SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Super Health Insurance

PROSPECTUS

Your greatest wealth is your health & everybody has differing levels of control over their own wellbeing. Life follows no fixed plan and sudden Illnesses, or accidental injury can sometimes leave you financially hurt and highly stressed. SBI General Insurance Company Limited (herein after the "Company", "We", "Our", "Us") introduce the Super Health Insurance product which protects you and your family, if you and your family members are Hospitalized during Policy Period and helps you to reduce your financial stress.

A. Key Features of the Policy

1. Comprehensive Policy with **27 Base Covers** and **7 Optional covers**
2. Multiple **Sum Insured** range from **3 Lacs to 2 Crores** available under the Policy.
3. **Long term Policy** options are available **up to 3 years**.
4. **Exclusive covers** like:
   - **Health Multiplier (Listed 37 Serious Illness)- Sum Insured** for listed Serious Illnesses would be increased by a multiplier as mentioned in the policy schedule
   - **ReInsure Benefit** offers reinstatement of **Sum Insured**, unlimited times for any illness in a policy year. It is triggered and becomes payable with the first paid claim itself and is available for all subsequent claims in a Policy Year. Single claim under this benefit will be payable up to 100%/200% of Base **Sum Insured** as specified in the Policy Schedule.
   - **Enhanced Cumulative Bonus (ECB)** will be applied by 50% (as specified in the Policy Schedule) of the Base **Sum Insured** of immediate preceding Policy Year in respect of each claim free Policy Year (where no claims are reported), provided the Policy is renewed with the Company without a break, subject to maximum cap of 100%/200% (as specified in the Policy Schedule) of the Base **Sum Insured** under the current Policy Year. If a claim is made in any particular Policy Year, the ECB accrued shall be reduced at the same rate at which it has accrued.
   - **Claims Shield Benefit** pays towards the Non-Medical expenses like gloves, food charges and other consumables during hospitalization.
   - **Annual Health Check-up** cover is available.
   - **Various discount options** like Family Individual Discount (>= 2 members), Long term discount (will not apply if instalment option is opted), SBI group entity discount, Direct Channel Discount.
   - **Out Patient (OPD) Cover** (Including Diagnostics and Pharmacy Expenses)
   - **Medical Treatment abroad (for listed 16 Major Illness)**
5. Optional Covers like Wellness **Benefit, Domestic Help/Staff Indemnity, Additional Basic Sum Insured for Accident related hospitalization, Enhanced Cumulative Bonus Safeguard, Enhanced ReInsure Benefit** are available.
6. Flexible benefit option of **Co-payment and Aggregate Deductible** are available to avail discount in premium.

B.1 Age Criteria & Eligibility

Minimum Entry Age	Adult: 18 years
	Dependent Child: 91 Days to 30 years
Maximum Entry Age	No Limit
Maximum Entry Age for Domestic Help /Staff Indemnity (Optional Cover)	65 years
Renewability	Lifelong
Policy Term	1/2/3 Years
Premium Payment Options	Single Premium, Annual, Half-yearly, Quarterly, and Monthly
How can You cover Yourself	Individual/Family Floater basis.
	In a family floater Policy, a maximum of 4 adults and any number of children can be included in a single Policy.
Who are covered (Relationship with respect to the Proposer)	Individual: Self, legally married spouse, son, son-in-law, daughter, daughter-in-law, father, mother, brother, brother-in-law, sister, sister-in-law, mother-in-law, father-in law, grandmother, grandfather, grandson, granddaughter, uncle, aunt, nephew, niece, or any other relationship having an insurable interest. Family Floater: Self, legally married spouse, dependent children (natural/legally adopted), Parents and/or Parents-in-law.

B.2 Plan & Sum Insured

You have option to choose any plan from below as per Your requirement.

Plan	Prime	Elite	Premier	Platinum	Platinum Infinite
Sum Insured Limit	3,00,000	3,00,000	3,00,000	10,00,000	50,00,000
	5,00,000	5,00,000	5,00,000	15,00,000	75,00,000
	7,00,000	7,00,000	7,00,000	20,00,000	1,00,00,000
	10,00,000	10,00,000	10,00,000	25,00,000	2,00,00,000
	15,00,000	15,00,000		30,00,000	
	20,00,000	20,00,000		40,00,000	
	25,00,000	25,00,000		50,00,000	

Scope of Cover

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** as specified in the **Policy Schedule**. Subject to otherwise terms and conditions of the **Policy**.

C. Hospitalization covers

C.1 In-patient Hospitalization Treatment:

If **You** are **hospitalized** for a minimum of 24 hours on the advice of **Medical Practitioner** as defined under the **Policy** due to Illness or **Accidental** Bodily Injury, sustained or contracted during the **Policy** Period, then **We** will pay **You** below listed **medical expenses** up to the Base **Sum Insured** and enhanced limits as specified in **Policy Schedule.**

a) Room rent and boarding expenses as provided by the **Hospital**/Nursing home up to the Room Rent limit as specific in the **Policy Schedule.**

b) **Intensive Care Unit** Expenses/ Intensive Cardiac Care Unit (ICCU) expenses.

c) Nursing Expenses as provided by the Hospital

d) Surgeon, Anaesthetist, **Medical Practitioner**, Consultants, Specialist Fees

e) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances

f) Consultation fees including Telemedicine by **Medical Practitioner**

g) Medicines, drugs, and consumables

h) Diagnostic procedures

i) The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

C.2 Shared accommodation Cash Benefit

The **Company** shall pay a daily cash amount as specified in **Policy Schedule** on per **hospitalization** basis for each continuous and completed 24 hours of Hospitalization during the **Policy Year** if the Insured Person is Hospitalised in shared accommodation in a Network Provider Hospital and such **Hospitalization** exceeds 48 consecutive hours.

What is not covered:

a. The Cover is not available for the time spent by the Insured Person in an **Intensive Care Unit** (ICU).

b. The claim for the same **Hospitalization** is not admissible under clause a) of Section C.1 (In-patient **Hospitalization** Treatment).

