SURAKSHA AUR BHAROSA DONO

Arogya Supreme

PROSPECTUS

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

• Key Features of the Policy

1. Comprehensive Policy with 20 Basic Covers and 8 Optional covers
2. Multiple Sum Insured range from 1Lac to 5Cr available under the Policy.
3. Long term Policy options are available up to 3 years.
4. Flexi benefit option of co-pay is available to avail discount in premium.
5. Exclusive covers like Domestic air ambulance cover, Compassionate Benefit, Recovery benefit and E-Opinion cover.
6. NCB Protector optional cover is available to protect Cumulative Bonus and Enhanced Cumulative Bonus
7. Preventive Health Check-up cover is available as Renewal Benefit.
8. Options to pay yearly premium in Monthly, Half yearly and Annually.
9. Various discount options like family discount, loyalty discount, online policy discount, long term policy discount

• Age Criteria & Eligibility

	Minimum	Maximum
Adult	18 yrs.	65 yrs.
Child	91 days	25 yrs.

- Family includes Self, Spouse, Dependent Children, Dependent Parents or Dependent Parents-in-Law.
- Renewal age is lifelong.

• Type of Policy

- Individual basis
- Individual Family basis
- Family Floater Basis

• Plan

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

- Pro
- Plus
- Premium

• Scope of Cover

We will pay under below listed Covers on Hospitalization of an Insured Person on advise of Medical Practitioner, due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured and limits including Cumulative Bonus / Enhanced Cumulative Bonus, if applicable as specified on the Schedule of Coverage in the Policy Schedule subject to otherwise terms and conditions of the Policy.

A. Hospitalization Covers

1. In-patient Hospitalization Treatment:

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

a) Room rent and boarding expenses as provided by the Hospital/Nursing home subject to below limits
   - 1% of base Sum Insured (excluding cumulative / enhanced cumulative bonus)

     OR
   - Single private Air-Conditioned room

     OR
   - At actuals up to Sum Insured

b) Intensive Care Unit Expenses
   - 2% of the base Sum Insured (excluding cumulative / enhanced cumulative bonus)

     OR
   - up to actual ICU/ICCU expenses as provided by Hospital

     OR
   - At actual up to Sum Insured

c) Nursing Expenses as provided by the Hospital

d) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees

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

f) Consultation fees including Telemedicine by Medical Practitioner

g) Medicines, drugs, and consumables

h) Diagnostic procedures

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

Conditions

i. The Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.

ii. If You are admitted in an ICU category those specified in the Policy Schedule of this Policy, then proportionate deductions shall not be applicable on the total Associated Medical Expenses in the proportion of the ICU Charges.

iii. In case of admission to a room at rates exceeding the limits as mentioned under 1.a and 1.b, the reimbursement of all other Associated Medical Expenses incurred at the Hospital, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of room rent charges.

iv. Proportionate deductions shall not apply in respect of the Hospitals which do not follow differential billings or for those expenses in respect of which differential billing is not adopted based on the room category.

v. Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:			
Plan	**Pro**	**Plus**	**Premium**
Sum Insured Limit	1,00,000	6,00,000	25,00,000
	2,00,000	7,50,000	30,00,000
	3,00,000	10,00,000	35,00,000
	4,00,000	12,50,000	40,00,000
	5,00,000	15,00,000	45,00,000
		17,50,000	50,00,000
		20,00,000	75,00,000
			1,00,00,000
			1,50,00,000
			2,00,00,000
			2,50,00,000
			3,00,00,000
			3,50,00,000
			4,00,00,000
			4,50,00,000
			5,00,00,000

2. Mental Healthcare

If You are hospitalized for any Mental Illness contracted during the Policy Period, We will pay Medical Expenses -upto the limit as specified in Policy Schedule, under Section C.1 in accordance with The Mental Health Care Act, 2017, subsequent amendments and other applicable laws and Rules provided that;

i. The Hospitalization is prescribed by a Medical Practitioner for Mental Illness

ii. The Hospitalization is done in Mental Health Establishment

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

3. HIV / AIDS Cover

If You are diagnosed with HIV during the Policy Period and require Hospitalization under Section C.1 in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and amendments thereafter, then We will pay medical expenses up to the Sum Insured as specified in Policy Schedule.

i. Medical Expenses which are arise from or are in way related to Human Immunodeficiency Virus (HIV) and/ or HIV related illness and including Acquired Immune Deficiency Syndrome (AIDS) being maintained throughout or AIDS Related Complex (ARC) and/or any mutant the period, derivative or variations thereof.

ii. Medical Expenses as listed in Section C.1

Conditions

- Claim under Section C.1 is admissible under the Policy
- Any Expenses taken at OPD for the treatment on HIV/AIDS shall be excluded
- HIV /AIDS Cover shall be examined and confirmed by Medical Practitioner
- The stage of AIDS experienced by You shall be the first incidence during the Policy Period

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

4. Genetic Disorder

If You are hospitalized due to any genetic disorder illness, We will pay Medical Expenses as listed in A.1 maximum up to Rs. 1,00,000/- subjects to claim under A.1 is admissible under the Policy. Waiting period for this cover shall be applied as mentioned in waiting period. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

5. Internal Congenital Anomaly

If You are hospitalized due to any Internal Congenital diseases, We will pay Medical Expenses of 25% of Sum Insured as listed in A.1 subject to claim under A.1 is admissible under the Policy. Waiting period for this cover shall be applied as mentioned in waiting period.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

6. Bariatric Surgery Cover

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

Eligibility:

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

Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type 2 Diabetes

Conditions

i. Our maximum liability will be restricted to up to Sum Insured

ii. Bariatric surgery performed for Cosmetic reasons is excluded.

