SURAKSHA AUR BHAROSA DONO

GROUP HEALTH INSURANCE POLICY

POLICY WORDING

PREAMBLE

This Policy is issued to the Insured based on the Proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, to Insurer upon payment of the Premium. This Policy records the agreement between Insurer and Insured and sets out the terms of insurance and the obligations of each party.

The Policy, the Schedule and any Endorsement shall be read together and any word or expression to which a specific meaning has been attached in any part of this Policy or of Schedule shall bear such meaning whenever it may appear.

Subject to the terms, Conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, Insurer undertakes to pay the Insured Person the hospitalization expenses arising out of an Injury or Illness/Disease and that are reasonably and necessarily incurred by or on behalf of such Insured Person, but not exceeding the sum Insured for the insured person as mentioned in the schedule of the policy. The following benefits are covered under this policy subject to the sub-limits as stipulated in the policy contract.

1. Room, Boarding Expenses
2. Medical Practitioners fees
3. Intensive Care Unit
4. Nursing Expenses
5. Surgical fees, operating theatre, Anesthetist, Anesthesia, Blood, Oxygen and their administration,
6. Physio therapy while being treated as inpatient and being part of the treatment.
7. Drugs and medicines consumed during hospitalization period.
8. Hospital miscellaneous services (such as laboratory, X-ray, diagnostic tests)
9. Dressing, ordinary splints and plaster casts.
10. Cost of Prosthetic devices if implanted during a surgical procedure.

Note: Insurer's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured for the Insured person as mentioned in the schedule.

DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the feminine wherever the context so permits:

"Accident" means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

"Administrator" means any third party administrator engaged by the Insurer for providing Policy and claims facilitation services to the Insured as well as to the Insurer and who is duly licensed by IRDA for the said purpose.

"Age" means completed years as at the Commencement Date of the Policy Period.

"Alternative treatments" mean forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

"Any One Illness" means any continuous period of illness and it includes a relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Associated Medical Expenses shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/ surgeon/ anaesthetist/ Specialist conducted within the same Hospital where the Insured Person has been admitted. The below expenses are not part of associate medical expenses

a. Cost of Pharmacy and consumables
b. Cost of implants and medical devices
c. Cost of diagnostics

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

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

Or

c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clocks;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out,
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Break in policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

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

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

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

"Critical Illness" means an illness, sickness or a disease or a corrective measure like Cancer of specified severity, Open Chest CABG, Aorta Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Stroke Resulting in Permanent Symptoms, First Heart Attack – Of Specified Severity, Kidney Failure Requiring Regular Dialysis, Primary Pulmonary Arterial Hypertension, Major Organ/ Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Coma of Specified Severity, Total Blindness and Permanent Paralysis of Limbs all all as defined in Scope of Cover & Benefits section of this Policy.

"Critical Illness Benefit" means the amount specified in the Schedule, which is the maximum amount for which Insurer may be liable to make payment for any or all Critical Illnesses covered subject to terms & conditions under this Policy and as stated in the Policy Schedule.

"Condition Precedent" means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

"Complaint or Grievance" means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

"Co-Payment" means a cost-sharing requirement under a health insurance policy that provides that a policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

"Cumulative Bonus" means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

"Day care Treatment" refers to medical treatment, and/or surgical procedure which is:

a. undertaken under General or Local Anesthesia in a Hospital/ Day care centre in less than 24 hrs because of technological advancement, and

b. which would have otherwise required a Hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

a. has qualified nursing staff under its employment

b. has qualified medical practitioner (s) in charge

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

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

"Diagnostic Centre" means the diagnostic centers which have been empanelled by Insurer (or Administrator) as per the latest version of the schedule of diagnostic centers maintained by Insurer, which is available to Insured on request.

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

"Dental treatment" means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

"Dependent Child/Children" means children / a child (natural or legally adopted), who are/is financially dependent on the Insured or Proposer aged between 3 months twenty three (23) years and who are unmarried.

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

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

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

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

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

iii. it requires your rehabilitation or for you to be specially trained to cope with it

iv. it continues indefinitely

v. it recurs or is likely to recur

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

a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b. the patient takes treatment at home on account of non availability of room in a hospital.

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

"Eligible Hospitalisation Expenses" means the expenses which the Insured/Insured Person is entitled to applicable room rent and other charges as given in the scope of cover under the policy.

"Emergency Care" means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

"Epidemic Disease" means a Disease which occurs when new cases of a certain Disease, in a given human population, and during a given

period, substantially exceed what is the normal "expected" Incidence Rate based on recent experience (the number of new cases in the population during a specified period of time is called the "Incidence Rate").

"Family" means and includes Insured Person/Insured Person's legal Spouse, Insured Person's legal & dependent children, Insured Person's legal & dependent siblings and dependent parents or dependent parents-in-law.

"Grace period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases.

Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

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

"Group" means any association of persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. Non-employer-employee groups, like employee associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add on benefit, borrowers of a bank, professional associations or societies may also be treated as a group. However, an association of persons coming together with a purpose of availing an insurance cover, will not be treated as a group for the purpose of this policy.

