SURAKSHA AUR BHAROSA DONO

HEALTH EDGE INSURANCE

POLICY WORDING

PREAMBLE

In consideration of payment of Premium by You and realized by Us, We will provide insurance cover to the Insured Person(s) under this Policy up to Sum Insured and/or limits as specified in the Policy Schedule subject to all terms, condition and exclusion as mentioned under the Policy and declaration, medical reports as provided by You. This Policy is subject to Your statements in respect of all the Insured Persons in Proposal form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy.

A. DEFINITIONS

1.1 Standard Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.
2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken.
3. **AYUSH Hospital** means 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:
   1) Central or State Government AYUSH Hospital; or
   2) Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council for Homeopathy; or
   3) 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 clock;
      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.
4. **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 AYUSH Medical Practitioner in charge round the clock;
   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.
5. **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 is approved.
6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
7. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.
   i. Internal Congenital Anomaly which is not in the visible and accessible parts of the body.
   ii. External Congenital Anomaly which is in the visible and accessible parts of the body.
8. **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.
9. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
11. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under:
    i. has qualified nursing staff under its employment.
    ii. has qualified medical practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
12. **Day Care Treatment** means medical treatment, and/or surgical procedure which is Undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hrs because of technological advancement, and which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **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.
14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and surgery.
15. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-

disclosure of any material fact.

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

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

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

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

18. **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.

19. **Hospital** means any institution established for In-patient Care and Day Care Treatment of diseases, 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:

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

    i. has qualified nursing staff under its employment round the clock,

    ii. has qualified Medical Practitioner(s) in charge round the clock,

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

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

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

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

22. **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 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 which leads to full recovery

    (b) Chronic condition - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:

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

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

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

        iv. it continues indefinitely

        v. it recurs or is likely to recur

23. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for or more than 24 hours for a covered event.

24. **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.

25. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

26. **Maternity Expenses** means

    i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

    ii. expenses towards lawful medical termination of pregnancy during the policy period.

27. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

28. **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.

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

30. **Medical Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:

    i. is required for the medical management of the illness or injury suffered by the Insured Person.

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

    iii. must have been prescribed by a medical practitioner.

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

31. **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.

32. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to

provide medical services to an insured by a Cashless facility.

33. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the Network.

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

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

36. **OPD Treatment** means the one 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.

37. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined 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.

38. **Pre-existing disease (PED)** means any condition, ailment, injury or disease:

    a) that is/are diagnosed by a physician not more than 24 months prior to the date of commencement of the policy issued by the insurer; or

    b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 24 months prior to the date of commencement of the policy.

39. **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.

40. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined 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.

41. **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.

42. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India.

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

44. **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.

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

46. **Senior citizen** shall have the same meaning assigned to it under Maintenance and Welfare of Parents and Senior Citizens Act, 2007.

47. **Specific waiting period** means a period up to 24 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.

48. **Surgery or Surgical Procedures** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.

49. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

1.2 Specific Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

Def. 1. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his profession whether he / she is trained or not.

Def.2. **Age** means completed years on last birthday as on Commencement Date.

Def.3. **Ambulance** means a motor vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

Def.4. **Assisted Reproduction Treatment**: Assisted Reproduction Treatment means Intra Uterine Insemination (IUI), Intra-Cytoplasmic Sperm Injection (ICSI), In-Vitro Fertilization (IVF) and TESA/ TESE (Testicular / Epididymal Sperm Aspiration / Extraction)

Def.5. **Associated Medical Expenses** means consultation fees, charges on operation theatre, surgical appliances and nursing, and expenses on anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person. Associated Medical Expenses does not include cost of pharmacy and consumables, cost of implants and medical devices, and cost of diagnostics.

Def. 6. **AYUSH Treatment** refers to hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 7. **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.

Def. 8. **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.

Def.9. **Biological Attack** or **Weapons** means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 10. **Chemical attack** or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 11. **Commencement Date** means the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule.