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

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

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

7. Advance Procedures:

We will pay Medically necessary Expenses either as In-Patient Hospitalization or as part of Day Care Treatment up to 25% of Sum Insured as specified in the Policy Schedule, incurred on Advance Procedures as below and not limited to the following:

i. Uterine Artery Emobalization and HIFU

ii. Balloon Sinuplasty

iii. Deep Brain Stimulation

iv. Oral Chemotherapy (covered as OPD also)

v. Immunotherapy - Monoclonal Antibody to be given as injection

vi. Intra Vitreal Injections

vii. Robotic Surgeries

viii. Stereotactic Radio Surgeries

ix. Bronchical 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)

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

8. Cataract Treatment

We will pay Medical Expenses incurred for treatment of Cataract as specified in the Policy Schedule, per eye including cost of lens during Policy Year, subject to claim admissible under the Policy. Waiting period for this cover shall be applied as mentioned in waiting period.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:		
Plan	**Pro**	**Plus / Premium**
Sum Insured limit	`50,000/- per eye	`1,00,000/- per eye

9. Pre-Hospitalization Cover:

We will pay Medical Expenses incurred by You up to the days as specified in Policy Schedule immediately before Your Hospitalization, provided that such Medical Expenses are incurred for same Illness/Injury for which subsequent hospitalization was required and claim under A.1 – Inpatient Hospitalization or A.11 – Domiciliary Hospitalization or A.12-Day Care Treatment or C.15 Alternative Treatment / AYUSH is admissible under the Policy.

We will pay expenses on reimbursement basis for the above cover.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:		
Plan	**Pro**	**Plus / Premium**
No of Days	30 days	60 days

10. Post-Hospitalization Cover:

We will pay Medical Expenses incurred by You up to the days as specified in Policy Schedule from the date of Your discharge from Hospital, provided that such costs are incurred in respect of the same Illness/Injury for which earlier Hospitalization was required and claim under A.1– In-patient Hospitalization or A.11 – Domiciliary Hospitalization or A.12-Day Care Treatment or C.15 Alternative Treatment/AYUSH is admissible under the Policy.

We will pay expenses on reimbursement basis for the above cover.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:			
Plan	**Pro**	**Plus**	**Premium**
No of Days	60 days	90 days	180 days

11. Domiciliary Hospitalization:

We will pay the Medical Expenses up to the Sum Insured as specified in the Policy Schedule, incurred on Domiciliary Hospitalization.

Condition

i. It has been prescribed by the treating Medical Practitioner and

ii. the condition the Insured Person is such that he/she could not be removed to a Hospital or

iii. the Medical Necessary Treatment is taken at Home on account of non-availability of room in Hospital or

iv. The Medical Practitioner advices the Insured Person to undergo treatment at home and continuous active line of treatment with monitoring of the health status by a Medical Practitioner for each day during treatment of Insured Person. All treatment records and chart should be duly signed by the Medical Practitioner.

Expenses incurred on Domiciliary Hospitalization in respect to following treatment are excluded under the Policy

i. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, at every sub-title,

ii. Arthritis, Gout and Rheumatism,

iii. Chronic Nephritis and Nephritic Syndrome,

iv. Diarrhea and all type of Dysenteries including Gastroenteritis,

v. Diabetes Mellitus and Insipidus,

vi. Epilepsy,

vii. Hypertension,

viii. Psychiatric or Psychosomatic Disorders of all kinds,

ix. Pyrexia of unknown Origin.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

12. Day Care Treatment

We will pay for the Medical Expenses under A.1 on hospitalization of Insured Person in Hospital or Day Care center for Day Care Treatment but not in the Outpatient department.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Note: For Indicative Day Care Procedures list refer Policy Wording.

13. Road Ambulance

We will pay for Road Ambulance services as specified in Policy Schedule, if You required;

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

ii. or from one Hospital to another Hospital

iii. of from Hospital to Home

Provided that claim under A.1 to A.8, A.12, A.14 or A.15, is admissible under the Policy.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:			
Plan	**Pro**	**Plus**	**Premium**
Sum Insured limit	`3,000/- per hospitalization	`5,000/- per hospitalization	`7,000/- per hospitalization

14. Organ Donor Expenses

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

Condition

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

ii. Inpatient Hospitalization claim is admissible for the Insured Person under A.1- In-Patient Hospitalization Treatment.

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

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

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment cover under C.6 is opted and specified in the Policy Schedule.

15. Alternative Treatment / AYUSH

We will pay Medical Expenses up to the Sum Insured as specified in the Policy Schedule, as listed under A.1 on Your Hospitalization in Hospital or AYUSH Hospital or AYUSH Day Care Centre for following Alternative Treatments prescribed by Medical Practitioner.

- Ayurvedic
- Yoga and Naturopathy
- Unani
- Siddha
- Homeopathy

Condition

i. The treatment cannot be taken on outpatient basis,

ii. The treatment has been undertaken in government Hospital or AYUSH Hospital or AYUSH Day Care Centre as defined in definition Section of Policy Wording

iii. Treatment taken is within India.

iv. AYUSH treatment shall be subject to the Guidelines and Standard Treatment Protocols issued by the Ministry of AYUSH, as applicable from time to time.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment as mentioned in C.6 is opted and specified in the Policy Schedule.

16. Recovery Benefit

We will pay lump sum amount as specified in the Policy Schedule upon Your Medically Necessary Hospitalization exceeding 10 consecutive and continuous days, provided that, claim is admissible under A.1 to A.7, A.14 or A.15

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

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

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

iv. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment as mentioned in C.6 is opted and specified in the Policy Schedule.