C.3 Health Multiplier (Listed 37 Serious Illness)

If **You** are diagnosed and **hospitalized** for any of the Serious **illness** (listed and defined below) and claim is admissible under Section C.1 (In-patient **Hospitalization** Treatment) or Section C.6 (Day Care Treatment) or Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments) then the Base **Sum Insured** for such serious Illness would be increased by a multiplier as mentioned in the **Policy Schedule**, provided that;

Condition:

a. Such enhancement in **Sum Insured** would be triggered only for treatment of the listed conditions, no other claim would be covered under the enhanced limit.

b. The enhanced limit provided under this benefit can only be utilized for the listed 37 Serious Illnesses and can be availed by any or all Insured Person(s) in the **Policy**.

c. The sequence of utilization of **Sum Insured** will be as below:

i. Base **Sum Insured** followed by;

ii. Health Multiplier (if applicable) followed by;

iii. Enhanced Cumulative Bonus/Loyalty Credit (if any) followed by;

iv. ReInsure benefit

d. The enhancement of limit will happen only once in policy year even if multiple listed Serious Illness is diagnosed.

e. The enhanced Limit cannot be carried forward to next **renewal**.

List of Serious Illness			
S. No	**Serious Illness**	**S. No**	**Serious Illness**
1	Cancer	20	Angioplasty
2	Kidney failure	21	Balloon Valvotomy/ Valvuloplasty
3	Multiple sclerosis with persisting symptoms	22	Carotid Artery surgery
4	Benign brain tumor	23	Open Chest Coronary Artery Bypass Grafting (CABG)
5	Parkinson's Disease	24	Pericardectomy
6	Alzheimer's Disease	25	Surgery to Place Ventricular Assist devices or Total Artificial Hearts
7	End stage liver failure	26	Myocardial Infarction
8	Motor neuron disease	27	Implantation of Pacemaker of Heart
9	End stage lung failure	28	Implantable Cardioverter Defibrillator
10	Bacterial Meningitis	29	Stroke
11	Aplastic Anaemia	30	Permanent paralysis of limbs
12	Pulmonary Thromboembolism	31	Burns
13	Primary (idiopathic) pulmonary hypertension	32	Blindness
14	Infective Endocarditis	33	Abdominal Aortic Aneurysm
15	Major organ /bone marrow transplant	34	Fulminant Viral Hepatitis
16	Replacement / Repair of heart valves	35	Severe Rheumatoid Arthritis
17	Aortic Dissection	36	Systematic Lupus Erythematous
18	Cardiomyopathy	37	Nephrotic syndrome
19	Surgery for Cardiac Arrhythmia		

C.4 Pre-hospitalization Medical Expenses

The Company shall indemnify the Pre-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section C.1 (In-patient **Hospitalization** Expenses), for the duration (as specified in the Policy schedule) immediately prior to the date of admissible **Hospitalization** covered under the Policy

C.5 Post-hospitalization Medical Expenses

The Company shall indemnify the Post-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section C.1 (In-patient **Hospitalization** Expenses), for the duration (as specified in the Policy schedule) from the date of discharge from the Hospital, following an admissible **Hospitalization** claim under the Policy

C.6 Day Care Treatment

We will indemnify the Medical Expenses incurred by the Insured Person's under any **Day Care Treatment** during the Policy **Period** following an **Illness** or Injury.

The above coverage is subject to fulfilment of following conditions:

a. The **Day Care Treatment** is advised in writing by a **Medical Practitioner** as **Medically Necessary Treatment.**

b. The **Day Care Treatment** would be covered if the Insured Person is admitted for more than 2 hours and would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer.

c. If **We** have accepted a claim under this benefit, **We** will also indemnify the Insured Person's Pre-**hospitalization** Medical Expenses and Post-**hospitalization** Medical Expenses in accordance with Sections C.4 and C.5.

What is not covered:

a. OPD Treatment and Diagnostic Services costs are not covered under this benefit

C.7 Domiciliary Hospitalization

We will indemnify on Reimbursement basis only, the **Medical Expenses** incurred for the Insured Person's Domiciliary **Hospitalization** during

the **Policy Period** following an **Illness** or Injury.

Conditions

The above coverage is subject to fulfilment of following conditions:

a. The Domiciliary **Hospitalization** continues for at least 3 consecutive days, wherein **We** will make payment under this benefit in respect of **Medical Expenses** incurred from the first day of Domiciliary **Hospitalization**;

b. The treating **Medical Practitioner** confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.

What is not covered:

Sections C.4 (Pre-hospitalization Medical Expenses) and Section C.5 (Post- hospitalization Medical Expenses) are not payable under this benefit.

C.8 Home Health Care

The **Company** shall indemnify the **Medical Expenses** incurred by the Insured Person on availing treatment at Home during the Policy Year, if prescribed in writing by the treating **Medical Practitioner**, provided that:

a. The treatment in normal course would require In-patient Care at a Hospital, and be admissible under Section C.1 (In-patient **Hospitalization** Treatment).

b. The treatment is pre-authorized by the Company as per procedure given under Claims Procedure – Section I.

c. Records of the treatment administered, duly signed by the treating **Medical Practitioner**, are maintained for each day of the Home treatment.

d. This Cover is not available on reimbursement basis.

C.9 Emergency Road Ambulance Cover (per hospitalization)

We will pay for expenses incurred up to the limit as specified in the **Policy Schedule**, on Road **Ambulance** Services if **You** required;

i. to be transferred to the nearest Hospital in an emergency

ii. or from one Hospital to another Hospital

iii. or from Hospital to Home

Provided that claim under Section C.1 (In-patient **Hospitalization** Treatment) or Section C.6 (Day Care Treatment) or Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments) is admissible under the **Policy**.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the **Policy Schedule**.

C.10 Air Ambulance Cover (Domestic)

We shall indemnify expenses incurred by the Insured Person during the **Policy Year** towards **Ambulance** transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid **Ambulance** transportation that ground transportation cannot provide from the site of first occurrence of the Illness or **Accident** to the nearest Hospital. The claim is subject to a maximum of **Sum Insured** as specified in the **Policy Schedule** against this Cover, and subject to the following conditions:

a. The air **Ambulance** transportation is advised in writing by a **Medical Practitioner.**

b. **Medically Necessary Treatment** is not available at the location where the Insured Person is situated at the time of emergency.

c. The air **Ambulance** provider is a registered entity in India.

d. The Insured Person is in India and the treatment is taken in India only.

e. No return transportation to the Insured Person's Home or elsewhere by the air **Ambulance** will be covered under this Cover.

f. A claim for the same **Hospitalization** is admissible under Section C.1(In-patient **Hospitalization** Expenses)

C.11 Organ Donor Expenses

We will pay **Medical Expenses** up to the **Sum Insured** as specified in the **Policy Schedule**, towards organ donor's **Hospitalization** for harvesting of the donated organ where an Insured Person is the recipient, provided that

Condition

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and

ii. **We** have accepted an inpatient **Hospitalization** claim for the Insured Person under In-Patient **Hospitalization** Treatment (section C.1).

iii. The Organ Donor's Pre-Hospitalization and Post-Hospitalization expenses are excluded under the **Policy**.

iv. Any other **Medical Expenses** or **Hospitalization** consequent to the harvesting is excluded under the **Policy**.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the **Policy Schedule**.