Def. 12. **Dependents** means only the family members listed below:

i. Your legally married spouse as long as she continues to be married to You

ii. Your children (natural or legally adopted), aged between 91 days maximum up to Age of 30 years and financially dependent on You

iii. Your natural parents or parents that have legally adopted You,

iv. Your parent-in-law as long as Your Spouse continues to be married to You

Def.13. **Family Floater** Members means any one or more of the following family members of the Insured Person:

i. Legally wedded spouse.

ii. Parents and/or parents-in-law.

iii. Dependent Children (i.e. natural or legally adopted) between the Age 91 days to Age 30 years. If the child above 18 years of Age is financially independent, he or she shall be ineligible for coverage under this Policy in the subsequent renewals.

Def.14. **HIV** means Human Immunodeficiency Virus

Def 15. **Home** means the Insured Person's place of permanent residence as specified in the Policy Schedule.

Def.16. **Insured Person/You/Your** means persons named in the Policy Schedule who are insured under the Policy and are Citizen of India in respect of whom the applicable premium has been received.

Def.17. **Life-threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not Pre-Existing Disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

Def.18. **Length of stay** means number of continuous and consecutive days of hospitalisation as specified in the Policy Schedule.

Def.19. **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def.20. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

Def.21. **Medical practitioner for mental illnesses** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;

Def.22. **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

Def.23. **Obesity means** abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index

Body Mass Index (BMI) is a simple index of weight for height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2)

The WHO definition is:

- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

Def.24. **Post-Natal Medical Expenses** means medical expenses incurred for the insured mother post the delivery for a period of 8 weeks.

Def.25. **Pre-Natal Medical Expenses** means medical expenses incurred for the insured mother during the maternity period prior to delivery.

Def.26. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.

Def.27. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

Def. 28. **Policyholder** means person who has proposed the Policy and in whose name the Policy is issued.

Def.29. **Policy Schedule** means the Policy Schedule attached to and

forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 30. **Policy Year** means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Policy Schedule.

Def.31. **Stay Fit Health Check-up** means a package of the medical test(s) undertaken for a general assessment of health status, excluding any diagnostic or investigative medical tests for evaluation of Illness or a disease.

Def.32. **E-Opinion** means a procedure whereby upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history. Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

Def.33. **Sub-fertility** means any form of reduced fertility with prolonged time of unwanted non-conception.

Def.34. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub- limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.

Def.35. **Sum Insured** means the maximum, total and cumulative liability of the Company to pay the claims made under the Policy in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year basis, for the following covers and in this order:

- Base Sum Insured
- Booster Benefit (if opted)
- Unlimited Refill (if opted)

Def.36. **Telemedicine** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

Def.37. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

Def.38. We/Our/Us/Company means the SBI General Insurance Company Limited

B. SCOPE OF COVER

We will pay under below listed Covers on Medically Necessary Treatment of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured and limits including Booster benefit (if applicable), as specified in the Policy Schedule. Subject to otherwise terms and conditions of the Policy.

Benefits under the policy:

The benefits available under this Policy are described below:

a. The Policy covers Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person during the Policy Period for an Illness, Injury or condition as described in the sections below and contracted or sustained during the Policy Period. The benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and any sub-limits for the benefit as maybe specified in Policy Schedule.

b. All the benefits (including optional benefits) which are available under the Policy along with the respective limits / amounts applicable based on the Sum Insured have been summarized in the Product Benefit Table in Annexure III.

c. All claims under the Policy must be made in accordance with the process defined under Section G.B.II.b.

d. All claims paid under any benefit except for those admitted under Section D.11 (E-Opinion) shall reduce the Sum Insured for the Policy Year in which the Insured Event in relation to which the claim is made has been occurred, unless otherwise specified in the respective section. Thereafter only the balance Sum Insured after payment of claim amounts admitted shall be available for future claims arising in that Policy Year.