Sum Insured options available:			
Plan	**Pro**	**Plus**	**Premium**
Sum Insured limit	`5,000/- per hospitalization	`10,000/- per hospitalization	`15,000/- per hospitalization

17. Domestic Emergency Assistance Services (including Air Ambulance)

We will provide the Emergency medical assistance as below when You are travelling within India 150 kilometers or more away from Your residential address as mentioned in the Policy Schedule for domestic services.

A) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined

by the Emergency service provider, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.

B) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

We will not provide services in the following instances:

1) Travel undertaken specifically for securing medical treatment.
2) Injuries resulting from participation in acts of war or insurrection.
3) Commission of an unlawful act(s).
4) Attempt at suicide.
5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

We will not evacuate or repatriate an Insured Person in the following instances:

1) Without medical authorization.
2) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his/her trip or returning home.
3) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.
4) With mental or nervous disorders unless Hospitalized.

Conditions

I. No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.

II. We will pay expenses if claim is admissible under this cover of the Policy.

III. Please call our call center as specified in the Policy Schedule with details on the name of the Insured Person and/ or Policyholder and Policy number for availing this Benefit.

IV. Claim would be reimbursed up to the actual expenses subject to a maximum of Sum Insured as specified in the Policy Schedule.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment as mentioned in C.6 is opted and specified in the Policy Schedule.

The above cover is available under Plan Arogya Supreme-Plus and Premium only.

Sum Insured options available:			
Plan	**Pro**	**Plus**	**Premium**
Sum Insured limit	Not Available	up to 5 Lacs	up to 10 Lacs

18. Sum Insured Refill

We will refill 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured including Cumulative Bonus or Enhanced Cumulative Bonus (if applicable) during the Policy Year. The total amount (Basic Sum Insured, Cumulative Bonus and Enhanced Cumulative Bonus and Sum Insured Refill) will be available to all Insured Person for all claims under A.1 during the current Policy Year.

Conditions:

i. Single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and Cumulative / Enhanced Cumulative Bonus earned (if applicable)

ii. Sum Insured Refill is available only once during Policy Year.

iii. A claim is admissible under this Benefit only if the claim is admissible under A.1- In-patient Hospitalization Treatment.

iv. If the Refilled Sum Insured is not utilized in a Policy Year, it will expire.

v. This benefit will not be considered while calculating the Cumulative Bonus / Enhanced Cumulative Bonus

vi. In case of an Individual Policy, refill is available to each Insured Person and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

vii. If the Policy is issued on a floater basis, the Sum Insured Refill will be available on a floater basis for all Insured Persons in the family.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment as mentioned in C.6 is opted and specified in the Policy Schedule.

19. Compassionate Visit

In the event of Hospitalization exceeding 5 days, the cost of economy class air ticket up to 1% of Sum Insured or maximum up to Rs 20,000/- whichever is lower as specified in Policy Schedule, incurred by the Insured Persons "immediate family member" while travelling to place of Hospitalization from the place of origin / residence and back will be reimbursed.

"Immediate family member" would mean spouse, children, and dependent parent.

Condition

i. This benefit is applicable in the event of the Insured Person being Hospitalized at a place away from his usual place of residence as mentioned in Policy Schedule.

ii. This benefit is available for only one Immediate Family Member.

iii. This benefit is not applicable if Medical Treatment is taken under A. 11 – Domiciliary Hospitalization

iv. Sum Insured limit of this cover is over and above of the base Sum Insured.

v. This benefit amount will not reduce the Sum Insured.

vi. This is available per Hospitalization of each Insured Person.

vii. This benefit will cover only on reimbursement basis.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

Note: This cover is applicable only to Arogya Supreme – Plus and Arogya Supreme-Premium plan

20. E-Opinion

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

Condition:

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

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

ii. It is agreed and understood that You are free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

iii. Appointments to avail of this benefit shall be requested through Our Website or through calling Our call center on the toll-free number specified in the Policy Schedule.

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

v. The E-Opinion provided under this benefit shall be limited to the covered Illness and not be valid for any medico legal purposes.

vi. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

E-Opinion options available			
Plan	**Pro**	**Plus**	**Premium**
No of E-Opinion	4 E-Opinion during the Policy Period		Unlimited

B. Renewal Benefit

1. Preventive Health Check-Up:

You will be eligible for a preventive health check-up as listed below at every year from 1st renewal year during which You have held Our Arogya Supreme Policy irrespective of claims made under the Policy.

Sum Insured	Test	
1Lac to 5 Lac	Hematology:	CBC + Hemoglobin
	Diabetes Profile:	Fasting Blood Sugar or random Blood Sugar
	Lipid Profile:	Total Cholesterol
	Liver Function:	SGOT + SGPT
	Kidney / Renal Function:	Bun and Creatinine
6Lac to 20 Lac	Hematology:	CBC + Hemoglobin
	Diabetes Profile:	Fasting Blood Sugar or random Blood Sugar
	Lipid Profile:	Total Cholesterol + HDL + LDL + Triglycerides
	Liver Function:	SGOT + SGPT + Bilirubin Total
	Kidney / Renal Function:	Bun and Creatinine + Uric Acid
	Thyroid:	TSH
25Lacs and above	Haematology:	CBC + ESR + Haemoglobin + PS
	Diabetes Profile:	Fasting Blood Sugar + HbA1c
	Lipid Profile:	Total Cholesterol + HDL Cholesterol + LDL Cholesterol + Triglycerides
	Liver Function Tests:	SGOT + SGPT + Bilirubin Total
	Kidney / Renal Function:	Bun and Creatinine + Uric Acid
	Thyroid Profile:	T3+ T4+ TSH
	Urine Analysis:	Urine Complete Analysis
	Iron Deficiency:	Iron Profile
	Thyroid:	TSH

