SURAKSHA AUR BHAROSA DONO

Arogya Sanjeevani Policy, SBI General Insurance Company Limited

PROSPECTUS

Serious Illness or accident along with routine health problem may disturb the financial planning of an individual and Family. Arogya Sanjeevani Policy, SBI General Insurance Company Limited provides financial protection against medical costs due to hospitalisation.

Who Can Buy This Policy?

Arogya Sanjeevani Policy, SBI General Insurance Company Limited can be bought by any individual between the age of 18 Years to 65 Years on Individual and Family floater basis.

(Family means self, spouse, dependent children ,parents, parents in law)

Age Criteria

Minimum Entry Age: Adult - 18 Years, Dependent Children: 3 months

Maximum Entry Age: 65 Years, Dependent Children:25 Years

There is no exit age applicable to the policy. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals under family floater.

Scope of Cover

Section I - Hospitalization Cover

I.A. Base Cover

I.a.1 – Hospitalization Medical Expenses

a) Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the Sum insured subject to maximum of Rs.5000/- per day.

b) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

c) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital/and the Insured is discharged on the same day.)

d) Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

Other Expenses

a) Expenses incurred on treatment of Cataract subject to sub limit of 25% of Sum insured or Rs.40,000/- whichever is lower, per eye.

b) Dental treatment necessitated due to disease or injury.

c) Plastic surgery necessitated due to disease or injury.

d) All the day care treatments.

e) Expenses incurred on Road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

I.A.2 – Pre-Hospitalization Medical Expenses

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

I.a.3 – Post-Hospitalization Medical Expenses

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

I.a.4 – Ayush Treatments

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

I.a.5 – Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured orRs.40,000/-, whichever is lower, per each eye in one policy year.

I.A.6

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, 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
viii. Stereotactic radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

Period Of Insurance:

The policy can be issued for Annual Period Only

Co Pay:

5 % on all admissible claim amount.

RENEWAL BENEFITS:

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported). provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. 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 CB for Such insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where insured Persons Renew their expiring policy by splitting the Sum insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years. the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

Waiting Period

The Company shall not be 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:

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 36 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 the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First Thirty Days 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.

3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, Surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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 preexisting 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 on portability stipulated by IRDAI, then wating period for the same would be reduced to the extent of prior coverage.

i. 24 Months waiting period

1. Benign ENT disorder
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benig breast lumps.
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non-Infective Arthritis
15. Piles, Fissures, and Fistula in Anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of;

1. Investigation & Evaluation (Code- Excl04)

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

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

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

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

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.

3. 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 comorbidities following failure of less invasive methods of weight loss

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

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

5. Cosmetic or plastic Surgery: (Code- Excl08)

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

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

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

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code-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.

9. Treatment for, Alcoholism. drug or substance abuse or any addictive condition and consequences thereof **(Code- Excl 12)**
10. 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)**
11. 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)**

12. Refractive Error:(Code- Excl15)

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

13. 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.

14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility this includes:

(i) Any type of sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity Expenses (Code - Excl 18):

i. Medical treatment expenses traceable to childbirth (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.

16. 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.

17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

19. Treatment taken outside the geographical limits of India

20. 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.

Pre Policy Medical Examination And Loadings

1) Medical Examinations:

Medical Tests as indicated in the grid below are applied to those proposed insured person/s whose age is >45 years of age and/or where the proposed insured person/s is/are suffering from an existing medical condition (as mentioned in the proposal form or is identified so in the reports from the medical tests applied), additional medical test/s (depending upon the type of medical condition) may be applied for understanding the complete health condition.

Medical Testing Grid* Medical Tests	
ME	Medical Examination
ECG	Electrocardiogram
CBC	Complete Blood Count
ESR	Erythrocyte Sedimentation Rate
HbA1c	Glycated Hemoglobin
SGPT	Serum Glutamate Pyruvate Transaminase
Sr. Creatinine	Serum Creatinine
Urine Routine	Urine Routine
Total Lipids	Total Lipids

If the proposal is accepted, the Insurer will reimburse 50% of the cost incurred towards the medical tests so undertaken at the advice of the insurer.