C. HOSPITALIZATION COVERS

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

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

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

c. Nursing Expenses as provided by the Hospital

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

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

f. Consultation fees including Telemedicine by Medical Practitioner

g. Medicines, drugs, and consumables

h. Diagnostic procedures

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

Conditions

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

ii. We shall be liable to pay any In-patient hospitalization Medical Expenses as per the opted number of days of Hospitalization at Policy inception or at renewal as specified in the Policy Schedule.

iii. Irrespective of Type of Policy, the opted number of days shall be applicable on per hospitalization basis.

iv. If unlimited number of days is opted there will be no restriction on maximum duration /Length of Stay for in patient hospitalization.

v. Multiple claims for Inpatient Care Hospitalization shall be covered under the Policy Period, however all claims made under In-patient care benefit shall be subject to maximum duration (length of stay)

for In-patient hospitalization, where 5 or 10 days is opted.

vi. The maximum liability of the Company to pay under this cover shall be limited to Sum Insured specified in the Policy Schedule

vii. Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

C.2 Pre-hospitalization Medical Expenses

We will indemnify on Reimbursement basis only, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury for duration of 30 days.

Conditions:

The above coverage is subject to fulfilment of following conditions:

i. We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or C.7 (Modern Treatments) or Section C.8 (AYUSH Treatments).

ii. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.7 (Modern Treatments) or Section C.8 (AYUSH Treatments).

iii. The expenses are incurred after the inception of the First Policy with Us. If any portion of these expenses is incurred before the inception of the First Policy with Us, then We shall be liable only for those expenses incurred after the commencement date of the First Policy, irrespective of the initial waiting period.

iv. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.

v. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which Section C.1 Inpatient Hospitalization Treatment or Section C.4 Day Care Treatment or Section C.8 AYUSH Treatments or Section C.7 Modern Treatments claim has been incurred.

vi. We shall not be liable to pay any Pre-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule immediately preceding the Insured Person's admission to Hospital under Section C.1 Inpatient Hospitalization Treatment or Section C.4 Day Care Treatment or Section C.8 AYUSH Treatments or Section C.7 Modern Treatments.

C.3 Post-hospitalization Medical Expenses

We will indemnify on Reimbursement basis only, the Insured Person's Post-Hospitalization Medical Expenses incurred following an Illness or Injury for duration of 60 days.

Conditions

The above coverage is subject to fulfilment of following conditions:

i. We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.7 (Modern Treatments) or Section C.8 (AYUSH Treatments).

ii. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.7 (Modern Treatments) or C.8 (AYUSH Treatments).

iii. The expenses incurred shall be as advised in writing by the treating Medical Practitioner.

iv. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.

v. Any claim admitted under this Section shall reduce the Sum Insured for the Policy Year in which Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.8 (AYUSH Treatments) or Section C.7 (Modern Treatments) claim has been incurred.

vi. We shall not be liable to pay any Post-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule immediately following the Insured Person's discharge from Hospital under C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.8 (AYUSH Treatments) or Section C.7 (Modern Treatments).

C.4 Day Care Treatment

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

Conditions:

The above coverage is subject to fulfilment of following conditions:

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

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

iii. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.2 and C.3.

What is not covered:

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

C.5 Emergency Road Ambulance Cover (per hospitalization)

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

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

ii. Or from one Hospital to another Hospital

iii. Or from Hospital to Home

Provided that claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.7 (Modern Treatments) C.8 (AYUSH Treatments) is admissible under the Policy.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

C.6 Bariatric Surgery Cover

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

Eligibility:

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

Body Mass Index (BMI);

A. Greater than or equal to 40 or

B. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity-related cardiomyopathy

2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type 2 Diabetes

Conditions

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

ii. Bariatric surgery performed for Cosmetic reasons is excluded.

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

iv. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

C.7 Modern Treatments/Advanced Procedures

a. The following procedures/treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Sections C.1 and C.4 respectively, in a Hospital of modern treatments and not limited to the following:

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

ii. Balloon Sinuplasty

iii. Deep Brain stimulation

iv. Oral chemotherapy

v. Immunotherapy- Monoclonal Antibody to be given as injection

vi. Intra vitreal injections

vii. Robotic surgeries

viii. Stereotactic radio surgeries

ix. Bronchical Thermoplasty

x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

xi. IONM - (Intra Operative Neuro Monitoring)

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

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.2 and C.3.

