SURAKSHA AUR BHAROSA DONO

HOSPICASH FLEXI INSURANCE

POLICY WORDING

PREAMBLE

In consideration of payment of Premium by You, We will provide insurance cover to the Insured Person(s) under this Policy up to Sum Insured and subject to waiting period, minimum hospitalization period and Deductible/Time Deductible/Aggregate Deductible/Co-Pay/Voluntary Co-Pay/Franchise as mentioned on Policy Schedule/Certificate of Insurance.

This Policy is subject to Your statements in respect of all the Insured Persons in Proposal Form /Enrolment Form, declarations, payment of premium and terms and conditions of this Policy.

DEFINITIONS

a) STANDARD DEFINITION

1 **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2 **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the hospital/day care centre where treatment was taken.

3 **AYUSH Day Care Centre** means or includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner(s) in charge

b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out

c. Maintaining daily records of patients and making them accessible to the insurance company's authorized representative

4 **AYUSH Hospital** is a healthcare facility wherein medical/surgical /para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or

c. AYUSH hospital standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion:

i. Having at least 5 in-patient beds

ii. Having qualified AYUSH Medical Practitioner in charge round the clock

iii. Having dedicated AYSUH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out

iv. Maintaining daily records of patients and making them accessible to the insurance company's authorized representative

5 **Condition Precedent** means a Policy term or condition upon which Our liability under the Policy is conditional upon.

6 **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.

b. **External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.

7 **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under –

a. has qualified nursing staff under its employment;

b. has qualified Medical Practitioner(s) in charge;

c. has a fully equipped operation theatre of its own where surgical procedures are carried out;

d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

8 **Day Care Treatment** means medical treatment, and/or surgical procedure which is

a. undertaken under General or Local Anesthesia in a hospital/ day care center in less than 24 hours because of technological advancement, and

b. which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9 **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

(Deductible will be applicable as specified under the Policy).

10 **Disclosure to information norm** - The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

11 **Emergency Care** means management for an Illness which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.

12 **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 or to induce the Company 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

13 **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

14 **Hospital** means any institution established for in-patient care and day care treatment of Illness and/or Injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section of 56(1) of the said Act OR complies with all minimum criteria as under:

a. Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

b. Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

c. Has qualified Medical Practitioner(s) in charge round the clock;

d. Has qualified nursing staff under its employment round the clock;

e. Maintains daily records of patients and makes this accessible to the insurance company's authorized personnel.

15 **Hospitalization or Hospitalised** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

16 **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

b. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

I. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests

ii. It needs ongoing or long-term control or relief of symptoms

iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. It continues indefinitely

v. It recurs or is likely to recur

17 **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

18 **In - patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving treatment.

19 **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

20 **Material Facts** means, all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

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

22 **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

a. Is required for the medical management of the Illness or Injury suffered by the Insured Person;

b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.

c. Must have been prescribed by a Medical Practitioner; and

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

23 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

24 **New-born Baby** means baby born during the Policy Period and is aged up to 90 days.

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

26 **Pre-existing Disease** means any condition, ailment, injury or disease:

a. That is / are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

27 **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

29 **Spouse** means the Primary Insured's legally married spouse as long as he/she continues to be married to the Primary Insured.

30 **Sum Insured** means, the amount as opted by you and stated in the Policy Schedule / Certificate of Insurance against the section/cover for each Insured Person for Individual Sum Insured and aggregately for all Insured members for a Floater Policy

31 **Unproven/Experimental Treatment** means the treatment including drug experimental therapy which is not based on

established medical practice in India, is treatment experimental or unproven.

b) SPECIFIC DEFINITION

1 **Age or Aged** means the completed age (in years) of the Insured Person as on his/ her last birthday.

2 **Alternative Treatments** are forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy (AYUSH) in the Indian context.

3 **Bank Rate** means, the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

4 **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule.

5 **Dependent** means the Insured Person's legal spouse or children or parents or parent-in-law who have been enrolled in the Group Policy.