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

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
c. has qualified Medical Practitioner (s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out.
e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

"Hospitalisation" means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

"Insured" means the group of persons/Corporate/organization/ institution/firm/society/ other entity engaged in any trade or business in India on whose name the Policy is issued named as Insured in the Schedule.

"Insured Person" means the person named in the Schedule/who is a resident of India and for whom the insurance is proposed and appropriate premium paid.

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

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

"Inpatient Care" means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

"Maternity expenses" shall include—

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
b. expenses towards lawful medical termination of pregnancy during the policy period.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"Medical Expenses" means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

"Medical Practitioner" means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The registered practitioner should not be the Insured or close family members.

"Medically Necessary" Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

a. is required for the medical management of the illness or injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a medical practitioner,
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Mental Illness/Disease" means any mental Disease or bodily condition marked by disorganization of personality, mind, and emotions to impair the normal psychological, social or work performance of the individual regardless of its cause or origin.

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

"Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to insured on payment by a cashless facility.

"Non- Network" means Any hospital, day care centre or other provider that is not part of the network.

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

"Newborn baby" means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

"Other Insurer" means any of the registered Insurers in India other than Us/Our/We SBI General Insurance Company Limited.

"OPD treatment" means a treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

"Package Service Expenses" means expenses levied by the Hospital for treatment of specific surgical procedures/medical ailments as a lump sum amount under agreed package charges based on the room criteria as defined in the tariff schedule of the hospital.

"Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

a) b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

"Policy" means the complete documents consisting of the Policy wording, Schedule and Endorsements and attachments if any.

"Policy Period" means the period commencing with the commencement date of the Policy & terminating with the expiry date of the Policy as stated in the Policy Schedule.

"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

"Pre-hospitalization Medical Expenses" means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Post-hospitalization Medical Expenses" means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

Explanation:

(i) "Material Information" for the purpose of these regulations shall mean all important, essential and relevant information and documents explicitly sought by insurer in the proposal form.

(ii) The requirements of "disclosure of material information" regarding a proposal or policy, apply both to the insurer and the prospect, under these regulations.

"Proposer" means the person furnishing complete details and information in the Proposal form for availing the benefits either for himself or towards the person to be covered under the Policy and consents to the terms of the contract of Insurance by way of signing the same.

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

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

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

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

"Senior Citizen" means any person, who has attained the Age of sixty years or above.

"Schedule" means that portion of the Policy which sets out Insured details, the type of Insurance cover in force, the Policy Period and the Sum Insured. Any Annexure and/or Endorsement to the Schedule shall also be a part of the Schedule.

"Specific waiting period" means a period up to 90 days or 12 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

"Sum Insured" means the specified amount mentioned in the schedule to this policy which represents the Insurers maximum liability for any or all claims under this policy during the currency of the policy subject to terms and conditions.

"Surgery/or Surgical Procedure" means manual and/or operative procedures required for treatment of an Illness or Accidental Bodily Injury, correction of deformities and defects, diagnosis and cure of Diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

"Unproven/Experimental treatment" means Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

"Waiting Period" No benefit shall be payable during the term of the Policy for the claim which occurs or where the hospitalisation for the claim has occurred within 30 days of first Policy issue Date. Waiting period is not applicable for the subsequent continuous uninterrupted renewals.

"We/Our/Us/Company/Insurer" means the SBI General Insurance Company Limited You/ Your/ Yourself means the Insured Person shown in the Schedule.

"Tele-consultation" means engagement between licensed tele-consultation service provider/ professional and the insured/ covered member that is provided via a range of technology enabled communication media other than face-to-face interactions, such as telephone, internet, and others.

SCOPE OF COVER

Insurer shall pay the expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories

but not exceeding the Sum Insured and subject to deduction of any deductible as reflected in the policy schedule in respect of such Insured person as specified in the Schedule:

1. Room, Board & Nursing Charges as provided by the hospital: up to 1% of the Sum Insured max Rs.1500/- for Normal Room per day. If admitted into Intensive Care Unit up to 2% of the Sum Insured per day max Rs.2500/-. In case the insured opts for a higher room category than his eligibility the same can be covered upon specific acceptance by the insurer or Administrator. In such a case we shall not recover any expenses towards proportionate deductions other than the defined 'associate medical expenses'
2. Medical Practitioner and Specialists Fees (Including Teleconsultation)
3. Anesthesia, Blood, Oxygen, Operation Theatre charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical expenses incurred which is integral part of the operation
4. **Pre-hospitalisation Expenses** - Insurer shall pay for expenses as defined in the policy and incurred 30 days prior to the date of admission into the hospital or Domiciliary Hospitalisation
5. **Post-hospitalisation Expenses** - Insurer shall pay for expenses as defined in the policy and incurred 60 days after the date of discharge from the hospital or Domiciliary Hospitalisation
6. **Day Care Expenses** - Insurer shall pay for Day Care expenses incurred on advanced technological surgeries and procedures requiring less than 24 hours of hospitalisation as per the attached list and subject to the condition that prior approval is obtained by the Insured Person/Insured from the Administrator/Insurer for such a Day Care Procedure/Expense.
7. **Non Network Hospitalisation Co-pay** - For all admissible claims where treatment is taken at hospitals which are not in the list of network providers empanelled by the Company/Administrator, insured person shall bear 10% of the eligible admissible claim as per terms of insurance or shall bear a % of the eligible admissible claim as stipulated in the schedule for the said purpose.
8. **Domiciliary Hospitalisation** - Insurer will cover Reasonable and Customary Charges towards Domiciliary Hospitalisation exceeding 3 days as defined in definition subject to 20% of the Basic Sum Insured or a maximum of up to Rs.20000, whichever is lesser, however domiciliary Hospitalisation benefits shall not cover:-
   i. Expenses incurred for pre and post domiciliary hospitalisation treatment or
   ii. Expenses incurred for treatment for any of the following Diseases
      a. Asthma
      b. Bronchitis
      c. Chronic Nephritis and Nephritic Syndrome
      d. Diarrhea and all type of Dysenteries including Gastro-enteritis
      e. Epilepsy
      f. Influenza, Cough and Cold
      g. Pyrexia of unknown Origin for less than 10 days
      h. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharingitis
      i. Arthritis, Gout and Rheumatism
9. **HIV/AIDS Cover**: We will cover expenses incurred for Inpatient treatment due to any condition caused by or associated with human immunodeficiency virus or variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS upto the Sum Insured or as specified in the policy schedule except for the conditions which are permanently excluded
10. Mental Illness Cover: We will cover for the expenses incurred for the inpatient Treatment for any mental illness or psychiatric or psychological ailment / condition upto the Sum Insured or as specified on the policy schedule.
11. Genetic Disorders or Diseases are covered up to the Sum Insured or as specified on the policy schedule.
12. Internal Congenital Diseases are Covered upto the Sum Insured or as specified on the policy schedule.
13. 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 of Sum Insured or as specified in the policy schedule, during the policy period but not limited to the following:
   A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
   B. Balloon Sinuplasty
   C. Deep Brain Stimulation
   D. Oral Chemotherapy
   E. Immunotherapy - Monoclonal Antibody to be given as injection
   F. Intra Vitreal Injections
   G. Robotic Surgeries
   H. Stereotactic Radio Surgeries
   I. Bronchial Thermoplasty
   J. Vaporisation of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
   K. IONM - (Intra Operative Neuro Monitoring)
   L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

EXCLUSIONS

We will not pay for any expenses incurred by Insured Person in respect of claims arising out of or howsoever related to any of the following and for any of the coverages offered under the policy including add on covers:

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 insurer.

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 Insurer.

2. Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90

Days/ 12 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/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

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

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

f) List of specific diseases/procedures

12 Months Waiting Period:

i. Any types of gastric or duodenal ulcers;

ii. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;

iii. Surgery on all internal or external tumor /cysts/nodules/ polyps of any kind including breast lumps;

iv. All types of Hernia and Hydrocele;

v. Anal Fissures, Fistula and Piles;

vi. Cataract;

vii. Benign Prostatic Hypertrophy;

viii. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;

ix. Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;

x. Surgery of Genitourinary tract;

xi. Calculus Diseases;

xii. Sinusitis, nasal disorders and related disorders;

xiii. Surgery for prolapsed intervertebral disc unless arising from accident;

xiv. Vertebro-spinal disorders (including disc) and knee conditions;

xv. Surgery of varicose veins and varicose ulcers;

xvi. Chronic Renal failure;

xvii. Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by Accidental Bodily Injury.

90 Days Waiting Period:

i. Hypertension, Heart Disease and related complications;

ii. Diabetes and related complications;

3. 30-day waiting period- Code- Excl03

a) 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.

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

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

4. Treatment outside India.

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

6. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

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

8. Refractive Error: (Code- Excl15)

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

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

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

10. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, dentures, artificial teeth and all other external appliances, and/or devices unless specifically covered.

11. Expenses incurred on Items for personal comfort like television, telephone, etc. incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital.

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

13. Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring hospitalization treatment.

14. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/ disease/ defect.

15. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol).

16. Breach of law: (Code- Excl10)

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

17. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

18. Venereal disease or any sexually transmitted disease or sickness. (excluding HIV / AIDS as mentioned under scope of cover)

19. 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.

20. 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

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

22. 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)**

23. Surgery to correct Deviated Nasal septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to our satisfaction that the condition is a result of an accidental injury.

24. Medical Practitioner's home visit Expenses during pre and post hospitalization period, Attendant Nursing Expenses.

25. Outpatient Diagnostic, Medical and Surgical procedures or treatments, non-prescribed drugs and medical supplies,

26. 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.

27. 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.

28. Expenses incurred at Hospital primarily for diagnosis irrespective of 24 hours hospitalization. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner, which ordinarily can be given without hospitalization.

29. 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- Excl13)**

30. 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.