C.8 AYUSH Treatment

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

C.9 Stay Fit Health Check-Up

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

Conditions:

The above coverage is subject to fulfilment of following conditions:

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

ii. The list of tests covered under this benefit will be Complete Blood Count (CBC), Urine Routine, Erythrocyte Sedimentation Rate (ESR), Fasting Blood Glucose, Electrocardiogram, S Cholesterol, Complete Physical Examination by Physician, Post prandial / lunch blood sugar (PPBS / PLBS), Uric Acid, Lipid Profile, Kidney function test, Serum Vitamin D, Serum Electrolytes, HbA1C, Thyroid profile (TSH), Liver Function Test (LFT), Treadmill test (TMT) and Ultrasound test.

iii. Irrespective of Individual or Family Floater, this benefit is available to all adult members above 18 years of age on individual basis.

iv. The benefit shall be available on Cashless basis and arranged with Our Network Provider. Where the test(s) cannot be arranged by Network Provider We may provide Reimbursement facility on approval basis.

v. Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Booster Benefit (if opted).

What is not covered:

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

D. OPTIONAL COVERS

On availing of this option, We will indemnify the Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person i.e. Domestic help in this case, during the Policy Period for an Illness, Injury or condition as described in the Section C.1 (Inpatient Hospitalization Treatment), Section C.4 (Day Care Treatment), Section C.8 (AYUSH), Section C.7 (Modern Treatments/Advanced Procedures), Section C.5 (Emergency Road Ambulance Cover) and Section C.6 (Bariatric Surgery Cover) of the base policy and contracted or sustained during the Policy Period

Conditions:

i. The maximum liability will be restricted up to the opted sum insured under this benefit as mentioned in the policy schedule.

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

iii. This will be an individual coverage.

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

v. The terms and conditions will remain the same as that of covered sections under this optional cover as described in the Section C.1 (Inpatient Hospitalization Treatment), Section C.4 (Day Care Treatment), Section C.8 (AYUSH), Section C.7 (Modern Treatments/Advanced Procedures), Section C.5 (Emergency Road Ambulance Cover) and Section C.6 (Bariatric Surgery Cover)

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

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

D.2 Hospital Daily Cash

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

Conditions:

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

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

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

Policy Schedule irrespective of the type of Policy.

iv. Payment under this benefit will not reduce the Base Sum Insured mentioned in policy Schedule.

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

vi. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

D.3 Accidental Death Cover for Primary Insured

On availing this option, We will pay a lump sum amount as specified in the Policy Schedule to the Primary Insured Person, if he/she suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Primary Insured Person's death within three hundred and sixty five (365) days from the date of Accident.

Conditions:

i. This cover can be only opted at the inception of the policy

ii. The defined Sum Insured in the Policy Schedule will be over and above the Base Sum Insured under Section C.

iii. Booster Benefit shall not be applicable on this cover.

For the purpose of this cover, Primary Insured Person shall mean the Insured Person who has paid the premium for this Policy.

D.4 Healing Benefit (>5 days of Hospitalization)

On availing this option, We will pay a lump sum amount as specified in the Policy Schedule upon Your Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, provided that, claim is admissible under Section C.1 (Inpatient Hospitalization Treatment) or Section C.8 (AYUSH Treatments).

Condition

i. This Benefit is over and above Base Sum Insured

ii. This is available per Hospitalization of each Insured Person

iii. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

The payment under this benefit will be made if Length of stay per hospitalization is more than 5 days

D.5 Unlimited Refill (Related and Unrelated Illness both)

On availing this option, this benefit is triggered and becomes payable for each and every claim from the first claim itself in a policy year.