C.12 ReInsure Benefit (Related and Unrelated illness both)

This benefit is triggered and becomes payable for each and every claim from the first claim itself in a **policy year**.

Conditions

The above coverage is subject to fulfilment of the following:

a. Single claim under this benefit will be payable up to 100%/200% of Base **Sum Insured** as specified in the **Policy Schedule**.

b. The sequence of utilization of **Sum Insured** will be as below:

   i. Base **Sum Insured** followed by;

   ii. Health Multiplier (if applicable) followed by;

   iii. Enhanced Cumulative Bonus (if any) followed by;

   iv. ReInsure benefit

c. Claims under this benefit will be payable only under Section C.1 (In-patient **Hospitalization** Treatment) or Section C.6 (Day Care Treatment) or Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments) arising in that **Policy Year** for any or all Insured Person(s).

d. Anyone Illness cover will not be applicable under this benefit.

C.13 Bariatric Surgery Cover

If **You** are **hospitalized** on the advice of a **Medical Practitioner** because of conditions mentioned below which required **You** to undergo Bariatric Surgery during the **Policy Period**, then **We** will pay **You**, Medical Expenses as listed in Section C.1 related to Bariatric Surgery

Eligibility:

For adults aged 18 years or older, presence of severe documented in contemporaneous clinical records, defined as any of the following:

Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

   i. **Obesity**-related cardiomyopathy

   ii. Coronary heart disease

   iii. Severe Sleep Apnea

   iv. Uncontrolled Type 2 Diabetes

Conditions

i. **Our** maximum liability will be restricted to up to Sublimit mentioned in the **Policy Schedule**.

ii. Bariatric **surgery** performed for Cosmetic reasons is excluded.

iii. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured shall obtain prior approval for cashless treatment from the **Company**.

iv. Standard Exclusion H. A. III. (Obesity / Weight Control) shall not be applicable to the extent of Sum Insured covered under this benefit.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the **Policy Schedule**.

C.14 Modern Treatments/Advanced Procedures

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Sections C.1 and C.6 respectively, in a Hospital of modern treatments and not limited to the following:

i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

ii) Balloon Sinuplasty

iii) Deep Brain stimulation

iv) Oral chemotherapy

v) Immunotherapy- Monoclonal Antibody to be given as injection

vi) Intra vitreal injections

vii) Robotic surgeries

vii) Stereotactic radio surgeries

viii) Bronchical Thermoplasty

ix) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

x) IONM - (Intra Operative Neuro Monitoring)

xi) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

b. If **We** have accepted a claim under this benefit, **We** will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.4 and C.5

C.15 AYUSH Treatment

We shall indemnify the Medical Expenses incurred by the Insured Person for Inpatient Care under Ayurveda, Unani, Siddha and Homeopathy systems of medicines during each **Policy Year** up to the **Sub-limit** specified against this Cover in the **Policy Schedule**, in any AYUSH Hospital.

C.16 Recovery Benefit

We will pay a lump sum amount as specified in the **Policy Schedule** upon **Your** Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, provided that, claim is admissible under Section C.1 (In-patient **Hospitalization** Treatment) or Section C.6 (Day Care Treatment) or Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments)

i. This Benefit is over and above base **Sum Insured**

ii. This Benefit amount will not reduce the **Sum Insured**

iii. This is available per **Hospitalization** of each Insured Person

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the **Policy Schedule**.

C.17 Claims Shield

If We have accepted a **Hospitalization** claim under Section C, then the items which are not payable as per List I – 'Expenses not covered' under Annexure II of the policy wording, related to that particular claim will become payable.

C.18 E-Opinion

You may choose E-Opinion on Your medical condition occurring during the **Policy Period. We** will facilitate E-Opinion from **Our** panel of **Medical Practitioner** under this cover.

Condition:

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. **You** may have option to choose E-Opinion from the list of Specialist as provided by **Us** on **Our** Website.

ii. It is agreed and understood that **You** are 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 of this benefit shall be requested through **Our** Website or through calling **Our** call center on the toll-free number specified in the **Policy Schedule**.

iv. Under this benefit, **We** are only providing **You** with access to an E-opinion and **We** shall not be deemed to substitute **Your** visit or consultation to an independent **Medical Practitioner**

v. The E-Opinion provided under this benefit 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**.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the **Policy Schedule**.

C.19 Annual Health Check-up

The Insured Person may avail a health check-up, only for preventive purposes, up to a sub-limit as specified in Your **Policy Schedule**.

Conditions

The above coverage is subject to fulfilment of following conditions:

a. This benefit is available only once in a **Policy Year** and all tests must have been done on the same date subject to the condition mentioned in the **policy schedule**.

b. The list of tests covered under this benefit will be Complete blood count, 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.

c. For **Family Floater**, this cover will be applicable only to adult members of the Family who are aged 18 years and above on the start date of **Policy**. For Individual, this cover will be applicable to each Insured Person who are aged above 18 years.

d. Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Enhanced Cumulative Bonus (C.22)/Loyalty Credit (C.23).

What is not covered:

Any unutilized test or amount cannot be carried forward to the next Policy Year

C.20 Maternity and Related Expenses Cover

C.20.1 Maternity Expenses (including Pre and Post Natal check-ups)

We will indemnify the Medical Expenses incurred up to the amount specified against this Benefit in the **Policy Schedule** for the Maternity

Expenses including Pre-natal Medical Expenses & Post-natal check-ups incurred in respect of the **Hospitalization** of the Insured Person for the delivery of the child during the **Policy Period**.