6 **Dependent Child** to a child (natural or legally adopted), who is financially dependent on the Policy Holder, does not have his / her independent source of income, is up to the age of 25 years and unmarried who have been enrolled in the Group Policy.

7 **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i) The condition of the patient is such that he/she is not in a condition to be moved to a hospital, or

ii) The patient takes treatment at home on account of non-availability of room in a hospital.

8 **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below

- legally wedded spouse
- Parents and/or Parents-in-law
- Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years.)

9 **Family Floater** means a Policy described as such in the Policy Schedule of Insurance where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date.

10 **Franchise** means an arrangement under a health insurance Policy that provides that the Insurer will not be liable up to the specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies but will pay for the entire amount of loss and days/hours when exceeds the agreed amount/days/hours.

11 **Group** - The definition of a group is as per the provisions of Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, read with group guidelines issued by IRDAI vide circular 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005, as amended/modified/ further guidelines issued, from time to time.

12 **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

13 **Insured Person** means the Insured Member or Dependants named in the Policy Schedule/Certificate of Insurance, who is/are covered under this Policy, for whom the insurance is proposed, and the appropriate premium is received.

14 **Master Policy/Group Policy** shall mean the Proposal, Group Policy Schedule, along with these Terms and Conditions, issued to the Policy Holder containing these terms and conditions of the insurance coverage and under which Certificates of Insurance will be issued to the respective Insured Beneficiary/ies and any endorsements attaching to or forming part thereof either on the commencement date or during the Cover Period.

15 **Mental health establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends.

16 **Policy** means Policy document, the Group Proposal Form / Enrolment Form, the Policy Schedule/Certificate of Insurance issued to Insured Persons, Annexures, insuring clauses (if applicable to individual sections), definitions, exclusions, conditions and other terms contained herein, including endorsements (as amended from time to time), attaching to or forming part hereof, either at inception or during the Policy Period.

17 **Policy Holder** means the person or entity named in the Policy Schedule as the Policy Holder.

18 **Policy Period** means the period commencing from Policy start date and time as specified in the Policy Schedule/Certificate of Insurance and terminating at midnight on the Policy end date as specified in the Policy Schedule/Certificate of Insurance.

19 **Policy Year** means a period of twelve months beginning from the date of commencement of the Policy Period and ending on the last day of such twelve-month period or Policy Period End Date or Cancellation Date whichever is earlier, as specified in the Policy Schedule.

For the purpose of Subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous Policy Year or Policy Period End Date or Cancellation date whichever is earlier.

20 **Policy Schedule/Certificate of Insurance** means the Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period and the limits and conditions to which the Benefits under the Policy are subject to, including any Annexures and/or endorsements.

21 **We/Our/Us/Insurer** means SBI General Insurance Company Limited.

22 **You/Your** means the Policy Holder or the Primary Insured person named in the Policy Schedule / Certificate of Insurance

COVERAGES

A. BASE COVER

The following benefits are payable subject to Terms and Conditions of the policy:

A.1 – Accident and sickness hospital cash benefit policy holder

In the event of Accidental Bodily Injury or illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation within the Policy Year, the Company will pay:

The Daily Allowance as stated in the Policy Schedule/Certificate of

Insurance, for each calendar day of Hospitalisation necessitated solely by reason of the Accidental Bodily Injury or illness for a maximum period as stated in the Policy Schedule/Certificate of Insurance, during each Policy Year.

A franchise/deductible of 1 day as stated in the Policy Schedule/Certificate of Insurance will be applicable, per hospitalization in a Policy Year. Our maximum liability shall be restricted to the daily allowance till opted length of stay and Waiting Period mentioned in the Policy Schedule/Certificate of Insurance.