Conditions:

The above coverage is subject to fulfilment of following conditions:

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

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

Base Sum Insured followed by; Booster Benefit (if any) followed by; Unlimited Refill

iii. Claims under this benefit will be payable only under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.8 (AYUSH Treatments) arising in that Policy Year for any or all Insured Person(s).

iv. For Family Floater Policies, the amount under this benefit will be available on a floater basis to all Insured Persons in that Policy Year.

v. Anyone Illness clause will not be applicable under this benefit.

D.6 Vector Borne Fixed Benefit

On availing this option, We will pay a lump sum amount as specified in the Policy Schedule as mentioned in the Policy Schedule under below listed covers on Medically Necessary Hospitalization of Insured Person due to:

1. Dengue
2. Malaria
3. Filaria (Lymphatic Filariasis)
4. Kala-azar
5. Chikungunya
6. Japanese Encephalitis
7. Zika Virus

Conditions:

i. Claim will be payable subject to fulfilment of the definition of the Vector Borne disease covered, continuous 48 hours of hospitalization due to the covered Vector Borne Diseases as listed above and defined below and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem).

ii. This benefit will be provided once in the lifetime of the per Insured Person, irrespective of Individual or Family Floater. The coverage under this benefit shall cease to exist upon occurrence of any one Claim is admitted by the Company.

iii. Insured Person shall not bear specified percentage of admissible Claim amount if Co-payment under Section D.15 is opted and specified in the Policy Schedule.

iv. Any Pre-existing illness will not be covered.

Definitions related to Section D.6 - Vector Borne Fixed Benefit:

1. Dengue

Diagnosis of Dengue Fever should be confirmed by a Medical Practitioner and Laboratory examination result countersigned by a pathologist/ microbiologist confirms the following:

- Immunoglobulins/ PCR test showing positive results for Dengue

2. Malaria

Diagnosis of Malaria should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/ Malaria in the patient's blood by laboratory examination countersigned by a pathologist/ microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. Filaria (Lymphatic Filariasis)

Commonly known as Elephantiasis, must be confirmed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

- Lymphoedema,
- Elephantiasis,
- Scrotal swelling

Filariasis will be payable only once in Insured's lifetime.

4. Kala-azar

Visceral leishmaniasis, also known as Kalaazar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia.

The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/ spleen/ lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease.

5. Chikungunya

Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue, and rash.

The diagnosis must be documented by a Medical Practitioner and

by Serological tests, such as enzyme-linked immunosorbent assays (E L I S A), confirming the presence of IgM and IgG anti-chikungunya antibodies.

Survival Period

Claim under this Cover is payable only if Insured Person survives 28 days from the diagnosis, fulfilment of the definition of the Critical illness covered and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem)

Condition:

i. The coverage under this benefit shall cease to exist upon occurrence of any one Critical Illness cover for which, Claim is paid by the Company. This benefit will be provided once in the lifetime of the per Insured Person.

ii. This optional cover cannot be opted again (by the insured who has claimed under this benefit) in any of the subsequent renewals. The base policy can be renewed continuously even after claim is paid under this benefit for the Insured who has claimed under this benefit.

Name of CI / Surgery
1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
3. Open Chest Coronary Artery Bypass Grafting (CABG)
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ /Bone Marrow Transplant*
9. Permanent Paralysis of Limbs
10. Motor Neuron Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms
12. Benign Brain Tumor
13. Blindness
14. Deafness
15. End Stage Lung Failure
16. End Stage Liver Failure
17. Loss of Speech
18. Loss of Limbs
19. Major Head Trauma
20. Primary (Idiopathic) Pulmonary Hypertension
21. Third Degree Burns
22. Alzheimer's Disease
23. Parkinson's Disease
24. Aorta Graft Surgery
25. Amputation of Feet Due to Complications from Diabetes
26. Myasthenia Gravis
27. Elephantiasis
28. Aplastic Anaemia
29. Loss of Independent Existence (Cover up to Age 74)
30. Dissecting Aortic Aneurysm
31. Progressive Scleroderma
32. Chronic Adrenal Insufficiency (Addison's Disease)
33. Other Serious Coronary Artery Disease
34. Severe Rheumatoid Arthritis
35. Cardiomyopathy
36. Infective Endocarditis
37. Medullary Cystic Disease
38. Apallic Syndrome
39. Creutzfeldt-Jacob Disease (CJD)
40. Ebola
41. Pneumonectomy
42. Brain Surgery
43. Severe Ulcerative Colitis
44. Chronic Relapsing Pancreatitis
45. Progressive Supranuclear Palsy
46. Terminal Illness
47. Fulminant Hepatitis
48. Crohn's Disease
49.Bacterial Meningitis
50.Loss of One Limb and One Eye
51.Necrotising Fasciitis
52.Muscular Dystrophy
53.Hemiplegia
54.Poliomyelitis
55.Tuberculosis Meningitis
56.Encephalitis
57.Myelofibrosis
58.Pheochromocytoma
59.Systemic Lupus Erythematosus with Lupus Nephritis
60.Eisenmenger's Syndrome