Reference of Test

- BUN - Blood Urea Nitrogen
- CBC – Complete Blood Count
- ESR - Erythrocyte sedimentation rate
- HDL – High Density Lipoprotein
- Hba1c - Glycated haemoglobin test
- LDL – Low Density Lipoprotein
- PS - Peripheral Smear
- SGOT - Serum glutamic oxaloacetic transaminase
- SGPT - Serum glutamic pyruvic transaminase
- TSH – Thyroid Stimulating Hormone

Other terms and Conditions applicable to this Benefit

i. This benefit cannot be carried forward if not utilized.

ii. For Family Floater, this cover will be applicable only to two (2) eldest members of the Family who are aged 18 years and above on the start date of Policy. For Individual, this cover will be applicable to each Insured Person who are aged above 18 years.

iii. This cover is applicable only to Insured Person covered under expiring Policy and who continue to remain insured in the subsequent Policy Year/renewal.

iv. Eligibility to avail this benefit, only if the Arogya Supreme Policy is renewed with Us.

v. Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Cumulative Bonus / Enhanced Cumulative Bonus

vii. The listed health check-ups shall be arranged by Us only on cashless basis through Our Network Providers. The request for the same can be raised through offline by sending the request on the dedicated email address or through Our Website or through calling Our call center on the toll-free number specified in the Policy Schedule.

vi. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representation made by Service Providers in relation to the health check-up.

2. Cumulative Bonus

On each Renewal of the Policy with Us, We will pay 15% of Basic Sum Insured under expiring Policy as Cumulative Bonus in the Policy provided that;

i. There has no claim under the Policy in expiring Policy Year under Section C

ii. Cumulative Bonus will be reduced at the same rate as accrued in the event of admissible claim under Section C of the Policy.

iii. Cumulative Bonus can be accumulated up to 100% of Basic Sum Insured

iv. Cumulative Bonus applied will be applicable only to Insured Person covered under the expiring Policy and who continue to remain insured in Renewal.

v. In case where the policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. Cumulative Bonus shall reduce in case of claim from any of the insured Persons.

vi. 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 Cumulative Bonus of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

vii. Cumulative Bonus shall be available only if the Policy is renewed / premium paid within the Grace Period.

viii. In case of multi-year policies, Cumulative Bonus that has accrued for the second and third Policy Year will be credited on Renewal. Accrued Cumulative Bonus may be utilized in case of any Claim during Policy Year.

Or

3. No Claim Discount

If opted, We shall provide a percentage of discount in premium at the renewal of the Policy, for each completed and continuous Policy Year, provided no claim has been made in the expiring Policy Year.

Note: 1. Insured Person can opteither Benefit D.2. Cumulative Bonus or Benefit D.3. No Claim Discount, if no claim has been made under the expiring Policy by any of the covered Insured Person(s).

2. If Insured Person opts for the No Claim Discount benefit, then the earned Cumulative Bonus shall become Nil.

3. If Insured Person opts to change the benefit from No Claim Discount to Cumulative Bonus at the time of renewal, the Cumulative Bonus will be reset to Nil and will commence afresh, regardless of the number of Claim-free Policy Years accumulated prior to the change.

C. OPTIONAL COVERS:

In consideration of payment of additional premium or reduction in the premium as applicable, it is hereby and agreed that We will pay/restrict the Sum Insured/expenses under below listed covers subject to all other terms, conditions, exclusion, and waiting period applicable to the Policy.

The below covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned in Policy Schedule.

1. Hospital Cash Benefit

We will pay per day Sum Insured up to maximum Number of days and in manner as specified in the Policy Schedule, if the Medically Necessary Hospitalization exceeds 24 hours, provided that, the claim is admissible under Section C.1 under this Policy.

Condition:

i. A deductible of 24 hours shall apply under this Benefit; thus, the benefits shall become payable only after the completion of the first 24 hours of Hospitalization of the Insured Person.

ii. In case of ICU hospitalization, We will pay per day Sum Insured maximum of 2 times of Hospital Cash Limit as specified in Policy Schedule

iii. Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule irrespective of the type of Policy.

iv. Payment under this benefit will not reduce the base sum insured mentioned in policy Schedule.

v. This benefit will be applicable each year for policies with term more than 1 year.

vi. This cover is on benefit basis and no cashless facility will be extended for this cover.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

Hospital Cash Benefit options available:				
Option	**1**	**2**	**3**	**4**
Benefit Amount	`500/-	`1,000/-	`2,500/-	`5,000/-
Number of days	5 days	10 days	15 days	45 days

2. Major Illness Benefit

We will pay 100% of Sum Insured or maximum up to `25,00,000/- whichever is lower as specified in the Policy Schedule, If the Insured Person who is aged 18 years or above covered under this Policy suffers from Major Illness as listed below (defined in Definition Section A.37), whose diagnosis first occurs after the applicable Waiting Period from commencement of the first Policy with Us.

List of Major Illness			
1	Cancer of specified severity	16	Major head Trauma
2	Open Chest CABG	17	Apallic Syndrome
3	Open Heart Replacement or Repair OF Heart Valves	18	Alzheimer's Disease
4	Myocardial Infarction (First Heart Attack of specific severity)	19	Blindness
5	Primary (Idiopathic) Pulmonary Hypertension	20	Major Organ / Bone Marrow Transplant
6	End Stage Lung Failure	21	Third Degree Burns
7	Surgery of Aorta	22	Deafness
8	Stroke Resulting In Permanent Symptoms	23	Loss of Speech
9	Permanent Paralysis Of Limbs	24	Aplastic Anaemia
10	Multiple Sclerosis With Persisting Symptoms	25	Bacterial Meningitis
11	Benign Brain Tumor Benign Brain Tumor	26	Loss Of Independent Existence
12	Parkinson's Disease	27	Kidney Failure Requiring Regular Dialysis
13	Brain Surgery	28	End Stage Liver Failure
14	Motor Neuron Disease with Permanent Symptoms	29	Encephalitis
15	Coma Of Specified Severity	30	Fulminant Viral Hepatitis