Note:

i. During the hospitalization period if the Insured Person is transferred from Normal room to ICU or vice versa the benefit would be payable only under one heading as specified above, as per the hospital bill for the respective day.

ii. In case of an Individual Policy, the Daily Allowance as stated in the Policy Schedule/Certificate of Insurance, for the opted no. of days will be available on Individual basis for Individual Policies and on Floater basis for Floater policies

B. Optional covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that Policy is extended to pay daily allowance as specified in the below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits and subject to co-payments/deductibles, if any, mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

B.1 – Accident hospital cash benefit

In the event of Hospitalization of Insured Person due to Accidental Bodily Injury during the Policy Period, the Company will pay:

Two times the Daily Allowance as stated in the Policy Schedule/Certificate of Insurance, for each calendar day of Hospitalisation required to be spent by the Insured Person in a Hospital during any period of Hospitalisation necessitated solely by reason of the Accidental Bodily Injury for a maximum period as stated in the Policy Schedule/Certificate of Insurance during each Policy Year.

- If this benefit is opted, We will not pay for Daily Cash benefit under Base cover above for the period when the Insured Person is hospitalized for Accidental Injury.
- A franchise/deductible of 1 day as stated in the Policy Schedule/ Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.

B.2 – ICU cash benefit

In the event of Accidental Bodily Injury or Illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation within the Policy Year, the Company will pay:

Two times the Hospital Daily Cash Allowance, for each calendar day of Hospitalisation required to be spent by the Insured Person in the Intensive Care Unit of a Hospital during any period of Hospitalisation necessitated solely by reason of the Accidental Bodily Injury or Illness for a maximum period of 15 days during the Policy Year.

- We will not pay for Daily Cash benefit in A.1. above for the period when the Insured Person is in Intensive Care Unit, if this cover is opted.
- A franchise/deductible of 1 day as stated in the Policy Schedule/ Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.

B.3 – Convalescence benefit

On availing this benefit, Policy is extended to pay lump sum amount equal to Five times the Hospital Daily Cash Allowance as mentioned in Certificate of Insurance in case of continuous and completed hospitalization beyond consecutive 10 calendar days due to Accidental Bodily Injury or Illness.

- This benefit shall be payable if claim under A.1 - Accident and Sickness Hospital Cash Benefit or A.2 - Accident Hospital Cash Benefit or B.2 - ICU Cash Benefit section is admissible under the policy.
- This benefit is available only once per Insured person during Policy Year.
- No Franchise / Deductible shall be applicable under the claim admissible in this section.

B.4 – Compassionate benefit

We will pay lumpsum Ten times the Hospital Daily Cash Allowance towards expenses as a Compassionate Benefit to the Nominee in case of Accidental Death of the Insured Person whilst in Hospital.

- This benefit shall be payable if claim under A.1 – Accident and Sickness hospital cash Benefit section is admissible under the Policy
- This benefit is available only once per Insured Person.
- No Franchise / Deductible shall be applicable under the claim admissible in this section.

B.5 – Day care treatment benefit

On availing of this benefit, We will pay Five times the Hospital Daily Cash Allowance as stated in the Policy Schedule/Certificate of Insurance, subject to maximum of Rs 10,000 per claim towards Day Care Treatment carried out in the Day Care Centre during the Policy Year

- No Deductible/ Franchise shall be applicable under the claim admissible in this section.
- The Benefit under this Section shall be available for a maximum of 2 Day Care Treatments per Insured Person per Policy Year and No deductible will be applicable.
- The list of admissible Day Care Treatment/ Procedures would be as per the list in Annexure III (The list of day care treatment is an indicative list and any other treatment which may get included in future shall be covered by the virtue of standard definition of "Day Care Treatment")

B.6 – Maternity hospital cash benefit

We will pay daily fixed benefit amount as specified in the Policy Schedule/ Certificate of Insurance for each calendar day of Hospitalisation, in case an Insured Person is hospitalized for delivery of a child / Medically Necessary Treatment during pregnancy/ lawful medical termination of pregnancy. Policy is restricted to pay for first 2 deliveries only.

- This benefit is subject to maternity waiting period of 3 Years and deductibles as specified in the Policy Schedule/Certificate of Insurance.
- We will not cover ectopic pregnancy under this benefit (although it shall be covered under Inpatient Accident and Sickness hospital Cash Benefit (Section A.1)).
- A franchise/deductible of 1 day as stated in the Policy Schedule/ Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.
- We will not pay for Daily Cash benefit under Base cover above, if the claim is admissible under this Section.

