,00,000
End of Policy Year 2				Deductible Reconstituted	No Deductible Reconstituted
Policy Year 3 (1-1-2023 to 31-12-2023)	No Claim				
Total of 3 years			9,00,000	5,00,000	7,00,000

Note:

- The Sum Insured gets freshen every year.
- For Plan 'Plus', the Deductible reconstituted to every Policy Year (1 year) whereas for Plan 'Pro' the Deductible gets reconstituted at the end of Policy Period (3 year)
- The Claims become payable once aggregate Deductible crosses. The Customer gets higher claim amount in Plan 'Pro' as compared to Plan 'Plus'.

Annexure I

Names of Ombudsman and Addresses of Ombudsmen centers

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	Shri R. M. Singh Insurance Ombudsman 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

Odhisa	Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	Shri Somnath Ghosh Insurance Ombudsman 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, Sonapat & Bahadurgarh.	Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri Somnath Ghosh Insurance Ombudsman 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.	Shri N. Sankaran Insurance Ombudsman 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	Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in

Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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.	Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	Ms Susmita Mukherjee Insurance Ombudsman 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, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P.-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand.	Ms Susmita Mukherjee Insurance Ombudsman 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).	Shri Sunil Jain Insurance Ombudsman 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in
The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in , on the website of General Insurance Council: www.gicouncil.in , our website www.sbigeneral.in	

Source:- CIO (cioins.co.in)

Annexure II

List I - Items for which coverage is not available in the policy

SI No	Item	SI No	Item
1	BABY FOOD	36	SPACER
2	BABY UTILITIES CHARGES	37	SPIROMETRE
3	BEAUTY SERVICES	38	NEBULIZER KIT
4	BELTS/ BRACES	39	STEAM INHALER
5	BUDS	40	ARMSLING
6	COLD PACK/HOT PACK	41	THERMOMETER
7	CARRY BAGS	42	CERVICAL COLLAR
8	EMAIL / INTERNET CHARGES	43	SPLINT
9	FOOD CHARGES OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL	44	DIABETIC FOOTWEAR
10	LEGGINGS	45	KNEE BRACES LONG/ SHORT/ HINGED
11	LAUNDRY CHARGES	46	KNEE IMMOBILIZER /SHOULDER IMMOBILIZER
12	MINERAL WATER	47	LUMBO SACRAL BELT
13	SANITARY PAD	48	NIMBUS BED OR WATER OR AIR BED CHARGES
14	TELEPHONE CHARGES	49	AMBULANCE COLLAR
15	GUEST SERVICES	50	AMBULANCE EQUIPMENT
16	CREPE BANDAGE	51	ABDOMINAL BINDER
17	DIAPER OF ANY TYPE	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
18	EYELET COLLAR	53	SUGAR FREE Tablets
19	SLINGS	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	55	ECG ELECTRODES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	56	GLOVES
22	Television Charges	57	NEBULISATION KIT
23	SURCHARGES	58	ANY KIT WITH NO DETAILS SPECIFIED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC
24	ATTENDANT CHARGES	59	KIDNEY TRAY
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE	60	MASK
26	BIRTH CERTIFICATE	61	OUNCE GLASS
27	CERTIFICATE CHARGES	62	OXYGEN MASK
28	COURIER CHARGES	63	PELVIC TRACTION BELT
29	CONVEYANCE CHARGES	64	PAN CAN
30	MEDICAL CERTIFICATE	65	TROLLY COVER
31	MEDICAL RECORDS	66	UROMETER, URINE JUG
32	PHOTOCOPIES CHARGES	67	AMBULANCE
33	MORTUARY CHARGES	68	VASOFIX SAFETY
34	WALKING AIDS CHARGES		
35	OXYGEN CYLINDER FOR USAGE OUTSIDE THE HOSPITAL		

List II- Items that are to be subsumed into Room charges

SI No	Item	SI No	Item
1	BABY CHARGES UNLESS SPECIFIED/INDICATED	22	HOUSE KEEPING CHARGES
2	HAND WASH	23	AIR CONDITIONER CHARGES
3	SHOE COVER	24	1M IV INJECTION CHARGES
4	CAPS	25	CLEAN SHEET
5	CRADLE CHARGES	26	BLANKET/VVARMER BLANKET
6	COMB	27	ADMISSION KIT
7	EAU-DE-COLOGNE / ROOM FRESHNERS	28	DIABETIC CHART CHARGES
		29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES

8	FOOT COVER	30	DISCHARGE PROCEDURE CHARGES
9	GOWN	31	DAILY CHART CHARGES
10	SLIPPERS	32	ENTRANCE PASS / VISITORS PASS CHARGES
11	TISSUE PAPER	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
12	TOOTH-PASTE	34	FILE OPENING CHARGES
13	TOOTH-BRUSH	35	INCIDENTAL EXPENSES / MISC. CHARGES NOT EXPLAINED
14	BED PAN	36	PATIENT IDENTIFICATION BAND / NAME TAG
15	FACE MASK	37	PULSEOXYMETER CHARGES
16	FLEXI MASK		
17	HAND HOLDER		
18	SPUTUM CUP		
19	DISINFECTANT LOTIONS		
20	LUXURY TAX		
21	HVAC		

List III - Items that are to be subsumed into Procedure Charges

SI No	Item	SI No	Item
1	HAIR REMOVAL CREAM	12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
2	DISPOSABLES RAZORS CHARGES (for site preparations)	13	SURGICAL DRILL
3	EYE PAD	14	EYE KIT
4	EYE SHEILD	15	EYE DRAPE
5	CAMERA COVER	16	X-RAY FILM
6	DVD, CD CHARGES	17	BOYLES APPARATUS CHARGES
7	CAUSE SOFT	18	COTTON
8	GAUZE	19	COTTON BANDAGE
9	WARD AND THEATRE BOOKING CHARGES	20	SURGICAL TAPE
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	21	APRON
11	MICROSCOPE COVER	22	TORNIQUET
		23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

SI No	Item	SI No	Item
1	ADMISSION/REGISTRATION CHARGES	9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
2	HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	10	HIV KIT
3	URINE CONTAINER	11	ANTISEPTIC MOUTHWASH
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	12	LOZENGES
5	BIPAP MACHINE	13	MOUTH PAINT
6	CPAP/ CAPD EQUIPMENTS	14	VACCINATION CHARGES
7	INFUSION PUMP- COST	15	ALCOHOL SWABES
8	HYDROGEN PEROXIDE/ SPIRIT/DISINFECTANTS ETC	16	SCRUB SOLUTION/STERILLIUM
		17	Glucometer & Strips
		18	URINE BAG