31. Investigation & Evaluation- (Code- Excl04)

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

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

32. Treatment with alternative medicines like ayurvedic, homeopathy, unani, acupuncture, acupressure, osteopath, naturopathy, chiropractic, reflexology and aromatherapy unless specifically covered under the policy.

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

34. Obesity/ Weight Control: (Code- Excl06)

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

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

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities

following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

35. Unproven Treatments: Code- Excl16

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

36. Costs of donor screening or treatment including organ extraction, unless specifically covered and specified in the schedule of the policy.

37. Disease / injury illness whilst performing duties as a serving member of a military or police force.

38. Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.

39. 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.

CONDITIONS

1. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

2. Disclosure to Information Norm:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure ofany material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

3. 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 a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Due Care

Where this Policy requires Insured to do or not to do something, then the complete satisfaction of that requirement by Insured or someone claiming on Insured behalf is a precondition to any obligation under this Policy. If Insured or someone claiming on Insured behalf fails to completely satisfy that requirement, then Insurer may refuse to consider Insured claim. Insured will cooperate with Insurer at all times.

5. Free look period

(1) Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.

(2) In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any claim, he shall have the option to return the Policy to the insurer for cancellation, stating the reasons for the same.

(3) Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

(4) A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (3) above.

6. Mis-description

This Policy shall be void and premium paid shall be forfeited to Insurer in the event of misrepresentation, mis-description or non-disclosure of any materials facts pertaining to the proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy by the Insured. Nondisclosure shall include non-intimation of any circumstances which may affect the insurance cover granted. The Misrepresentation, mis-description and non-disclosure is related to the information provided by the proposer/insured to the Insurer at any point of time starting from seeking the insurance cover in the form of submitting the filled in proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy and ends only after all the Contractual obligations under the policy are exhausted for both the parties under the contract.

7. Insured Person

Only those persons named as the Insured Person in the Schedule shall be covered under this Policy. The details of the Insured Person are as provided by Insured. A person may be added as an Insured Person during the Policy Period after Insured's Proposal has been accepted by Insurer, an additional premium has been paid and Insurer's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person as an Insured. Cover under this Policy shall be withdrawn from any Insured Person upon such Insured giving 15 days written notice to be received by Insurer.

8. Premium

The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of Insurer signed by a duly authorized official of Insurer. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of Insurer to make any payment under this policy. No waiver of any terms provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of Insurer.

9. Package Service Expenses as defined under the policy will be payable only if prior approval for the said package service is provided by Administrator / Insurer upon the request of the Insured Person or Insured.

10. Mechanism for continuity of coverage for Individual members covered under the group insurance:

In the event of the group policy under which the Insured Person is a covered member and which is being discontinued or not renewed or Insured person leaving the group on account of resignation/termination or otherwise, the Insured Person has the option of taking a standard individual health policy of the Insurer without any benefit of continuity of cover for any additional benefits that the Insured Person may have enjoyed under the group policy and for which additional premium has been charged. In such an event, all the waiting periods as stipulated under the Individual Health policy will be applicable with due adjustment for the Uninterrupted period in completed years for which the Individual was covered under the Group Health policy issued by us. However, any such benefit would be restricted to the maximum of his eligibility of sum insured under the Individual health policy or the sum insured enjoyed by the individual under the Group Health policy whichever is lower. Also, all the underwriting rules and regulations of our Individual health policy would be applicable for acceptance of such risk.

11. Unhindered access

The Insured/Insured person shall extend all possible support & co-operation including necessary authorisation to the insurer for accessing the medical records and medical practitioners who have attended to the patient.

12. Claims Procedures

I. Reimbursement:

a. The Insured Person shall without any delay consult a Doctor and follow the advice and treatment recommended, take reasonable steps to minimize the quantum of any claim that might be made under this Policy and intimation to this effect can be forwarded to insurer accordingly.

b. In respect of post hospitalization claims, the claims must be lodged within 15 days from the completion of post hospitalisation treatment subject to maximum of 75 days from the date of discharge from hospital.

c. The Insured Person shall submit himself for examination by Insurer's medical advisors as often as may be considered necessary by Insurer. In such an event the Insurer will bear all expenses incurred with the prior approval/permission of the Insurer to the Insured Person for making himself available for the said examinations.

d. Insured / Insured person shall submit all original bills, receipts, certificates, information and evidences from the attending Medical Practitioner / Hospital / Diagnostic Laboratory as required by Insurer.

e. On receipt of intimation from Insured / Insured Person regarding a claim under the policy, Insurer / Administrator is entitled to carry out examination and obtain information on any alleged Injury or Disease requiring Hospitalisation of the Insured Person, if and when insurer may reasonably require.

ii. Cashless:

ADMINISTRATOR will provide the User guide & identity card to insured. User guide will have following details:

a. Contact details of all Administrator offices

b. Website address of Administrator

c. List of network providers with their contact details

d. Procedure for availing cashless benefits at Network providers

e. Claim submission guidelines.