Survival Period

Claim under this Cover is payable only if Insured Person survives 30 days from the diagnosis, fulfillment of the definition of the Major illness covered and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post-mortem)

Condition:

i. The coverage under this benefit shall cease to exist upon occurrence of any one Major Illness covered for which Claim is admitted by the Company.

ii. Benefits under this Section shall be available on an individual basis to each eligible Insured Person above the age of 18 years up to the limits specified in the Policy Schedule irrespective of the type of Policy.

iii. Any Pre-existing Major illness will not be covered.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

3. Additional Sum Insured for Accidental Hospitalization

We will provide an additional 1.5 times, or 2 times of base Sum Insured towards Medical Expenses incurred for In- Patient Hospitalization Treatment as given in Section C.1, as specified in the Policy Schedule. This cover applicable only an Emergency caused solely and directly due to an Accident-causing Injury, of the Insured Person who is Hospitalized for the treatment of such Injury.

Provided that,

i. This Benefit shall be utilized only after base Sum Insured has been completely exhausted.

ii. This benefit shall be available only once during the Policy Year.

iii. This benefit shall be available only for such Insured Person for whom Accidental Hospitalization claim is accepted under this Policy.

iv. Sum Insured Refill will not apply to this cover.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under C.6 is opted and specified in the Policy Schedule.

4. Enhanced Cumulative Bonus

On availing of this option, Cumulative Bonus percentage mentioned under B.2 – Cumulative Bonus will stand modified by 25% or 50% maximum up to 200% of basic Sum Insured as specified in Policy Schedule subject to;

i. All other terms, condition of Renewal Benefit B-2 shall remain unaltered.

ii. This benefit shall be available only if D.2. Cumulative Bonus has been opted under the Policy and shall not be available when benefit D.3. No Claim Discount is opted.

Enhanced Cumulative Bonus Options available:			
Plan	**Pro**	**Plus**	**Premium**
Limit of Enhanced Cumulative Bonus	25% up to a maximum of 200%	50% up to a maximum of 200%	50% up to a maximum of 200%

5. No Claim Bonus Protector

On availing of this option, We will protect the percentage of Cumulative Bonus and Enhanced Cumulative bonus as specified in the Policy Schedule at subsequent renewal.

Provided that,

i. Claim amount shall not be exceeding 50,000 in expiring Policy.

ii. This benefit shall be available only if D.2. Cumulative Bonus has been opted under the Policy and shall not be available when benefit D.3. No Claim Discount is opted.

6. Co-Payment

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

7. Any Room Upgrade

On availing this option at inception, the Insured Person shall be eligible to upgrade the room type category, eligibility to any Room in a hospital excluding suite and above.

Provided that claim under A.1 is admissible under the Policy.

Note: This option is available for Sum Insured 5 Lacs to 20 Lacs only

8. Deductible

The Insured Person shall bear on his/her own account an amount equal to the opted deductible specified in the Policy Schedule for any admissible claim amount.

Condition:

i. Our liability to make payment under the Policy in respect of any claim made in the Policy Year will only commence once the deductible has been exhausted.

ii. You may opt for deductible only at the inception of the Policy.

iii. Deductible under this section shall not apply to any claim under A.3 (HIV/AIDS Cover), A.4 (Genetic Disorder), A.5 (Internal Congenital Anomaly), A.7 (Advance Procedure), A.8 (Cataract Treatment), A.13 (Road Ambulance), A.16 (Recovery Benefit), A.17 (Domestic Emergency Assistance Services), A.19 (Compassionate Visit), A.20 (E-Opinion).

iv. A Deductible does not reduce the Sum Insured.

Note: On availing of this cover at inception Insured Person is eligible for discount on premium as below.

Deductible 10K							
Sum Insured	**0-18**	**19-35**	**36-45**	**46-55**	**56-60**	**61-65**	**66-70**
100,000	62%	42%	36%	33%	32%	31%	31%
200,000	46%	30%	27%	25%	23%	23%	20%
300,000	41%	27%	22%	20%	20%	19%	16%
400,000	39%	26%	19%	18%	18%	17%	16%
500,000	31%	23%	18%	16%	16%	15%	13%
600,000	28%	21%	17%	15%	15%	14%	12%
750,000	25%	20%	15%	13%	13%	13%	10%
1,000,000	22%	18%	13%	12%	12%	11%	9%
1,250,000	20%	16%	12%	11%	11%	10%	8%
1,500,000	19%	15%	11%	10%	10%	9%	7%
1,750,000	17%	15%	11%	9%	9%	9%	7%
2,000,000	16%	14%	10%	9%	9%	8%	6%
2,500,000	15%	13%	9%	8%	8%	7%	5%
3,000,000	14%	12%	8%	7%	7%	7%	5%
3,500,000	13%	11%	8%	7%	7%	6%	5%
4,000,000	12%	11%	7%	6%	6%	6%	4%
4,500,000	11%	10%	7%	6%	6%	6%	4%
5,000,000	11%	10%	7%	6%	6%	6%	4%
7,500,000	9%	9%	6%	5%	5%	5%	3%
10,000,000	8%	8%	5%	4%	4%	4%	3%
15,000,000	6%	7%	4%	3%	4%	3%	2%
20,000,000	6%	6%	4%	3%	3%	3%	2%
25,000,000	5%	6%	3%	3%	3%	3%	2%
30,000,000	5%	5%	3%	3%	3%	2%	1%
35,000,000	4%	5%	3%	2%	3%	2%	1%
40,000,000	4%	5%	3%	2%	2%	2%	1%
45,000,000	4%	5%	3%	2%	2%	2%	1%
50,000,000	4%	4%	3%	2%	2%	2%	1%