2) Loadings:

a. We may apply Medical Underwriting loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

b. For Medical Age Band cases or cases with medical history will be subject to medical UW and will attract medical Loading on the premium, the maximum loading % will not exceed 100% of Base Premium under any policy

c. Medical Underwriting loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy.

d. We will inform You about the applicable Medical underwriting loading with time bound exclusion (if any) through a counteroffer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counteroffer letter. In case, you neither accept the counteroffer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

Renewal Conditions

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. 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.

Portability Benefits

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 30 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

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

Alterations In The Policy

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.

Cancellation And Free Look

1) Cancellation

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.

iii. The Company may cancel the Policy at any time on grounds of misrepresentation, nondisclosure 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.

2) Free Look:

i. 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.

ii. 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.

iii. 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.

iv. 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.

Grievance Redressal Procedure

Stage 1:

If you wish to register your grievances directly with us, you may write to us at head.customercare@sbigeneral.in or gro@sbigeneral.in or call our toll free number- 1800 102 1111. After examining the matter, final response would be conveyed within a period of 14 days from the date of receipt of your complaint. In our initial acknowledgement of receipt letter, we will provide the name and title of the person who is handling your Grievance. This person will have the authority necessary to investigate and resolve the Grievance.

For Senior Citizens:

Senior citizens can reach us through the following dedicated channels:

Email: Seniorcitizengrievances@SBIGeneral.in

Toll-Free Number: 1800 102 1111 (Available 24/7)

Details of our Grievance Redressal Officer is mentioned on our website at https://www.sbigeneral.in/grievance-redressal

Note: The Company shall endeavour to maintain the regulatory TAT of 14 days in resolving your grievances.

Alternatively, you may Register your grievance with the regulator through Bima Bharosa which is a grievance redressal platform provided by the Insurance Regulatory and Development Authority of India (IRDAI). You may access the Bima Bharosa Portal using the following link: https://bimabharosa.irdai.gov.in/Home/Home

Stage 2: Escalation to Insurance Ombudsman

If you feel that the response to your Grievance was unsatisfactory, or if you believe your concerns have not been adequately addressed by the company, you may escalate the matter to the Insurance Ombudsman.

Submit your Grievance online: https://www.cioins.co.in/Ombudsman

Automatic Change In Coverage

Not Applicable

Change In Sum Insured

Sum Insured can be changes (Increase and Decrease) only at the time of renewal for more detail please refer policy wordings.

Claim Procedure

1. Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,

ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre- authorization letter to the hospital after verification.

iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,

vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

2. Procedure for reimbursement of claims:

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

S. No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from of post hospitalization treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

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

Claim Documents

1. Claims 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

S. No	Type of Hospitalization	Notify Us or Our TPA (either at Our call centre or in writing)
1	Planned Hospitalization	within 48 hours of the Hospitalization but not later than discharge from the Hospital.
2	Emergency Hospitalization	within twenty-four (24) hours of Your admission to hospital or before discharge whichever is earlier
3	Diagnosis or actual undergoing of procedure	within 10 days from the date of occurrence of such event

The following details are to be provided to Us at the time of intimation of Claim:

- Health Card ID number
- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Hospitalisation/ Critical Illness
- Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)
- Date of Admission if applicable
- Any other information, documentation as requested by Us

1.A Claim Cashless Process

Cashless facility is available for Hospitalization only at our Network Provider. The Insured Person can avail Cashless facility at Network Provider, by presenting the health card as provided by Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card, any other identity proof as approved by Us).

1.A.1 For Planned Hospitalization

a. The Insured Person should at least forty-eight (48) hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

b. The Network Provider will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDAI.

c. The Network Provider shall electronically send the filled pre-authorization form along with all the relevant details to the twenty-four (24) hour authorization/cashless department of TPA along with contact details of the treating Medical Practitioner and the Insured Person.

d. Upon receiving the pre-authorization form and all related medical information from the Network Provider, the eligibility of cover under the Policy will be verified.

e. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the Network Provider. Wherever additional information or documents are required, the same will be called for from the Network Provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of six (6) hours from the receipt of last complete documents.

f. The authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any Co-Payment or Deductible and non- payable items if applicable.

g. The authorisation letter shall be valid only for a period of fifteen (15) days from the date of issuance of authorization In the event that the cost of Hospitalization exceeds the authorized limit as mentioned in the authorization letter:

a. The Network Provider shall request for an enhancement of authorisation limit.

b. Eligibility will be verified, and the enhancement will be evaluated on the availability of further limits.

c. In the event of a change in the treatment during Hospitalization of the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us.