Conditions:

a. The **Company** shall be liable under this Benefit only if the Insured Person for whom the Claim is made under this Benefit is covered for a continuous period as specified in the **Policy Schedule**.

b. If the Insured person is covered as a single Adult on an individual basis under the policy, the Company shall be liable to pay the claim under this benefit, after a waiting period of 48 months from the date of issuance of the first policy with **Us**, provided that the policy has been renewed continuously with **us** without any break and **We** have received at least 5 continuous annual premiums under the **Policy**.

c. For any other family combination under the policy, the **Company** shall be liable to pay the claim under this benefit, after a waiting period of 24 months from the date of issuance of the first policy with **Us**, provided that the policy has been renewed continuously with us without any break and **We** have received at least 3 continuous annual premiums under the **Policy**.

d. Fresh waiting period as mentioned above under (b) and (c) would apply for all the policies which are issued with continuity under **portability** guidelines either from our existing Health Product or any other Non-Health or Standalone Health Insurance **Company**

e. The insured person for whom the claim has been made under (b) & (c) above has to be the female insured covered under the policy and respective waiting periods [as mentioned above under (b) and (c)] shall apply.

f. Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit.

g. For this purpose, 'week' shall constitute any consecutive 7 days.

h. Medical Expenses for ectopic pregnancy are not covered under this Benefit.

i. Pre-natal check-ups will be covered from the date of confirmation of pregnancy and Post-natal check-ups for a period up to eight (8) weeks from delivery.

C.20.2 New Born Baby Cover

We will indemnify up to the amount specified against this Benefit in the **Policy Schedule** for the Medical Expenses incurred in respect of a New Born Baby whose claim under Section - C.20.1 (Maternity Expenses) is admissible by the **Company**.

a. The coverage will be available in respect of a New Born Baby for 90 days from date of delivery and will be covered under Maternity Expenses Sum Insured as specified in the Policy Schedule.

b. New Born Baby older than 90 days and less than or equal to 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.

The waiting period for internal congenital anomalies and genetic disorder shall not apply to **new born baby** covered under **policy**.

Exclusion F.A.XV of the **Policy Wordings** Terms & Conditions shall be not applicable to Section C.20

C.21 Child Vaccination Cover

We will reimburse the expenses up to the limit specified in the **Policy Schedule** during the **Policy Period** on vaccination of the Child till he/she completes 12 year of Age.

Conditions:

a) Child has to be an Insured under the **Policy**.

b) Coverage of the New Born Baby on birth shall be subject to the addition of the New Born Baby older than 90 days and less than or equal to 1 year as an Insured Person under the **Policy** by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.

c) Expenses can be claimed under this Section on a Reimbursement basis only.

C.22 Enhanced Cumulative Bonus

Enhanced Cumulative Bonus (ECB) will be applied by 50% of the Base **Sum Insured** of immediate preceding **Policy Year** in respect of each claim free **Policy Year** (where no claims are reported), provided the Policy is renewed with the **Company** without a break, subject to maximum cap of 100%/200% (as specified in the **Policy Schedule**) of the Base Sum Insured under the current Policy Year. If a claim is made in any particular **Policy Year**, the ECB accrued shall be reduced at the same rate at which it has accrued.

Conditions:

a. In case where the **Policy** is on individual basis as specified in the **Policy Schedule**, the ECB shall be added and available individually to the Insured Person if no claim has been reported. ECB shall reduce only in case of claim from the same Insured Person.

b. In case where the **Policy** is on floater basis, the ECB shall be added and available to the family on floater basis, provided no claim has been reported from any Family Member. ECB shall reduce in case of claim from any of the Insured Persons.

c. ECB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

d. 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 ECB 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 ECB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

e. 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 30 years, the ECB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the **Sum Insured** of each Renewed **Policy**

f. If the **Sum Insured** has been reduced at the time of Renewal, the applicable ECB shall be reduced in the same proportion to the **Sum Insured** in current Policy.

g. If the **Sum Insured** under the **Policy** has been increased at the time of Renewal, the ECB shall be calculated on the **Sum Insured** of the last completed **Policy Year**.

h. If a claim is made in the expiring **Policy Year**, and is notified to the **Company** after the acceptance of Renewal premium any awarded ECB shall be withdrawn.

i. The sub-limits applicable to various Benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

j. In case of Mid-term addition in floater policies, the accumulated ECB will be available among all the Insured Persons including the newly added member on floater basis.

k. In case of Mid-term addition in Individual policies, the ECB will be accrued for the newly added member from subsequent renewal after completion of 1 year in the policy

C.23 Loyalty Credit (Sum Insured enhancement irrespective of claim)

If the Insured Person cover under the Policy is renewed with Us without a break, We will increase the Base **Sum Insured** applicable under the Policy by 50% of Base **Sum Insured** of immediate preceding Policy Year for each successive renewal. The **Sum Insured** increase will be subject to the maximum of 100% of Base **Sum Insured**.

Conditions:

a. In case where the policy is on individual basis as specified in the **policy schedule**, the loyalty credit shall be added and will be available individually to the insured person.

b. In case where the policy is on floater basis, the loyalty credit shall be added and available to the family on floater basis.

c. Loyalty credit shall be available only if the policy is renewed/ premium paid within the **grace period**.

d. 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 loyalty credit 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 loyalty credit to be carried forward for credit in such renewed policy shall be the lowest one that is applicable among all the insured persons.

e. 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 30 years, the loyalty credit of the expiring policy shall be apportioned to such renewed policies in the proportion of the **Sum Insured** of each renewed policy

f. If the **Sum Insured** has been reduced at the time of **renewal**, the applicable loyalty credit shall be reduced in the same proportion to the **Sum Insured** in current policy.

g. If the **Sum Insured** under the policy has been increased at the time of **renewal**, the loyalty credit shall be calculated on the **Sum Insured** of the last completed policy year.

h. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

i. In case of Mid-term addition in floater policies, the accumulated Loyalty Credit will be available among all the Insured Persons including the newly added member on floater basis.

j. In case of Mid-term addition in Individual policies, the Loyalty Credit will be accrued for the newly added member from subsequent **renewal** after completion of 1 year in the policy.