Option available to Reduce Waiting period of Maternity

In consideration of payment of additional premium, it is hereby declared and agreed that We will provide reduction/waiver of waiting period for Maternity Hospital Cash Benefit as specified in Policy Schedule/Certificate of Insurance. Insured Person may have an option to choose the reduction/waiver of waiting period as below.

Option 1. 9 months waiting period

We will reduce waiting period for Maternity Hospital Cash benefit from 3 years to 9 months. We are not liable to make any payment in respect of Maternity Expenses within 9 months from the date of Inception of the first Policy.

Option 2. 1 year waiting period

We will reduce waiting period for Maternity Hospital Cash Benefit from 3 years to 1 year. We are not liable to make any payment in respect of Maternity Hospital Cash Benefit within 1 year from the date of Inception of the first Policy.

Option 3. 2 years waiting period

We will reduce waiting period for Maternity Hospital Cash Benefit from 3 years to 2 years. We are not liable to make any payment in respect of Maternity Hospital Cash Benefit within 2 years from the date of Inception of the first Policy.

Option 4. No maternity waiting period

On availing this option, Waiting Period for Maternity Hospital Cash Benefit shall not be applicable.

If Maternity Hospital Cash Benefit cover is opted, then under the General Exclusion Excl-18 -Maternity Expenses stands deleted.

B.7 – Other waiting periods

In consideration of payment of additional premium by the Proposer/ Insured Person, to the Company and realization thereof by the Company, it is hereby agreed and declared that Hospital Daily Cash Policy is extended to reduce waiting period mentioned in Pre-Existing Diseases (Code- Excl01), Specified disease/procedure waiting period- Code- Excl 02 &30-day waiting period- Code- Excl 03 i.e. Disease Specific and Pre-Existing Waiting Period up to the option opted by Insured Beneficiary and as specified in the Policy Schedule.

Option 1. 30 days waiver -

Subsequent to this endorsement, 30-day waiting period- Code- Excl03 cover stands deleted for all the Insured Persons in the Policy.

All other policy terms and conditions remain unaltered.

Option 2: 2 years Specific illness waiting period -

Subsequent to this endorsement, specified disease/procedure waiting period- Code- Excl02 cover stands modified for all the Insured Persons in the policy with reference to waiting period being increased to 24 months.

All other policy terms and conditions remain unaltered.

Option 3: Specific illness Waiting Period Waiver -

Subsequent to this endorsement, specified disease/procedure waiting period- Code- Excl02 cover stands waived for all the Insured Persons in the policy

All other policy terms and conditions remain unaltered.

Option 4: 1 year waiting period for Pre-Existing Diseases -

Subsequent to this endorsement, General Exclusions (Code- Excl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 1 year

All other policy terms and conditions remain unaltered.

Option 5: 2 years waiting period for Pre-Existing Diseases

Subsequent to this endorsement, General Exclusions (Code- Excl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 2 years.

All other policy terms and conditions remain unaltered.

Option 6: 3 years waiting period for Pre-Existing Diseases

Subsequent to this endorsement, General Exclusions (Code- Excl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 3 years.

All other policy terms and conditions remain unaltered.

Option 7: No waiting period for Pre-Existing Diseases

Subsequent to this endorsement, General Exclusions (Code- Excl01) stands deleted for all the Insured Persons in the policy.

All other Policy terms and conditions remain unaltered.

B.8 – INCREASED DEDUCTIBLE/FRANCHISE

The Company hereby agrees and declared that upon opting this optional cover, We will provide discount mentioned and time bound deductible/franchise of day(s) as specified in the Certificate of Insurance will be applicable for any claim under Section A i.e. Base Covers and Section B i.e. Optional covers excluding B5 i.e. Day Care Treatment Benefit

If this optional cover is opted then the increase Deductible/ Franchise will supersede existing Deductible/ Franchise of the policy.