iii. Intimation of claims:

a. In the event of Accidental Bodily Injury or Disease / Illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation, a hospitalization benefit will be payable as per the Policy conditions, that may result in a claim as per Policy terms and condition, then as a condition precedent to Insurer's liability, Insured / Insured person must provide intimation to Insurer immediately and in any event within 48 hours from date of hospitalisation. However, the Insurer at his sole discretion may relax this condition subject to a satisfactory proof/ evidence/justification being produced on the reasons for such a delay beyond the stipulated period. The intimation can be sent by Insured / Insured Person through various modes like email / telephone/ fax/ in person / letter or any other suitable mode.

b. Insured/Insured Person will need to submit the below mentioned documents for the processing of Hospitalisation Claims within 30 days from the date of discharge from the Hospital, however the Insurer at his sole discretion may relax this condition subject to a satisfactory proof/evidence being produced on the reasons for such a delay beyond the stipulated 30 days up to a maximum period of 60 days.

iv. Claims Submission:

Insured / Insured Person will submit the claim documents to the Administrator . Following is the document list for claim submission:

a. Duly filled Claim form,

b. Valid Photo Identity Card

c. Original Discharge card/certificate/ death summary

d. Copies of prescription for diagnostic test, treatment advise, medical references

e. Original set of investigation reports

f. Itemized original hospital bills, original receipts and related original medical expenses receipts, pharmacy bills in original with prescriptions.

v. Claims Processing:

On receipt of claim documents from Insured/Insured Person, Insurer/Administrator shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the claimant about the same in writing with reason for repudiation.

vi. Penal Interest Provision :

1) The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim submission.

2) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of claim submission to the date of payment of claim at a rate 2o/o above the bank rate.

(Explanation: Bank Rate means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due)

13. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

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

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

14. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

15. Multiple Policies

a. Indemnity Policies:

A Policyholder can file for Claim settlement as per his/her

choice under any Policy. The Insurer of that chosen Policy shall be treated as the primary Insurer.

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

b. Benefit based Policies:

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

16. 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 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 or misrepresentation, non-disclosure of material facts or fraud.

17. Termination of Policy

This Policy terminates on earliest of the following events-

a. Cancellation of policy by as per the cancellation provision.

b. On the policy expiry date.

18. Arbitration & Conciliation

i. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of two Arbitrators and one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.

ii. It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore provided, if the Insurer has disputed or not accepted liability under or in respect of this Policy.

iii. It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such Arbitrator/Arbitrators of the amount of the loss shall be first obtained.

iv. The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.

19. 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.

20. Withdrawal of 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.

21. 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

22. 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

23. 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.

25. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

26. Disclaimer

If Insurer shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify Insurer in writing that he does not accept such disclaimer and

intends to recover his claim from Insurer then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

27. Geographical limits

All medical/ surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

28. Redressal of Grievance

If You have a grievance about any matter relating to the Policy, or Our decision on any matter, or the claim, You can address Your grievance as follows:

Stage 1: Bima Bharosa

You can register your grievances with the regulator using the following link: https://bimabharosa.irdai.gov.in/Home/Home

Stage 2: Head – Customer Care

Alternatively, if you wish to register your grievances directly with us, you may write to the Head – Customer Care. We aim to respond to all Grievances within 7 days. In our initial acknowledgment of receipt letter, we will provide the name and title of the person that is handling your Grievance. This individual will have the authority necessary to investigate and resolve the Grievance.

Email: head.customercare@sbigeneral.in
Toll-Free Number: 1800 102 1111 (Available 24/7)

For Senior Citizens:
Senior citizens can reach us through the following dedicated channels:
Email:Seniorcitizengrivences@sbigeneral.in
Toll-Free Number: 1800 102 1111 (Available 24/7)

Stage 3: Grievance Redressal Officer (GRO)

In case, you are still not satisfied with the decision/resolution communicated by the above officer or have not received any response within 5 Business days, you may escalate the matter to the Grievance Redressal Officer (GRO) which will undergo a detailed case investigation, and we aim to resolve the issue within 7 days from the date of receipt of your Grievance at GRO Desk
Email: gro@sbigeneral.in
Phone: 022-45138021

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

Stage 4: 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

Office of Insurance the Ombudsman	Jurisdiction of Office
Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Pondicherry.
Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of of Union Territory of Pondicherry.
Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Etawah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
Shri Sunil Jain Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.sbigeneral.in	

Source:- CIO (cioins.co.in)

ANNEXURE I - DAY CARE LIST

The following are the listed Day care procedures and such other Surgical Procedures that necessitate less than 24 hours Hospitalisation due to medical/technological advancement/ infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the policy.