C.24 Medical Treatment abroad (Listed Major illness, Diagnosis in India)

We will pay the Medical Expenses incurred towards the Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to any of the below listed Illness or for below listed procedures that occurs or manifests itself during the Policy Period:

S. No	Name of Major Illness	S. No	Name of Major Illness
1	Cancer Treatment Surgery	9	Kidney Transplant Surgery in case of End Stage Renal Failure
2	Heart Valve Replacement	10	Surgical Treatment of Coma
3	Bone Marrow Transplant	11	Surgery for Pheochromocytoma
4	Pulmonary Artery Graft Surgery	12	Liver Transplant Surgery in case of End Stage Liver Disease
5	Aorta Graft Surgery	13	Pneumonectomy - Removal of an entire lung
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	14	Surgical removal of an eyeball
7	Surgical Treatment for Stroke	15	Heart transplant surgery
8	Lung Transplant Surgery in case of End Stage Lung Disease	16	Craniotomy for Cerebral Aneurysm

Conditions:

1) The above listed Illness must be diagnosed in India.
2) The symptoms of the listed Illness first occur or manifest itself during the Policy Period and after completion of the applicable waiting periods as specified in the Policy Schedule.
3) Expenses can be claimed under this Section on a Reimbursement basis only.
4) For availing treatment abroad, it should be a 'Planned Medical treatment abroad'.
5) The treating medical Practitioner must recommend the necessity of treatment abroad, considering the medical condition and availability of treatment at an international centre of excellence which is best in class.
6) The Hospitalization is towards Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.
7) 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.
8) Claim amount will be paid in INR in Indian account of the Insured.
9) The onus of procuring all the medical documents/requirements to adjudicate any claim will be on the Insured Person.
10) Section C.3 (Health Multiplier) and Section C.12 {ReInsure Benefit (Related and Unrelated illness both)} will not be applicable if claim is admissible under Section C.24 (Medical Treatment abroad).

C.25 Out Patient (OPD) Cover (Including Diagnostics and Pharmacy Expenses)

We will indemnify the Medical Expenses incurred up to the per member amount specified (subject to per family limit) against this Benefit in the Policy Schedule for the allopathic OPD expenses including Diagnostics and Pharmacy.

What all is covered under this:	
Professional Fees	Fees for medically necessary consultation and examination by medical practitioners to assess your health for any illness.
Diagnostic	Medically necessary out-patient diagnostic procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) etc. used to make a diagnosis for treatment from a diagnostic center.
Pharmacy	Drugs and medicines prescribed by a Medical Practitioner.

Conditions:

a. 20% co-payment will be applicable on Professional Fees
b. 30% co-payment will be applicable on Diagnostics and Pharmacy Expenses to be borne by the Insured
c. The cover excludes expenses incurred towards Spectacles, Contact Lenses, Physiotherapy, Cosmetic Procedures, Ambulatory Devices like Walkers, any type of Dental treatment, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.
d. Expenses can be claimed under this Section on a Reimbursement basis only.

C.26 Out Patient (OPD) - Dental and Vision Cover

We will indemnify the Medical Expenses incurred up to the limit specified against this Benefit (if applicable) in the Policy Schedule for the OPD- Dental and Vision Cover.

Conditions:

a. Out-patient dental treatment is covered for, limited to below:

   For the immediate relief of dental pain; taken by you from a dentist, provided that We will pay only for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents.
b. The cover excludes for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer and Replacing any dental appliance which is lost or stolen.
c. Diagnostics and Pharmacy Expenses are not covered
d. 50% co-payment will be applicable for each and every admissible claim under this benefit.
e. The cover excludes expenses incurred towards Spectacles, cost of frame, any type of lenses like Contact Lenses, etc. and Sunglasses.
f. Expenses can be claimed under this Section on a Reimbursement basis only.

C.27 Out Patient and Prescribed Diagnostic test (Cancer Diagnosed Patients)

We will indemnify the Medical Expenses incurred up to the limit specified against this Benefit (if applicable) in the Policy Schedule for the Out Patient and Prescribed Diagnostic test.

a. Insured must be a Cancer diagnosed patient. This diagnosis must be evidenced by histological evidence of malignancy and confirmed by a pathologist

b. The cover will not cover for any type of Pharmacy/Treatment either prescribed or OTC.

c. Out-patient consultation to be taken only by a registered and qualified specialist Medical Practitioner.

d. Expenses can be claimed under this Section on a Reimbursement basis only.

D. Optional covers

D.1 Enhanced ReInsure Benefit

On availing this option, We will refill up to 200% Basic Sum Insured instead of up to 100% (as mentioned in Policy Schedule under section C.12 – ReInsure Benefit) on complete or partial utilization of Your existing Policy Sum Insured including Enhanced Cumulative Bonus (if applicable) during the Policy Year. The total amount (Basic Sum Insured and Enhanced Cumulative Bonus and Enhanced ReInsure) will be available to all Insured Person for all claims under Section C.1 during the current Policy Year.

Rest all terms and conditions remain same as that of Section C.12 - ReInsure Benefit.

D.2 Enhanced Cumulative Bonus Safeguard (if claim amount is 1Lac or less, No reduction in Enhanced Cumulative Bonus)

On availing of this option, We will protect the percentage of Enhanced Cumulative Bonus (Section C.20) as specified in the Policy Schedule at subsequent renewal.

Provided that,

a. Claim amount shall not be exceeding 100,000 in expiring Policy.

b. You are eligible to avail this option only at inception of the Policy.

D.3 Co-payment

On availing this option, 10% or 20% Co-Payment as specified in the Policy Schedule, shall be applied on each and every admissible claim after Deductible wherever applicable under this Policy, once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent Renewal.

This co-payment will be additive to any other co-payment in the Policy, if applicable.

D.4 Aggregate Deductible

On availing this option, The Insured Person shall bear on his/her own account an amount equal to the opted deductible specified in the Policy Schedule for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year. The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted.

Conditions:

a. This Cover can be opted only at inception of the Policy or during subsequent Renewals.

b. Once the Aggregate Deductible option is opted by the Insured Person, it cannot be opted out or reduced at any time during the Policy Year or at subsequent Renewals. Deductible however can be increased at the time of Renewal.

c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted before the Company pays for claims of any Family Member covered under the Policy.

d. Deductible under this section shall not apply to any claim under Section C.2 (Shared Accommodation Cash Benefit), C.9 (Emergency Road Ambulance Cover), C.13 (Bariatric Surgery Cover),C.10(Air Ambulance Cover (Domestic), C.18 (E-Opinion), C.19(Annual Health Check-up), C.16(Recovery Benefit).

e. A Deductible does not reduce the Sum Insured.