Deductible 25K							
Sum Insured	**0-18**	**19-35**	**36-45**	**46-55**	**56-60**	**61-65**	**66-70**
100,000	88%	75%	69%	65%	65%	65%	67%
200,000	77%	60%	55%	51%	49%	49%	43%
300,000	72%	56%	47%	43%	43%	43%	37%
400,000	72%	53%	41%	39%	40%	38%	36%
500,000	59%	49%	39%	36%	35%	34%	29%
600,000	56%	47%	36%	34%	33%	32%	27%
750,000	53%	44%	34%	31%	30%	29%	24%
1,000,000	49%	41%	30%	28%	27%	26%	21%
1,250,000	46%	39%	28%	26%	25%	24%	19%
1,500,000	43%	37%	26%	24%	23%	22%	17%
1,750,000	42%	35%	25%	23%	22%	21%	16%
2,000,000	40%	34%	24%	22%	21%	20%	15%
2,500,000	38%	32%	22%	20%	19%	18%	13%
3,000,000	36%	31%	20%	18%	18%	17%	12%
3,500,000	34%	30%	19%	17%	17%	16%	11%
4,000,000	33%	29%	18%	17%	16%	15%	11%
4,500,000	32%	28%	18%	16%	15%	14%	10%
5,000,000	31%	27%	17%	15%	15%	14%	9%

Deductible 25K							
Sum Insured	**0-18**	**19-35**	**36-45**	**46-55**	**56-60**	**61-65**	**66-70**
7,500,000	28%	24%	15%	13%	12%	12%	8%
10,000,000	26%	23%	13%	12%	11%	10%	7%
15,000,000	23%	20%	11%	10%	10%	9%	6%
20,000,000	21%	19%	10%	9%	9%	8%	5%
25,000,000	20%	18%	10%	8%	8%	7%	4%
30,000,000	19%	17%	9%	8%	7%	7%	4%
35,000,000	18%	16%	8%	7%	7%	6%	4%
40,000,000	17%	16%	8%	7%	7%	6%	3%
45,000,000	17%	15%	8%	7%	6%	6%	3%
50,000,000	16%	15%	7%	7%	6%	6%	3%

• Waiting Period and Exclusions

1. Waiting Periods

We are not liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

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

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

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

c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Note: The above waiting period shall not be applicable for claims arising due to COVID-19, Major Illness-Benefit, Hypertension, Diabetes and Cardiac Condition. Waiting period specific to these ailments are mentioned below in IV, V, VI.

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

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

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

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

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

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

A. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. Kidneystone, Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/fistula in anus, Hemorrhoids including
Pilonidal sinus	Gout and rheumatism
Benign tumors, cysts, nodules, polyps including breast lumps	Osteoarthritis and osteoporosis
Polycystic ovarian diseases	Fibroids (fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate
Genetic Disorder	

B. Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy
Dilatation and curettage (D&C)	Nasal concha resection
Myomectomy for fibroids	Surgery of Genito urinary system
Surgery on prostate	Cholecystectomy
Hernia	Hydrocele/Rectocele
Surgery for prolapsed inter vertebral disc	Joint replacement surgeries
Surgery for varicose veins and varicose ulcers	Surgery for Nasal septum deviation
Surgery for Perianal Abscesses	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries

III) Pre-Existing Diseases (Code-Excl01):

a) Expenses related to the treatment of a Pre-Existing Diseases (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 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.

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

V) Major Illness-Benefit: A waiting period of 90 days shall apply for all claims under Major Illness Benefit

VI) COVID 19 – A waiting period of 15 days shall apply for all claims of COVID 19.

2. Standard Exclusions

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

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

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

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

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

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

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

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

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

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

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

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type 2 Diabetes

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

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

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

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

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

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

VII. Breach of Law (Code- Excl 10)

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

VIII. Excluded Providers (Code-Excl 11)

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

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

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

XI. Dietary Supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care Procedures. (Code-Excl 14)

XII. Refractive Error (Code-Excl 15)

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

XIII. Unproven Treatments (Code- Excl 16)

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

XIV. Sterility and Infertility (Code-Excl 17)

Expenses related to sterility and infertility. This includes:

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

iv. Reversal of sterilization

XV. Maternity (Code-Excl 18)

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

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

XVI. 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.

XVII. 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.

XVIII. Treatment taken outside India.

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

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

XXI. Vaccination or inoculation except as part of post-bite treatment for animal bite.

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

XXIII. Dental treatment and surgery of any kind, unless requiring inpatient Hospitalization.

XXIV. An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self-Injury, or attempted suicide while sane or insane.

XXV. Any treatment taken on outpatient basis except specific conditions which can be taken on outpatient basis only and claims are approved by the Company.

XXVI. All Non-Medical Expenses as per Annexure-2 of the Policy.

XXVII. 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.

• Period of Insurance

The policy can be issued for a tenure of 1 / 2/ 3 Years.

• Rating Factors

- Age of the Insured Person
- Sum Insured
- Plan Type
- Address of Insured Person

• Discount and Loading

Discount Type	Discount % on Premium
Online Discount / Direct business discount	10%
Additional Family Member Discount (Non-Floater Basis)	5% for 2 or more adult members
Loyalty discount	2.5%
*Employee discount	5%
Policy Tenure Discount	2 years Policy: 4%
	3 years Policy: 6%
Regional Discount	For Zone 2 region: 30%
Co-Pay Discount	10% Co-Pay: 15% discount
	20% Co-Pay: 30% discount

*Employee discount is applicable only for permanent employee of SBI Group of companies.