Microsurgical operations on the middle ear

1. Stapedectomy
2. Revision of a stapedectomy
3. Other operations on the auditory ossicles
4. Myringoplasty (Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain
10. Incision of the mastoid process and middle ear
11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

18. Excision and destruction of diseased tissue of the nose
19. Operations on the turbinates (nasal concha)
20. Other operations on the nose
21. Nasal sinus aspiration

Operations on the eyes

22. Incision of tear glands
23. Other operations on the tear ducts

24. Incision of diseased eyelids
25. Excision and destruction of diseased tissue of the eyelid
26. Incision of diseased eyelids
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids Trauma surgery and orthopaedics
73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration

Operations on the breast

78. Incision of the breast
79. Operations on the nipple

Operations on the digestive tract

80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.
87. Laparoscopic cholecystectomy

Operations on the female sexual organs

88. Incision of the ovary
89. Insufflation of the Fallopian tubes
90. Other operations on the Fallopian tube
91. Dilatation of the cervical canal
92. Conisation of the uterine cervix
93. Other operations on the uterine cervix
94. Incision of the uterus (hysterotomy)
95. Therapeutic curettage
96. Culdotomy
97. Incision of the vagina
98. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99. Incision of the vulva
100. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

101. Incision of the prostate
102. Transurethral excision and destruction of prostate tissue

103. Transurethral and percutaneous destruction of prostate tissue
104. Open surgical excision and destruction of prostate tissue
105. Radical prostatovesiculectomy
106. Other excision and destruction of prostate tissue
107. Operations on the seminal vesicles
108. Incision and excision of periprostatic tissue
109. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

110. Incision of the scrotum and tunica vaginalis testis
111. Operation on a testicular hydrocele
112. Excision and destruction of diseased scrotal tissue
113. Plastic reconstruction of the scrotum and tunica vaginalis testis
114. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

115. Incision of the testes
116. Excision and destruction of diseased tissue of the testes
117. Unilateral orchidectomy
118. Bilateral orchidectomy
119. Orchidopexy
120. Abdominal exploration in cryptorchidism
121. Surgical repositioning of an abdominal testis
122. Reconstruction of the testis
123. Implantation, exchange and removal of a testicular prosthesis
124. Other operations on the penis

Operations on the spermatic cord, epididymis und ductus deferens

125. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126. Excision in the area of the epididymis
127. Epididymectomy
128. Reconstruction of the spermatic cord
129. Reconstruction of the ductus deferens and epididymis
130. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

131. Operations on the foreskin
132. Local excision and destruction of diseased tissue of the penis
133. Amputation of the penis
134. Plastic reconstruction of the penis
135. Other operations on the penis

Operations on the urinary system

136. Cystoscopical removal of stones

Other Operations

137. Lithotripsy
138. Coronary angiography
139. Haemodialysis
140. Radiotherapy for Cancer
141 Cancer Chemotherapy

ANNEXURE II

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHAR ES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER FOR USAGE OUTSIDE THE HOSPITAL
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOTWEAR
45	KNEE BRACES LONG/ SHORT/ HINGED
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER

52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

No.	Item
1	BABY CHARGES UNLESS SPECIFIED/INDICATED
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH-PASTE
13	TOOTH-BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	1M IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/VVARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES NOT EXPLAINED
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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

ENDORSEMENTS

It is hereby agreed that any or all endorsements issued with this Policy or endorsed thereon in shall be expressly subject to the terms and conditions and exclusions of this Policy, except to the extent expressly varied by the endorsement and shall become applicable only upon endorsement and after our receipt of requisite additional premiums. All other Policy terms, conditions and exclusions shall remain unchanged.

1. **Ambulance expenses cover:**

   It is hereby declared and agreed that we will reimburse 1% of Sum Insured per Person per Policy period up to a maximum of ₹1500 towards the utilisation of an ambulance for the Insured Person being transported to the hospital for treatment of the illness/disease/injury and upon producing the bills in original. Ambulance services used are to be of a licensed operator.

   All other terms and conditions under the policy remain unaltered.

2. **Annual medical check-up:**

   We will reimburse the reasonable and customary charges incurred by an Insured Person for a health check-up at any of the Insurer's empanelled diagnostic centre or at any other diagnostic centre, provided that:

   a. The Health Check-up is to be undertaken within the Policy Period,

   b. Our maximum liability under this Endorsement will be limited to - 1% of sum insured up to a maximum of ₹2500 Per Policy Period.

   All other terms and conditions under the policy remain unaltered.

3. **Maternity Benefit Extension with waiting period of 9 months:**

   It is hereby declared and agreed that the exclusion No.20 of the "Exclusions" stands deleted and Insurer will reimburse medical expenses up to the limits and sub limits as mentioned in the Schedule against the Insured Persons. Expenses incurred towards the normal baby care after delivery is not covered under this benefit.

   Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the term of the policy. These Benefits are admissible only if the expenses are incurred in a Hospital as an in-patient in India.

   The benefit under this Policy shall be payable after a period of 9 months from the date of inception of the Policy in so far as the period of 9 months applicable for payment of any claim under this benefit. However, Insurer may at its absolute discretion relax the above period of 9 months in case of a medical emergency or accident resulting in delivery, mis-carriage or abortion.

   Claim in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any one Insured Person. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

   Expenses incurred in connection with voluntary medical termination of pregnancy are not covered.