D.5 Domestic Help/Staff Indemnity

On availing of this option, We will indemnify the Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person i.e. Domestic help in this case, during the Policy Period for an Illness, Injury or condition as mentioned in Policy Schedule and as described in the Section C.1(In-patient Hospitalization Treatment), Section C.6(Day Care Treatment), Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments), Section C.9(Emergency Road Ambulance Cover) and Section C.13(Bariatric Surgery Cover) of the base policy and contracted or sustained during the Policy Period.

Conditions:

a. Maximum liability will be restricted up to the opted Sum Insured under this benefit as mentioned in the policy schedule.

b. The Sum Insured under this cover is independent of the Sum Insured of the base policy.

c. This will be an individual coverage.

d. Can be opted only at inception but can be opted out in any of the subsequent renewals.

e. The terms and conditions will remain the same as that of covered sections under this optional cover as described in the Section C.1(In-patient Hospitalization Treatment), Section C.6(Day Care Treatment), Section C.14 (Modern Treatments), Section C.15 (AYUSH Treatments) Section C.9(Emergency Road Ambulance Cover) and Section C.13(Bariatric Surgery Cover).

f. All Exclusions of the prevailing base policy will be applicable.

Domestic Help/Staff means, a person who is employed against a remuneration in any household, part time or full-time basis to do the household work, driving and/or other activities, but does not include any member/Relative of the of the employer or his family. Relative in the purview of this definition means a person connected by blood or marriage.

D.6 Additional Basic Sum Insured for Accident related hospitalization

On availing this option, We will provide an additional 2 times of base Sum Insured towards Medical Expenses incurred for In-Patient Hospitalization Treatment as given in Section C.1, as specified in the Policy Schedule. This cover applicable only an Emergency caused solely and directly due to an Accident-causing Injury, of the Insured Person who is Hospitalized for the treatment of such Injury.

Conditions:

1. This Benefit shall be utilized only after base Sum Insured has been completely exhausted.
2. This benefit shall be available only once during the Policy Year.
3. This benefit shall be available only for such Insured Person for whom Accidental Hospitalization claim is accepted under this Policy.
4. The sequence of utilization of Sum Insured will be as below:
   a. Base Sum Insured followed by;
   b. Enhanced Cumulative Bonus/Loyalty Credit (if any) followed by;
   c. Additional Basic Sum Insured for Accident related hospitalization followed by;
   d. ReInsure benefit

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

D.7 Wellness Benefit

On availing this option, The Insured Person may avail wellness services as mentioned in the Policy Schedule. The services may include any or all as specified in the policy schedule:

Services	Utilization Parameter (if applicable as per Policy Schedule)
D.7.1 Health Assistance (A.I. Personal Fitness coaching)	Unlimited
D.7.2 Dietician and Nutrition E-consultation	Unlimited
D.7.3 Unlimited Gym Membership	**Option 1** - Eligible Customer must utilise Gym Services at least once in the first 6 months (from policy start date) to activate the next 6 months. Once suspended, cannot be activated thereafter. **Option 2** - Eligible Customer must utilise Gym Services at least once every quarter (3mth periods from policy start date) to activate the next quarter. Once suspended, cannot be activated thereafter.
D.7.4 Walk Healthy Benefit	Collect health benefits by taking steps counted on our App or Activity tracker of the vendor and get discount up to 30% on renewal premium.

Condition:

a. The Insured on availing this optional cover can utilize the above services (as applicable as per Policy Schedule) during the policy period subject to above mentioned utilization parameter.

b. The above mentioned optional covers (D.7.1 to D.7.4) can only be opted at inception of the policy and cannot be opted at subsequent renewals.

c. This cover will be available on optional basis. D 7.1 [Health Assistance (A.I. Personal Fitness coaching)], D7.2[Dietician and Nutrition E-consultation],D7.3 [Unlimited Gym Membership] can be availed only as a combination with or without D 7.4[Walk Healthy Benefit] and D 7.4 [Walk Healthy Benefit] can be given on standalone optional basis also.

d. The services will be provided through an empanelled Service Provider. It is entirely for the Insured Person to decide whether to obtain these services.

e. We shall not be responsible for any disputes arising between the Insured Person and the Service Provider

f. The services provided under this benefit, does not constitute Medical Advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

D.7.4.1 Conditions Applicable to Walk Healthy Benefit [Section D.7.4]

What is covered: We will offer a discount on Renewal premium if the eligible Insured Person(s) achieves the health points target on the mobile application provided by Us as per the grid mentioned below.

Conditions –

The above coverage is subject to fulfilment of following conditions:

a) Steps taken by the Insured Person, who is covered as an adult under the policy, everyday are recorded. Steps counted by the mobile App We provide you to use ONLY would be considered.

b) Steps accumulated in last 3 months of the Policy Period would not be considered for discount on premium for the first renewal. The last 3 months are NOT LOST and will be considered in the next Policy Period. All renewals thereafter, will consider points gained in the Policy Period.

c) The mobile app must be downloaded within 180 days of the Policy commencement to avail this benefit. The step count completed by an eligible Insured Person would be tracked on this mobile application.

d) We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation.

e) Discount (if eligible as per the grid below) under this benefit can be availed only by Adult Insured person under the policy.

f) For any mid-term additions under the Base policy, the coverage under Section D.7 (Wellness Benefit) can only be opted at subsequent renewal.

Policy duration	**End of 9 months**	**Steps at the end of 9 months (A) This will be considered for discount on the first renewal.**	**Steps in next 3 months (B)**	**Total Steps considered for discount (A + B) from 2nd Policy Period onwards**	**Discount on renewal premium (Renewal policy start date 1st Jan 2023**			
					NOTE: Discount applicable on the member's premium in Individual Sum Insured policies and on the Policy premium in case of Floater			
					Individual Sum Insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2022	1500000			0%	0%	0%	0%
		1500001-2250000			5%	2.50%	1.65%	1.25%
		2251000 – 3000000			15%	7.50%	5.0%	3.75%
		3000001 – 3750000			20%	10%	6.65%	5.00%
		>=3751000			30%	15%	10.0%	7.50%