Loading Type	Loading % on Premium
Premium Payment Mode Loading	Monthly or Quarterly – 2%

• 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.

• 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.

• Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance Policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy. Wherever, the Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Sums Insured only on the enhanced limits.

• 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.

• 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.

• Premium Payment In Installment

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

i. Grace Period would be given to pay the instalment premium due for the Policy. In case of monthly instalment option, a Grace Period of 15 days is applicable. Whereas, in case of Single, Half Yearly, Quarterly instalment options, a Grace Period of 30 days is applicable.

ii. During such Grace Period, coverage will be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Periods for Pre-existing Diseases, Moratorium period etc in the event of payment of premium within the stipulated Grace Period

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a Claim, all subsequent premium instalments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending instalments from the Claim amount due under the Policy.

Option	Installment Premium Option
Option 1	Half yearly
Option 2	Quarterly
Option 3	Monthly
Option 4	Single

• Premium Zones

For the purpose of Policy issuance, the premium will be computed basis the city of residence provided by the Insured Person in the proposal form. Classification of cities would be as under:

Zone 1 – Mumbai & MMR/Pune/Ahmadabad/Delhi & NCR/ Kolkata/ Chennai/ Bangalore / Hyderabad

Zone 2 - Rest of India

Note: Insured Person of any zone can be availed Pan-India Treatment without any Co-Pay.

• Sequence Of Sum Insured Utilisation

The utilization of Sum Insured and limits thereof as applicable across various Benefits shall be as follows:

a. Sum Insured

b. Accumulated Cumulative Bonus / Enhanced Cumulative Bonus (as applicable)

c. Refill of Sum Insured

In the aforesaid sequence of utilization of Sum Insured, in case insured person has utilized a specific limit or is not eligible for a specific limit, then may choose to utilize from the next available limit in the given sequence as may be applicable.

• Implants, Medicines & Medical Devices – Statutory Price Compliance

The liability of the Company towards the cost of medicines, implants, stents, surgical devices or consumables shall be limited to the ceiling prices notified by the National Pharmaceutical Pricing Authority (NPPA) https://nppa.gov.in/medicaldevices-2 or any other competent statutory authority, wherever applicable, along with applicable taxes. Any amount charged by the hospital in excess of such notified ceiling prices shall not be payable by the Company.

• Cancellation Of Policy

a) Cancellation by you -

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

i. refund proportionate premium for unexpired Policy Period, if the term of Policy upto one year and there is no Claim (s) made during the Policy Period.

ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

b) Cancellation by Us

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, nondisclosure of material facts or fraud.

c) Free Look Period

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.

• Underwriting And Loadings

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

ii. The maximum risk loading applicable for an individual shall not exceed above 100% per Insured Person. Loadings will be applied from the Inception Date of the first Policy including subsequent Renewals. There will be no loadings based on individual claims experience on Renewals for the Policies Renewed with Us continuously without any break.

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

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

• Pre-Policy Medical Examination

Pre-policy medical check-up may be required for Sum Insured 50Lac and above, if You are aged above 45 years and You are suffering from an existing medical condition (as disclosed in proposal form), additional medical check-up may be applied for understanding the complete health condition.

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

- Medical tests will be facilitated by Us through Tele MER and full cost of all such tests will be borne by Us for all accepted or rejected proposals.

  OR

  You may undergo for medical tests as suggested by Us. In case of acceptance of Your proposal by Us then We will reimburse 50% of the cost incurred by You for such medical test.

• Claim Process:

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

Procedures	Cashless Hospitalization	Reimbursement Claims
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website or Our TPAs Website	
Claim Intimation timelines	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier.
Particulars to be provided to us for Claim notification	1. Policy Number 2. Name of the Insured Person(s) named in the Policy schedule / Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner Hospital 5. Date and time of event if applicable 6. Date of admission	
Particulars to be provided for preauthorization	1. Policy Number 2. Name of the Insured person(s) named in the Policy schedule availing treatment 3. Nature of disease/Illness/Injury 4. Name and address of the attending 5. Medical Practitioner/ Hospital 6. Date of admission & probable date of discharge 7. Approximate Claim Expenses 8. Treatment Details 9. Claim Form / Pre-Authorization Request form 10. Any other relevant information as required 11. cKYC Form and KYC Documents	Not Applicable
Process for obtaining Pre-Authorization	I. If the particulars are not provided in full or are insufficient for us to consider the request in Pre-defined Claim Form, We will request additional information or documentation II. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may;· • Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or • Reject the request for preauthorization specifying reasons for the rejection.	Not Applicable
List of Documents	Not Applicable	As listed below

• List of Documents for Reimbursement Claims:

1. Duly filled and signed claim form
2. Certified copy of Hospital discharge Summary
3. Certified copy of final hospital bill, pharmacy bills, Investigation labs bills
4. All original reports of Investigations done
5. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form with cKYC Form
6. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
7. Certified copy of Death certificate issued by municipal authority (in case of death of insured)
8. KYC details and Documents

• List of Documents for Major Illness Benefit Cover

1. Duly filled and signed claim form
2. Certified copy of first hospital consultation & first diagnostic report
3. Certified copies of hospital treatment records, investigation reports and follow up details with Medical assessment certificate (if applicable)
4. In case of death, certified copy of death certificate, Medical certificate of cause of death
5. Duly filled and signed Central KYC Registry form (applicable for benefit of Rs 1,00,000 & above)
6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable for benefit of Rs 1,00,000 & above)
7. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.