   Pre-natal and post-natal expenses are not covered unless the same require Hospitalisation and within the meaning of hospitalisation as defined under the standard policy wordings. This benefit is available as a part of Maternity Sublimit.

   All other terms and conditions under the policy remain unaltered.

4. **Maternity Benefit Extension without waiting period of 9 months:**

   It is hereby declared and agreed that the exclusion No.20 of the "Exclusions" stands deleted and Insurer will reimburse medical expenses up to the limits and sub limits as mentioned in the Schedule against the Insured Persons. Expenses incurred towards the normal baby care after delivery is not covered under this benefit.

   Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the term of the policy. These Benefits are admissible only if the expenses are incurred in a Hospital as an in-patient in India.

   Claim in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any one Insured Person. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

   Expenses incurred in connection with voluntary medical termination of pregnancy are not covered.

   Pre-natal and post-natal expenses are not covered unless the same require Hospitalisation and within the meaning of hospitalisation as defined under the standard policy wordings. This benefit is available as a part of Maternity Sublimit.

   All other terms and conditions under the policy remain unaltered.

5. **New Born Cover from Day One:**

   It is hereby declared and agreed that we will cover the new born babies of any Insured Person from the date of birth of the baby, for any disease/sickness/ailment/Injury. The limit opted for this cover is distinct and is not inclusive of the maternity cover limit opted. All other terms and conditions under the policy remain unaltered.

6. **Critical Illness Cover:**

   It is hereby declared and agreed that we will reimburse the Reasonable and Customary Charges incurred for the treatment of "Critical Illness" as defined below and under the policy up to an additional SumInsured limit equal to his/her Basic Sum Insured. This benefit will be available to the insured persons only upon exhaustion of the Basic Sum Insured under the standard hospitalisation benefit available under the policy. All the monetary sub-limits as applicable under the policy would be applicable for this cover also. Provided that

   1. The **Insured Person** is first diagnosed as suffering from a Critical Illness during the Policy Period
   2. **Critical Illness** means –
      1. Cancer of specified severity,
      2. Open Chest CABG
      3. Aorta Graft Surgery,
      4. Open Heart Replacement or Repair of Heart Valves
      5. Stroke Resulting in Permanent Symptoms
      6. First Heart Attack – Of Specified Severity
      7. Kidney Failure Requiring Regular Dialysis
      8. Primary Pulmonary Arterial Hypertension,
      9. Major Organ/ Bone Marrow Transplant
      10. Multiple Sclerosis with Persisting Symptoms
      11. Coma of Specified Severity
      12. Total Blindness
      13. Permanent Paralysis of Limbs

All as defined below only:

1. Cancer
   I. A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.
   II. The following are excluded -
   1. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
   2. Any skin cancer other than invasive malignant melanoma
   3. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
   4. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
   5. Chronic lymphocyctic leukaemia less than RAI stage 3
   6. Microcarcinoma of the bladder
   7. All tumours in the presence of HIV infection.

2. Open Chest CABG

1. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.
2. The following are excluded:
   1. Angioplasty and/or any other intra-arterial procedures
   2. any key-hole or laser surgery.

3. Aorta Graft Surgery

The actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Surgery following traumatic injury to the aorta is not covered. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of the aorta is removed during the operative procedures. Surgery performed using only minimally invasive or intra- arterial techniques such as percutaneous endovascular aneurysm with insertion of a stent graft are excluded.

4. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

5. Stroke Resulting in Permanent Symptoms

a. Any cerebrovascular incident producing permanent neurological sequelae.This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

b. The following are excluded:
   1. Transient ischemic attacks (TIA)
   2. Traumatic injury of the brain
   3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

6. First Heart Attack – Of Specified Severity

i. The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:
   1. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
   2. new characteristic electrocardiogram changes
   3. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

ii. The following are excluded:
   1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
   2. Other acute Coronary Syndromes
   3. Any type of angina pectoris.

7. Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

8. Primary Pulmonary Arterial Hypertension

Primary Pulmonary Hypertension is characterized by elevated pulmonary artery pressure with no apparent cause and substantial right ventricular enlargement confirmed by a Cardiologist with the help of investigations including Cardiac Catheterization (cardiac catheterization proving the pulmonary pressure to be above 30 mm of Hg), resulting in permanent irreversible physical impairment of at least Class IV ofthe New York Heart Association (NYHA) Classification of Cardiac Impairment and resulting in the Insured being unable to perform his / her usual occupation.

The latest NYHA Classification of Cardiac Impairment shall be used. Diagnosis and Treatment – 39th Edition"):

Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or angina pain.

Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

9. Major Organ/ Bone Marrow Transplant

a) The actual undergoing of a transplant of:
   a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

b) The following are excluded:
   a. Other stem-cell transplants
   b. Where only islets of langerhans are transplanted

10. Multiple Sclerosis with Persisting Symptoms

a. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:
   i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
   iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes at least one month apart.

b. Other causes of neurological damage such as SLE and HIV are excluded.

11. Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

a. no response to external stimuli continuously for at least 96 hours;
b. life support measures are necessary to sustain life; and
c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12. Total Blindness:

Total, permanent and irreversible loss of all sight in both eyes as a result of sickness or accident. Diagnosis has to be confirmed by a specialist (best by an ophthalmologist) and evidenced by specific test results.

13. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

14. Pre-existing Disease Exclusion Waiver:

It is hereby declared and agreed that the exclusion No.1 of the "Exclusions" stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons. All other terms and conditions under the policy remain unaltered.

15. First year Exclusions Waiver:

It is hereby declared and agreed that the exclusion No.3 of the "Exclusions" stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons. All other terms and conditions under the policy remain unaltered.

16. First 30 days Exclusion Waiver:

It is hereby declared and agreed that the exclusion No.2 of the "Exclusions" stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons.

All other terms and conditions under the policy remain unaltered.

17. Coverage for Ayurvedic Medicine:

It is hereby declared and agreed that Ayurvedic Treatment is covered upto Sum Insured, subject to and for treatment taken as inpatient in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/ National Accreditation Board on Health. The hospitalisation should be for a minimum period of 24 hours for being eligible for the reimbursement.

All other terms and conditions under the policy remain unaltered.

18. Coverage for Homeopathic and Unani system of medicine:

It is hereby declared and agreed that Homeopathy and Unani Treatment cover is covered upto Sum Insured, subject to and for treatment taken as inpatient in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/National Accreditation Board on Health. The hospitalisation should be for a minimum period of 24 hours for being eligible for the reimbursement.

All other terms and conditions under the policy remain unaltered.

19. Exclusion of Domiciliary Hospitalisation:

It is hereby declared and agreed that notwithstanding anything to the contrary contained in the within written policy, the coverage under this policy shall exclude any expenses for Domiciliary Hospitalisation. Subject otherwise to the terms and conditions of this policy.

All other terms and conditions under the policy remain unaltered.

20. Exclusion of Pre and Post Hospitalisation cover:

It is hereby declared and agreed that notwithstanding anything to the contrary contained in the within written policy, the coverage under this policy shall exclude the expenses arising out of Pre & Post Hospitalisation. Subject otherwise to the terms and conditions of this policy.

All other terms and conditions under the policy remain unaltered.

21. Coverage for Out Patient Treatment:

It is hereby declared and agreed that We will cover Outpatient Treatment for the Insured Person, provided that

i. Our maximum liability under this Endorsement for reimbursement of expenses will be limited to a maximum of 2% of the sum insured during the entire policy period. Subject otherwise to the terms and conditions of this policy

All other terms and conditions under the policy remain unaltered.

22. Coverage for Dental Expenses:

It is hereby declared and agreed that We will pay/reimburse the Reasonable and Customary charges of any necessary dental treatment during the Policy Period taken from a dentist by an Insured Person and Exclusion No.13 stands deleted for all Insured Persons to this extent, provided that:

i. We will only pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and
ii. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper

and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer, and

iii. Our maximum liability under this Endorsement will be limited a maximum reimbursement of 2% of the sum insured for the entire policy period.

All other terms and conditions under the policy remain unaltered.

23. Corporate Buffer (Additional Sum Insured for the total Group):

It is hereby declared and agreed that an additional sum insured as stipulated in the schedule of the policy will be available to the Insured which is in addition to the basic sum insured reflected in the policy schedule per person/family.

We will provide a Corporate Floater as stated in the Policy Schedule during the Policy Period subject to the following sub limits:

a. This sum insured will be available for those insured person, who have already exhausted their sum insured limit subject to a per person limit.

b. However, the amount is restricted to coverage as stated in the Policy Schedule of each and every Illness in respect of each and every Insured person or His family (if applicable).

The Corporate Buffer will not be available for Maternity & Non Allopathic Treatment / Claims. All other terms and conditions under the policy remain unaltered.

24. Coverage for congenital internal Diseases:

It is hereby agreed and declared that Exclusion no: 15 under the policy stands deleted. All other terms and conditions of the policy remain unaltered.

25. Voluntary Co-pay option:

For all admissible claims insured person shall bear % of all eligible and admissible claims as per terms and conditions of insurance and as stated in the policy schedule. All other terms and conditions of the policy remain unaltered.

26. Enhancement of Room rent sub-limits:

It is hereby agreed and declared that Room, Board & Nursing Charges as provided by the hospital/nursing home stands enhanced to ----------% of the Sum Insured max ₹/- for Normal Room per day and up to ----------% of the Sum Insured per day max ₹/- if admitted to Intensive Care Unit.

All other terms and conditions of the policy remain unaltered.

27. Family Floater Cover:

It is hereby agreed and declared that this policy covers the Primary Insured and his Family as defined in the policy on a Family Floater basis under which the Policy definition of the Sum Insured shall be replaced with the following:

Sum Insured: means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by the Primary Insured and all Dependents during the Policy Period, except where a particular benefit is expressed to be subject to its own limit in which case that limit, which is subject to the Sum Insured, represents Our maximum liability for any and all claims made by the Primary Insured and all Dependents in respect of that benefit.