iii. Irrespective of the type of Policy the benefits under this Section shall be available on an individual basis to each Insured Person whose age is between 18 to 45 years, up to the limits specified in the Policy Schedule.

iv. Any Pre-existing Critical illness will not be covered.

v. The Sum Insured is independent and over and above of Base Cover

vi. This cover can be only opted at the inception of the policy.

vii. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

Definitions related to Section D.7 – Critical Illness Fixed Benefit:

1. Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of specific severity)

The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1. Any type of angina pectoris
2. Other acute Coronary Syndromes
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

3. Open Chest Coronary Artery Bypass Grafting (CABG)

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

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. 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:

i. No response to external stimuli continuously for at least 96 hours;

ii. Life support measures are necessary to sustain life; and

iii. 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.

6. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

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.

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7. Major organ/bone marrow transplant

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

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

The following are excluded:

1. Other stem-cell transplants
2. Where only islets of langerhans are transplanted

8. 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.

9. Motor neuron disease with permanent symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico-spinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

10. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

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.

II. Other causes of Neurological damage due to SLE is excluded

11. Benign Brain Tumor

i. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

ii. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

A. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

B. Undergone surgical resection or radiation therapy to treat the brain tumor.

iii. The following conditions are excluded:

Cyst, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumor of the spinal cord.

12. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

i. Corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

iii. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

13. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

14. End Stage Lung Failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 liter measured on 3 occasions 3 months apart;

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia;

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

iv. Dyspnea at rest.

15. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

16. Loss of speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords.

The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

17. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

18. Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

Spinal cord injury

19. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

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

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

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and

toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

20. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

21. Alzheimer's Disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 3 months:

Activities of Daily Living are defined as:

i. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding – the ability to feed oneself once food has been prepared and made available.

vi. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:

Alcohol-related brain damage.

22. Parkinson's disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant Neurologist.

i. The diagnosis must be supported by all of the following conditions:

ii. The disease cannot be controlled with medication;

iii. Objective signs of progressive impairment; and

There is an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following "activities of daily living" for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: The ability to move from bed to an upright chair or wheelchair and vice versa;

iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding: The ability to feed oneself once the food has been prepared and made available;

vi. Mobility: The ability to move indoors from room to room on level surfaces.

Drug-induced or toxic causes of Parkinsonism are excluded.

23. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The insured person understands and agrees that we will not cover:

i. Surgery performed using only minimally invasive or intra arterial techniques.

ii. Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures.

Aorta graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

24. Amputation of Feet due to Complications from Diabetes

Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Registered Doctor who is a specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

25. Myasthenia Gravis

An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:

Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification given below; and

The Diagnosis of Myasthenia Gravis and categorization are confirmed by a Registered Doctor who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.

Class II: Eye muscle weakness of any severity, mild weakness of other muscles.

Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.

Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.

Class V: Intubation needed to maintain airway.

26. Elephantiasis

Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a Registered Doctor who is a specialist physician. There must be clinical evidence of permanent massive swelling of legs, arms, scrotum, vulva, or breasts. There must also be laboratory confirmation of microfilariae infection.

Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

27. Aplastic Anaemia

Chronic Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

i. Regular Blood product transfusion;

ii. Marrow stimulating agents;

iii. Immunosuppressive agents; or

iv. Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a haematologist acceptable to the Company using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

i. Absolute neutrophil count of 500/mm³ per cubic millimetre or less

ii. Platelets count of 20,000/mm³ per cubic millimetre or less

iii. Absolute erythrocyte Reticulocyte count of 20,000/mm³ per cubic millimeter or less and Temporary or reversible Aplastic Anaemia is excluded.

28. Loss of Independent Existence (cover up to Insurance Age 74)

The insured person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of daily living:

I. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances; Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iii. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

iv. Feeding: the ability to feed oneself once food has been prepared and made available;

v. Mobility: The ability to move indoors from room to room on level surfaces

29. Dissecting Aortic Aneurysm

A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Doctor who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

30. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

i. Localised scleroderma (linear scleroderma or morphea);

ii. fasciitis; and

iii. CREST syndrome.

31. Chronic Adrenal Insufficiency (Addison's Disease)

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:

i. ACTH simulation tests;

ii. Insulin-induced hypoglycemia test;

iii. Plasma ACTH level measurement;

iv. Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

32. Other Serious Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary angiography, regardless of whether or not any form of coronary artery intervention or surgery has been performed.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery (but not including their branches).

33. Severe Rheumatoid Arthritis

The Unequivocal Diagnosis of severe rheumatoid arthritis with all of the following factors:

Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.

At least 3 joints are damaged or deformed such as finger joint, wrist, elbow, knee joint, hip joint, ankles, cervical spine or feet toe joint as confirmed by clinical and radiological evidence and cannot perform at least 3 types of daily routines permanently for at least 180 days.

34. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Consultant cardiologist, who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification criteria Class IV,: Inability to carry out any activity without discomfort.

Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echo-graphic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

35. Infective Endocarditis

I. Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

i. Positive result of the blood culture proving presence of the infectious organism(s);

ii. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and the severity of valvular disease/ risk factors and

II. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Consultant a cardiologist.

36. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

i. The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;

ii. Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

iii. The Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

37. Apallic Syndrome

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to us and the patient should be documented to be in a vegetative state for a minimum of at least one month in order to be classified as UWS, PVS, Apallic Syndrome.

38. Creutzfeldt-Jacob Disease (CJD)

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

39. Ebola

Infection with the Ebola virus where the following conditions are met:

i. Presence of the Ebola virus has been confirmed by laboratory testing;

ii. There are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and

iii. The infection does not result in death.

40. Pneumonectomy

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life insured.

The following conditions are excluded:

i. Removal of a lobe of lungs (lobectomy)

ii. Lung resection or incision

41. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Doctor who is a qualified specialist.

42. Severe Ulcerative Colitis

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances. All of the following criteria must be met:

i. The entire colon is affected, with severe bloody diarrhoea and

ii. The necessary treatment is total colectomy and ileostomy; and

iii. The diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

43. Chronic Relapsing Pancreatitis

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterized by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

44. Progressive Supranuclear Palsy

Confirmed by a Registered Doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

45. Terminal illness

The conclusive diagnosis of an illness, which in the opinion of a Registered Doctor who is an attending Consultant and agreed by our appointed Registered Doctor, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

46. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following

i. Rapid decreasing of liver size as confirmed by abdominal ultrasound; and

ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required); and Rapid deterioration of liver function tests; and

iii. Deepening jaundice; and

iv. Hepatic encephalopathy

This excludes

a. Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

b. Fulminant Viral Hepatitis caused by alcohol, toxic substance or drug.

47. Severe Crohn's Disease

Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

i. Stricture formation causing intestinal obstruction requiring admission to hospital, and

ii. Fistula formation between loops of bowel, and

iii. At least one bowel segment resection.

The diagnosis must be made by a Registered Doctor who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

48. Bacterial Meningitis

Bacterial infection resulting in inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit.

This diagnosis must be confirmed by:

i. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

ii. A consultant neurologist.