• List of Documents for Hospital Daily Cash Cover

1. Duly filled and signed claim form
2. Certified copy of Hospital discharge Summary with pre & post hospitalization consultation details (if any)
3. Certified copy of Diagnostic report confirming diagnosis.
4. Certified copy of final hospital bill with detailed break up
5. Duly filled and signed Central KYC Registry form (applicable only in case of benefit above Rs 1 Lakh)
6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable only in case of benefit above Rs 1 Lakh)
7. Beneficiary (Primary Insured) bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.

Note:

- Case specific additional documents may be requested if required for justified claim decision & processing.
- Certified copies of document meaning documents attested by any vested authority (e.g. Notarized Documents, attested from Gazetted officer, SBI Branch Manager, Special Executive officer, any officer who is having authority of attestation of documents).

• Claim Document Submission Address

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

Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team
SBI General Insurance Company Limited,
9th Floor, Westport, Pan Card Club Road, Baner,
Pune, Maharashtra – 411 045

• Conditions for obtaining Cashless Facility:

i. Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers and empanelled Service providers are available on Our Website and can be obtained by Contacting Our TPA.

ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.

iv. We will make payment for the Cashless authorized amount directly to the Network Provider.

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

• Claim documents submission:

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

• 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.

• Claim Settlement

i. The Company shall settle or reject a claim within 15 days from the date of receipt of Claim submission.

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 Claim Submission to the date of payment of claim at a rate 2% above the bank rate.

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

• Payment of Claim

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

• TPA Facilitator

All Claim related documents need to be sent to below address:

Accident & Health Claims team

SBI General Insurance Company Limited

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

Pune, Maharashtra – 411 045.

• Renewal Process

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.

• 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

• Portability

The Insured Person will have the option to port the Policy to other Insurers by applying to such Insurer to port the entire Policy along with all the members of the Family, if any, at least 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

• Anti Rebating Warning

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 punishable with fine which may extend to Ten Lakh rupees

• 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

CONTACT US

For any product or service related information or assistance, here's how you can reach 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

DISCLAIMER

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

Annexure attached to this Prospectus:

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

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (`)	Sum Insured (`)	Premium (`)	Discount, if any Family member discount)	Premium after Discount (`)	Sum Insured (`)	Premium or consolidated premium for all members of family (`)	Floater discount if any	Premium after discount (`)	Sum Insured (`)
35 yrs	6580	500000	6580	5%	6251	500000	42794	0	42794	500000
30 yrs	6580	500000	6580	5%	6251	500000				
15 yrs	4109	500000	4109	5%	3904	500000				
10 yrs	4109	500000	4109	5%	3904	500000				
60 yrs	17552	500000	17552	5%	16674	500000				
55 yrs	12085	500000	12085	5%	11481	500000				
Total Premium for all members of the Family is `51015/- when each member is covered separately. Sum Insured available for each individual is `5,00,000/-			Total Premium for all members of the Family is `48,464/- when they are covered under a single policy. Sum Insured available for each family member is `5,00,000/-				Total Premium when policy is opted on floater basis is `42794/- Sum Insured of `5,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Pro Plan.
- For premium calculation, a family size of 6 members is considered (2 Adult + 2 Dependent Child + 2 Dependent Parents).
- Illustration is given for Sum Insured ₹ 5Lac
- Premium is calculated for Zone 2 for illustration purpose

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (`)	Sum Insured (`)	Premium (`)	Discount, if any Family member discount)	Premium after Discount (`)	Sum Insured (`)	Premium or consolidated premium for all members of family (`)	Floater discount if any	Premium after discount (`)	Sum Insured (`)
35 yrs	10254	1500000	10254	5%	9741	1500000	71647	0	71647	1500000
30 yrs	10254	1500000	10254	5%	9741	1500000				
15 yrs	6463	1500000	6463	5%	6140	1500000				
10 yrs	6463	1500000	6463	5%	6140	1500000				
60 yrs	27661	1500000	27661	5%	26278	1500000				
55 yrs	19072	1500000	19072	5%	18118	1500000				
Total Premium for all members of the Family is `80,167 /- when each member is covered separately. Sum Insured available for each individual is `15,00,000/-			Total Premium for all members of the Family is `76,159 /- when they are covered under a single policy. Sum Insured available for each family member is `15,00,000/-				Total Premium when policy is opted on floater basis is `71,647/- Sum Insured of `15,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Plus Plan.
- For premium calculation, a family size of 6 members is considered (2 Adult + 2 Dependent Child + 2 Dependent Parents).
- Illustration is given for Sum Insured ₹15 Lac
- Premium is calculated for Zone 2 for illustration purpose.

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (`)	Sum Insured (`)	Premium (`)	Discount, if any Family member discount)	Premium after Discount (`)	Sum Insured (`)	Premium or consolidated premium for all members of family (`)	Floater discount if any	Premium after discount (`)	Sum Insured (`)
35 yrs	13204	2500000	13204	5%	12544	2500000	87350	0	87350	
30 yrs	13204	2500000	13204	5%	12544	2500000				
15 yrs	8341	2500000	8341	5%	7924	2500000				
10 yrs	8341	2500000	8341	5%	7924	2500000				
60 yrs	35218	2500000	35218	5%	33457	2500000				
55 yrs	24353	2500000	24353	5%	23135	2500000				
Total Premium for all members of the Family is `102,661/- when each member is covered separately. Sum Insured available for each individual is `25,00,000/-			Total Premium for all members of the Family is `97,528/- when they are covered under a single policy. Sum Insured available for each family member is `25,00,000/-				Total Premium when policy is opted on floater basis is `87,350/- Sum Insured of `25,00,000/- is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Premium Plan.
- For premium calculation, a family size of 6 members is considered (2 Adult + 2 Dependent Child + 2 Dependent Parents).
- Illustration is given for Sum Insured ₹25 Lac
- Premium is calculated for Zone 2 for illustration purpose.