Policy duration	**End of 21 months**	**Steps at the end of 21 months (A).This will be considered for discount on the first renewal.**	**Steps in next 3 months (B)**	**Total Steps considered for discount (A + B) from 2nd Policy Period onwards**	**Discount on renewal premium (Renewal policy start date 1st Jan 2023**			
					NOTE: Discount applicable on the member's premium in Individual Sum Insured policies and on the Policy premium in case of Floater			
					Individual Sum Insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2022	3000000			0%	0%	0%	0%
		3000001 – 4500000			5%	2.50%	1.65%	1.25%
		4500001 – 6000000			15%	7.50%	5.0%	3.75%
		6000001 – 7500000			20%	10%	6.65%	5.00%
		>=7501000			30%	15%	10.0%	7.50%

Policy duration	End of 33 months	Steps at the end of 33 months (A).This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st Jan 2025 NOTE: Discount applicable on the member's premium in Individual Sum Insured policies and on the Policy premium in case of Floater			
					Individual Sum Insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2024	Upto 4500000			0%	0%	0%	0%
		4500001 – 6750000			5%	2.50%	1.65%	1.25%
		6751000– 9000000			15%	7.50%	5.0%	3.75%
		9000001 – 11250000			20%	10%	6.65%	5.00%
		>=11251000			30%	15%	10.0%	7.50%

E. 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:

I) First Thirty Days Waiting Period:

a) 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.

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve (12) months.

c) 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 Hypertension, Diabetes and Cardiac Condition and for claims under Section C.24 – Medical Treatment abroad. Waiting period specific to these ailments are mentioned in E. IV and V.

II) Specified diseases and Procedures Waiting Period:

a) Expenses related to the treatment of listed Conditions; Surgeries/treatments shall be excluded until the expiry of 24/12 months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If any of the specified disease / procedures falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms of Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i. 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	

ii. 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

III) Pre-Existing Diseases:

a) 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.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the Policy after 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.

IV) 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.

V) Medical Treatment Abroad: Expenses related to the treatment taken abroad for any listed Major Illness under this benefit within 36 months from the first Policy Commencement Date shall be excluded.

VI) Maternity and Related Expenses Cover: Single Adult – 48 months and All other Family Combinations – 24 months

F. 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.

G. 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

H. General Exclusions

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:

A. Standard Exclusions

I. Investigation and Evaluation (Code-Excl 04):

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

II. Rest Cure, rehabilitation, and respite care (Code- Excl 05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a) 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.

b) Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

III. Obesity / Weight Control (Code- Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type 2 Diabetes

IV. Change of Gender Treatments (Code- Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.

V. Cosmetic or Plastic Surgery (Code- Excl 08)

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

VI. Hazardous or Adventure Sports (Code- Excl 09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

VII. Breach of Law (Code- Excl 10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

VIII. Excluded Providers (Code-Excl 11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by Us 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.

IX. Treatment for alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12)

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

XI. 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 Procedures. (Code- Excl 14)

XII. Refractive Error (Code-Excl 15)

Expenses related to the treatment for correction of eye-sight due to refractive error less than 7.5 dioptres

XIII. Unproven Treatments (Code- Excl 16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

XIV. Sterility and Infertility (Code-Excl 17)

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

XV. Maternity (Code-Excl 18) (Not Applicable for Section C.20 - Maternity and Related Expenses Cover)

a) Medical treatment expenses traceable to child-birth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;

b) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

B. Specific Exclusions

I. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

II. Nuclear, chemical or biological attack or weapons, 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:

1. 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.
2. 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.
3. 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.

III. Treatment taken outside India (Section C.24 - Not applicable for product plan variants wherein Medical Treatment Abroad is covered).

IV. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident

V. Convalescence, general debility, "run-down" condition, rest cure, external congenital anomaly.

VI. Vaccination or inoculation except as part of post-bite treatment for animal bite or for product plan variants wherein Child Vaccination cover is covered.

VII. Medical practitioner's home visit expenses during Pre and Post hospitalization period, attendant nursing expenses.

VIII. 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.

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

X. 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 Organisation (WHO) protocols,

d. Published guidelines by healthcare providers,

e. Guidelines set by medical societies like cardiological society of India, neurological society of India etc

XI. 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.

I. Claims Procedure

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.	
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 / Certificate of Insurance 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 4. Name and address of the attending 5. Medical Practitioner/ Hospital 6. Date of admission & probable date of discharge 7. Approximate Claim Expenses 8. Treatment Details 9. Claim Form / Pre-Authorization Request form 10. Any other relevant information as required 11. cKYC Form and KYC Documents	Not Applicable
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
Procedure for Cashless Claims in case of Home Health Care	On receipt of duly filled pre-authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may: a. Issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or b. Reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable

- List of Documents for Reimbursement Claims:

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 cKYC 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

- Claim Document Submission Address

  All claim related documents needs 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.

  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.

- **Standard Condition for Claim Process**

Claim Settlement

i. The Company shall settle or reject a claim 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 Insured Person 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 Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Fraud

If any claim made by the Insured Person, is any respect of 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 Insured Person who has made that particular claim, who shall be jointly and severally liable for such repayment to Us.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

Complete Discharge

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

Payment of Claim

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

J. Renewal Policy

Renewal Conditions:

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.

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 (3) months before the changes are affected.

K. 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

L. Withdrawal of the Policy

A. 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.

B. 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.

M. 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.

N. 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 Policholder. 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.

O. Pre-Policy Health Checkup

Medical Tests are applicable to all insured person(s), as per Plan, Sum Insured chosen and Age of Insured Person as mentioned below.

Also, in case of any adverse disclosure by insured member, underwriters may ask for additional medical test as suitable to take prudent underwriting decision.

	Prime / Elite	Premier	Platinum	Platinum Infinite
Pre-policy medical check-up	For SI 3 lacs, 5 Lacs, 7 Lacs, 10 Lacs >55 years	>55 years	For SI 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs - >45 years	>=16 years
	For SI 15Lacs, 20 Lacs, 25 Lacs > 45 years		For SI 30 Lacs, 40 Lacs, 50 Lacs - >=18 years	

Below process shall be applied as per Our medical underwriting suggestion:

- Medical tests will be facilitated by Us and full cost of all such tests will be borne by Us.

P. Premium Payment In Installments

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 instalments from the Claim amount due under the Policy.

Option	Instalment Premium Option	Option	Instalment Premium Option
Option 1	Half yearly	Option 3	Monthly
Option 2	Quarterly	Option 4	Annual Premium

Q. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, 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.