All other policy terms and conditions remain unaltered.

WAITING PERIOD AND EXCLUSIONS

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy;

Standard Exclusions

1. **Pre-Existing Diseases (Code- Excl01)**
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.
2. **Specified disease/procedure waiting period- Code- Excl02**
   a. Expenses related to the treatment of the listed conditions; surgeries/treatments shall be excluded until the expiry of 1 Year of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
   d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   e. List of specific diseases/procedures
      - Cataract
      - Benign Prostatic Hypertrophy
      - Hysterectomy/myomectomy for menorrhagia or fibro-myoma or prolapse of uterus

- Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism
- Surgery of Genitourinary tract
- Calculus Diseases of any etiology
- Sinusitis and related disorders
- Surgery for prolapsed intervertebral disc unless arising from accident
- Surgery of varicose veins and varicose ulcers
- Chronic Renal failure including dialysis

3. 30-day waiting period- Code- Excl03

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Maternity Waiting period (applicable only if optional cover "Maternity Hospital Cash Benefit" is opted) - 36 months waiting period applicable in case an Insured Person is hospitalized for delivery of a child / Medically Necessary Treatment during pregnancy/ lawful medical termination of pregnancy.

5. Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

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

6. Rest Cure, rehabilitation and respite care- Code- Excl05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

7. Obesity/ Weight Control: Code- Excl06

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

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

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

8. Change-of-Gender treatments: (Code- Excl07)

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

9. Cosmetic or Plastic Surgery: (Code- Excl08)

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

10. Hazardous or Adventure sports: (Code- Excl09)

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

11. Breach of law: (Code- Excl10)

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

12. Excluded Providers: (Code-Excl 11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However. in case of life-threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

14. Treatments received in heath 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- Exel13)**

15. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

16. Refractive Error:(Code- Excl15)

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

17. Unproven Treatments:(Code- Exel16)

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.

18. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

vi. Reversal of sterilization

19. Maternity (Code-Excl 18)

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

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

Specific Exclusions

20. Any medical treatment outside India.

21. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

22. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);

c. nuclear weapons material;

d. nuclear equipment or any part of that equipment;

23. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

24. Injury or Disease caused by or contributed to by nuclear weapons/materials.

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

26. Prostheses, corrective devices, medical appliances, external medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

27. Treatments in health hydro, spas, nature care clinics and the like.

28. Treatment with alternative medicines and other treatment methods including but not limited to , acupuncture, acupressure, osteopath, , chiropractic, reflexology and aromatherapy.

29. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

30. Vaccination or inoculation except as post bite treatment for animal bite.

31. Convalescence (unless opted under Section B.3), general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.

32. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy.

GENERAL TERMS AND CLAUSES

A. Standard general terms and clauses

I. Condition Precedent to the contract

a. Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Insured Person.

b. Condition Precedent to Admissible of Liability

The Due observance and fulfilment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

c. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

b. 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.

e. Nominee

The Insured Person 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 Your death. 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 Insured Person, the Company will pay the nominee (as named in the Policy Schedule) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

f. Assignment

The Benefits under this Policy are assignable subject to applicable Laws.

ii. Conditions applicable during the contract

1. Cancellation:

a. Cancellation by you:

i. You may cancel this policy at any time by giving Us written notice in 15-days by recorded delivery. In the event of such cancellation, We shall refund premium for the unexpired Policy Period as detailed below.

1 Year Policy Period:

Policy Period	**1**
Period of Cancellation	% Return Premium
1 – 3 months	75%
4 – 6 months	50%
6 – 9 months	25%
9 – 12 months	0%

Greater than 1 Year Policy Period

Premium refund = [(Premium charged for the original tenure – Premium expected for the tenure when the policy is cancelled) – any other fixed cost/penalties if applicable]

For example, if the original tenure of the policy is 32 months and the premium charged, say, is INR 10,000. If the policy is cancelled in 21st month and the premium expected for tenure of 21 months is INR 7,000. along with fixed cost incurred for this policy is say, INR 250

Then the premium refund to the customer is : INR 10,000 – INR 7,000 – INR 250 = INR 2,750.