At the time of discharge:

a. The Network Provider may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.

b. Upon receipt of the final authorisation letter, the Insured Person may be discharged by the Network Provider.

c. Ensure that the final authorization letter is signed by the Insured Person.

d. Ensure to take photocopies of relevant medical records for future reference.

1.A.2 For Emergency Hospitalization

a. The Insured Person may approach the Network Provider for Hospitalization

b. Insured Person will need to provide health card / health insurance Policy at hospital admission counter

c. The Network Provider shall forward the request for authorization to TPA within twenty-four (24) hours of admission to the Hospital or before discharge whichever is earlier.

d. In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating as per their norms.

e. The Network Provider shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued

The Network Provider will send the claim documents to TPA within fifteen (15) days from the date of discharge from Hospital. List of necessary claim documents to be submitted for Cashless are as following:

- Claim Form duly filled and signed
- Original signed pre-authorisation request
- Copy of authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original Hospital Main Bill along with break up Bill and original receipts
- Original Investigation Reports, X Ray, MRI, CT Films, HPE etc.
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted)

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

There can be instances where Cashless Facility may be denied for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to TPA which will be considered by Us subject to the Policy Terms &Conditions.

We in Our sole discretion, reserves the right to modify, add or restrict any Network Provider for Cashless services under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable/latest list of Network Provider on TPA's website or by calling call centre.

1.B Claim Reimbursement Process

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim to Our / TPA office not later than thirty

(30) days from the date of discharge from the Hospital. You can obtain a Claim Form from any of Our / TPA Offices or download a copy from Our website https://www.sbigeneral.in

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

What all is covered under this:		
Sr No	**List of Documents / Information**	
1	Duly Filled and Signed Claim Form	Y
2	Discharge Summary	Y
3	Medical Records (Indoor Case Papers, OT notes, PAC Notes etc.)	Y
4	Original Hospital Main Bill	Y
5	Original Hospital Bill Break-up	Y
6	Original Pharmacy Bills	Y
7	Prescriptions for the medicines purchased (except hospital supply) and investigations done outside the hospital	Y
8	Consultation Papers	Y
9	Investigation Reports	Y

10	Digital Images/CDs of the Investigation Procedures (if required)	Y
11	MLC/FIR Report (If applicable)	Y
12	Original Invoice/Sticker (If applicable)	Y
13	Post Mortem Report (If applicable	Y
14	Disability Certificate (If applicable)	Y
15	Attending Physician Certificate (If applicable)	Y
16	Ante-natal Record (If applicable)	Y
17	Birth Discharge Summary (If applicable	Y
18	Death Certificate (If applicable)	Y
19	KYC (Photo ID card, If applicable)	Y
20	Bank Details with Cancelled Cheque (If applicable)	Y

a. The above list is indicative, and We may call for any additional documents/ information/ subject the Insured Person to additional medical examinations as required to ascertain the admissibility of any Benefit including Optional Covers under the relevant Section of the Policy, based on the circumstances of the claim on a case to case basis.

b. Our branch offices shall give due acknowledgement of collected documents. In case there is a delay in the submission of claim documents, then in addition to the documents mentioned above, the claimant is also required to provide Us the reasons for such delay in writing. We shall condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the Policy Holder or Insured Person anyone claiming from their behalf, as the case may be. or Insured Person anyone claiming from their behalf, as the case may be.

Premium Payment in Instalments

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.

Revision And Modification Of The Policy Product

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

Withdrawal Of The Product

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the Policy has been maintained without a break.

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 **Fax No:** 1800227244, 18001027244	**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 **Fax No:** +91 20 49334525

SURAKSHA AUR BHAROSA DONO

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 the 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 published prospectus or tables of the insurer
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh rupees.