R. Loadings

i. We may apply a risk loading (additional premium) on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Person, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.

ii. The maximum risk loading applicable for an individual shall not exceed above 150% per Insured Person. Loadings will be applied from the Inception Date of the first Policy including subsequent Renewals. There will be no loadings based on individual claims experience on Renewals for the Policies Renewed with Us continuously without any break.

iii. We will inform You about the applicable risk loading through a counteroffer letter and We will only issue the Policy once We receive your consent and applicable additional premium. In case, You neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.

iv. Your Policy shall not be issued unless We receive Your consent.

S. Discounts

Insured is eligible for discount on premium as below:

Family Individual Discount (>= 2 members)	5%
SBI group entity discount	5%
Long term discount (will not apply if instalment option is opted)	2 years - 4% 3 years - 6%
Direct Channel Discount	10%

T. 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 upto 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:

The Company 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.

U. Redressal of Grievances

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 number 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 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/0449cac1bcd144bbb160d3f6b714fbbd.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

V. Contact Us

Contact details for Policy Servicing	Contact details for Claim Servicing
SBI General Insurance Company Limited, **Address:** 9th Floor, Wing A & B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099. **Email:** customer.care@sbigeneral.in ; seniorcitizengrievances@sbigeneral.in (for Senior Citizens) **Toll free number** 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7) **Website:** www.sbigeneral.in	**Accident & Health claims team,** **SBI General Insurance Company Limited,** **Address:** 9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045. **Email:** sbig.health@sbigeneral.in **Toll Free number:** 1800 210 3366, 1800 210 6366 **Website:** www.sbigeneral.in

W. Section 41 of Insurance Act 1938 (Prohibition of Rebates)

I. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

II. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees IRDAI Regulation no 5- This Policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation Disclaimer: the above is descriptive only. The actual terms and conditions can be found in the policy document. Insured's are advised to read the policy document completely for a full description of the terms and conditions of coverage and the exclusions relating thereto.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

DISCLAIMER

THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. PROSPECTS ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING THERETO BEFORE CONCLUDE THE SALE. IRDAI Reg No. 144

Annexure attached to this Prospectus:

Annexure – I – Benefit Illustration in respect of individual and family floater basis

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)			Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)			Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)		
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any Family member discount)	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	8,214	500000	8,214	5%	7,803	500000	71,373	0	71,373	500000
30 yrs	8,214	500000	8,214	5%	7,803	500000				
15 yrs	5,082	500000	5,082	5%	4,828	500000				
10 yrs	5,082	500000	5,082	5%	4,828	500000				
60 yrs	27,448	500000	27,448	5%	26,076	500000				
56 yrs	27,448	500000	27,448	5%	26,076	500000				
Total Premium for all members of the Family is ₹81,488/- when each member is covered separately. Sum Insured available for each individual is ₹5,00,000/-			Total Premium for all members of the Family is ₹77,414/- when they are covered under a single policy. Sum Insured available for each family member is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹71,373/- Sum Insured of ₹5,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Elite Plan. do
- Family size is considered 6 = 2 Adult + 2 Dependent Child + 2 Dependent Parents.
- Illustration is given for Sum Insured 5 Lac

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)			Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)			Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any Family member discount)	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	15,039	1000000	15,039	5%	14,287	1000000	85,974	0	85,974	1000000
30 yrs	15,039	1000000	15,039	5%	14,287	1000000				
15 yrs	6,066	1000000	6,066	5%	5,763	1000000				
10 yrs	6,066	1000000	6,066	5%	5,763	1000000				
60 yrs	32,190	1000000	32,190	5%	30,581	1000000				
56 yrs	32,190	1000000	32,190	5%	30,581	1000000				
Total Premium for all members of the Family is ₹1,06,590/- when each member is covered separately. Sum Insured available for each individual is ₹10,00,000/-			Total Premium for all members of the Family is ₹1,01,261/- when they are covered under a single policy. Sum Insured available for each family member is ₹10,00,000/-				Total Premium when policy is opted on floater basis is ₹85,974/- Sum Insured of ₹10,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Premier Plan.
- Family size is considered 6 = 2 Adult + 2 Dependent Child + 2 Dependent Parents.
- Illustration is given for Sum Insured 10 Lac

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)		
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	20,602	1500000	20,602	5%	19,572	1500000	1,05,731	0	1,05,731	1500000
30 yrs	20,602	1500000	20,602	5%	19,572	1500000				
15 yrs	9,509	1500000	9,509	5%	9,033	1500000				
10 yrs	9,509	1500000	9,509	5%	9,033	1500000				
60 yrs	37,637	1500000	37,637	5%	35,756	1500000				
56 yrs	37,637	1500000	37,637	5%	35,756	1500000				
Total Premium for all members of the Family is ₹1,35,496/- when each member is covered separately. Sum Insured available for each individual is ₹15,00,000/-			Total Premium for all members of the Family is ₹1,28,721/- when they are covered under a single policy. Sum Insured available for each family member is ₹15,00,000/-				Total Premium when policy is opted on floater basis is ₹1,05,731/- Sum Insured of ₹15,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Platinum Plan.
- Family size is considered 6 = 2 Adult + 2 Dependent Child + 2 Dependent Parents.
- Illustration is given for Sum Insured 15 Lac

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)		
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	45,944	5000000	45,944	5%	43,647	5000000	1,67,682	0	1,67,682	5000000
30 yrs	45,944	5000000	45,944	5%	43,647	5000000				
15 yrs	15,368	5000000	15,368	5%	14,600	5000000				
10 yrs	15,368	5000000	15,368	5%	14,600	5000000				
60 yrs	54,676	5000000	54,676	5%	51,942	5000000				
56 yrs	54,676	5000000	54,676	5%	51,942	5000000				
Total Premium for all members of the Family is ₹2,31,976/- when each member is covered separately. Sum Insured available for each individual is ₹50,00,000/-			Total Premium for all members of the Family is ₹2,20,377/- when they are covered under a single policy. Sum Insured available for each family member is ₹50,00,000/-				Total Premium when policy is opted on floater basis is ₹1,67,682 /- Sum Insured of ₹50,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Platinum Infinite Plan.
- Family size is considered 6 = 2 Adult + 2 Dependent Child + 2 Dependent Parents.
- Illustration is given for Sum Insured 50 Lac

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.