Note 1: If the policy is cancelled in the last 3 months of the policy tenure, then there will be no premium refund. For example, in the

above scenario, if the policy is cancelled in 30th, 31st or 32nd months, then there will be no premium refund.

Note 2: All other terms and conditions of the policy cancellations will be applicable

b. Cancellation by Us:

We reserve the right to cancel this Policy from inception immediately upon becoming aware of any misrepresentation, fraud, non-disclosure of material facts or non-cooperation by or on behalf of You. No refund of premium shall be allowed in such cases.

2. Free Look Period

The Free Look Period shall be applicable on new health insurance policies and not on renewals of the Policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

3. Deletion of Insured during the policy period

Mid-term deletion only allowed on account of death of the insured person, pro-rate refund of premium of the deceased insured person for the balance period of the policy will be effective. Provided no claim has been made.

4. Withdrawal of the Product-

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. Specific terms and clauses

I. Condition Precedent to the contract

a. Age Limit

To be eligible to be covered under the Policy or get any benefits under the Policy, the Insured Person should have attained the age of at least 18 years on the date of commencement of the Policy. Dependent children can be covered from 91 days and up to 25 years of age.

* Note - Adult Cover is compulsory for the Child Cover.

b. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two Arbitrators **who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended).**

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

c. Currency

The monetary limits applicable to this Policy will be in INR.

d. 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.

e. Material Change

The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

f. Notice and Communication

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

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

g. Premium

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

h. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

i. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

j. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy

Schedule shall be deemed to form part of the Policy and shall be read together as one document.

II. Conditions applicable during the contract

a. Alterations in the Policy

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

b. Revision and Modification of the Policy Product-

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

c. Conditions when a claim arises

On the occurrence of that may give rise to a claim under this Policy, the claim procedures set out below shall be followed.

Procedures	Reimbursement Claims
Claim Intimation	If you meet with any Accidental bodily Injury or suffer an Illness that may result in a claim, then as a Condition Precedent to Our liability, you must comply with the following claim procedures. • Call Toll free customer care number 1800 22 1111/1800 102 1111 • e-mail to customer.care@sbigeneral.in • SMS "CLAIM" to 561612 • website (www.sbigeneral.in) -> Claim Intimation (Section)
Claim Intimation timelines	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
List of Documents	As listed below

• List of necessary claim documents/information to be submitted for reimbursement are as following:

1. Duly filled and signed claim form
2. Certified copy of Hospital discharge Summary with first consultation paper (if any)
3. Certified copy of Diagnostic report confirming diagnosis.
4. Certified copy of final hospital bill with detailed break up
5. KYC documents of primary insured/beneficiary
6. Beneficiary (Primary Insured) bank account / NEFT details

Any additional documents may be called as required based on the circumstances of the claim.

• Claim documents submission

All claim related documents need to be sent to below address within 30 days of date of discharge from hospital. Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team:

SBI General Insurance Co Ltd

3rd & 4th Floor, Lotus Park, Plot No 18-19,

Road No. 16, Wagle Industrial Estate, Thane – 400604

• 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.

d. 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.

vi. 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.

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 Company.

- **Complete Discharge**

  Any payment to the 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.

C. Standard Conditions for renewal of the contract

Renewal Conditions:

i. The Policy is ordinarily lifelong renewable unless You or anyone acting on behalf of You has acted in a fraudulent manner or any misrepresentation under or in relation to this policy or renewal of the Policy poses a moral hazard.

ii. The Company shall endeavor to give notice for Renewal. however, We are not under obligation to give any notice for renewal.

iii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.

iv. Request for renewal along with requisite premium shall be received by Us before the end of the Policy Period.

v. Your premium will also change if any changes in Sum Insured and/or the terms

vi. A grace period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, any treatment availed for an Illness contracted during the grace period will not be admissible under the Policy. For Renewal received after completion of 30 days grace period, the policy would be considered as a fresh policy.

D. Grievances Redressal Procedure

If You may have a grievance that requires to be redressed, You may contact Us with the details of the grievance through:

For Queries / Service request Registration

Call SBI General Insurance on Toll Free - 1800 22 1111 / 1800 102 1111 Monday to Saturday (8 am - 8 pm).

Fax us at 1800 22 7244

Email us at customer.care@sbigeneral.in.

Visit us at any of our Branches

We will acknowledge receipt of your concerns & will respond to you within 72 hours.

Level 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

Level 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 Chairman of the Grievance Redressal Committee at: gro@sbigeneral.in. The Committee will look into the appeal and decide the same expeditiously on merits.

Level 3

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

Level 4

If Your issue remains unresolved You may approach IRDAI by calling on the Toll-Free no. 155255 or You can register an online complaint on the website http://igms.irda.gov.in

ANNEXURE I – COVERAGE SUMMARY

Product Type	Individual and Floater basis
Basis of Payment	Benefit basis
Policy Period	Minimum 12 months,after 12 months, in multiples of 1month, Maximum up to 60 months

Sr. No	Coverage Name	Benefit Amount/ Sum Insured limit/Sub-limit/	Deductible/Co-Payment	Hospital Daily Cash Limit Basis	Admissibility under Base cover
Base Cover					
1.	Accident and Sickness Hospital Cash Benefit	Per Day Hospital Daily Cash(HDC) limit 500/750/ 1000/1500/2000/ 2500/3000/3500/ 4000/4500/5000. Maximum no. of days options – 10/ 15/20/30/60/90/ 100	Base Deductible - 1 day Options: Deductible-2 days Franchise-1 day Franchise-2 days	Inbuilt	Yes
2.	Accident Hospital Cash Benefit	Twice the HDC limit per day Maximum no. of days options - 10, 15, 20, 30, 60, 90, 100	Base Deductible - 1 day Options: Deductible - 2 days Franchise-1 day Franchise-2 days	Inbuilt	Yes
3.	ICU Cash Benefit t	Twice the HDC limit per day max upto 15 days	Base Deductible 1 day Options: Deductible - 2 days	Inbuilt	Yes

				Franchise-1 day Franchise-2 days	
4.	Convalescence Benefit	5x HDC if hospitalization is more than 10 days Payable once in Policy Year per Person	NA	Over and Above	Yes
5.	Compassionate Benefit	10x HDC if accidental death whilst in hospital. Payable once in lifetime of the Insured Person	NA	Over and Above	Yes
6.	Day Care Treatment Benefit	5x HDC, subject to max of Rs. 10K per claim Maximum 2 Day Care Treatments will be payable per Insured Person in a Policy Year	NA	Over and Above	No
7.	Maternity Hospital Cash Benefit	Per day Hospital Daily Cash (HDC) limits (Rs.) – 500/750/1000/1500/2000/2500/3000/3500/4000/4500/5000 Max no of days - 5, 10 days Waiting period - 36 months	Base Deductible-1 day Options: Deductible-2 days Franchise-1 day Franchise-2 days	Over and Above	No
		Option to reduce Maternity waiting period: **Option 1**. 2 years **Option 2**. 1 year **Option 3**. 9 months **Option 4**. No maternity waiting period	NA		
8.	Other Waiting Period	**Option 1**: 30 days Waiting Period waiver **Option 2**: 2 years Specific illness waiting period **Option 3**: Specific illness Waiting Period Waiver **Option 4**: 1 year waiting period for Pre-Existing Diseases **Option 5**: 2 years waiting period for Pre-Existing Diseases **Option 6**: 3 years waiting period for Pre-Existing Diseases **Option 7**: No waiting period for Pre-Existing Diseases	NA	Not Applicable	Yes
9.	Increased Deductible /Franchise	Increase/Decrease Deductible/ Franchise for each and every claim Options: Deductible-2 days Franchise-1 day Franchise-2 days	NA	Not Applicable	Yes