49. Loss of One Limb and One Eye

Total, permanent and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the elbow or knee. The loss of sight of one eye must be clinically confirmed by a Registered Doctor who is an eye specialist, and must not be correctable by aides or surgical procedures.

50. Necrotising Fasciitis

Necrotizing fasciitis is a progressive, rapidly spreading, infection located in the deep fascia causing necrosis of the subcutaneous

tissues. An unequivocal diagnosis of necrotizing fasciitis must be made by a Registered Doctor who is a specialist and the diagnosis must be supported with laboratory evidence of the presence of a bacterium that is a known cause of necrotising fasciitis. There must also be widespread destruction of muscle and other soft tissues that results in a total and permanent loss or function of the affected body part.

51. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

52. Hemiplegia

The total and permanent loss of the use of one side of the body through paralysis persisting for a period of at least 6 weeks and with no foreseeable possibility of recovery caused by illness or injury, except when such injury is self-inflicted.

53. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

i. Poliovirus is identified as the cause,

ii. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

54. Tuberculosis Meningitis

Meningitis caused by tubercle bacilli, resulting in permanent neurological deficit persisting for at least 180 consecutive days. Such a diagnosis must be confirmed by a Registered Doctor who is a specialist in neurology. Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are not present on clinical examination and expected to last throughout the lifetime of life insured.

55. Encephalitis

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks. The permanent deficit should result in permanent inability to perform three or more Activities for Daily Living (listed below).

The Activities of Daily Living are:

Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

i. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

ii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iii. Mobility: the ability to move indoors from room to room on level surfaces;

iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding: the ability to feed oneself once food has been prepared and made available.

56. Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

57. Pheochromocytoma

Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

The Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

58. Systemic Lupus Erythematosus with Lupus Nephritis

A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:

Class I Minimal Change Lupus Glomerulonephritis

Class II Mesangial Lupus Glomerulonephritis

Class III Focal Segmental Proliferative Lupus Glomerulonephritis

Class IV Diffuse Proliferative Lupus Glomerulonephritis

Class V Membranous Lupus Glomerulonephritis

59. Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:

I. Mean pulmonary artery pressure > 40 mm Hg;

ii. Pulmonary vascular resistance > 3mm/L/min (Wood units); and

iii. Normal pulmonary wedge pressure < 15 mm Hg.

D.8 Claims Safeguard

On availing this option, If We have accepted a Hospitalization claim under Section C, then the items which are not payable as per List I – 'Expenses not covered' under Annexure II related to that particular claim will become payable

D.9 Out Patient (OPD) Cover

On availing this option, We will indemnify the Medical Expenses per member incurred up to the amount specified against this Benefit in the Policy Schedule for the OPD expenses including Diagnostics and

Pharmacy, irrespective of type of Policy (floater or individual basis cover)

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

Condition:

i. 50% co-payment will be applicable on Professional Fees

ii. 30% co-payment will be applicable on Diagnostics and Pharmacy Expenses to be borne by the Insured

iii. The cover excludes expenses incurred towards Spectacles, Contact Lenses, Physiotherapy, Preventive tests, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, any type of Dental treatment, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

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

D.10 Booster Benefit

On availing this option, Booster Benefit be applied, Sum Insured is increased by 50% (as specified in the Policy Schedule) of the Base Sum Insured of immediate preceding Policy Year in respect of each claim free Policy Year (where no claims are reported), provided the Policy is renewed with the Company without a break, subject to maximum cap of 200% (as specified in the Policy Schedule) of the Base Sum Insured under the current Policy Year. If a claim is made in any particular Policy Year, the Booster Benefit accrued shall be reduced at the same rate at which it has accrued.

Condition:

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

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

iii. Booster Benefit shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Booster Benefit for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the Booster Benefit to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

v. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 30 years, the Booster Benefit of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable Booster Benefit shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal, the Booster Benefit shall be calculated on the Sum Insured of the last completed Policy Year.

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

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

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

xi. In case of Mid-term addition in Individual policies, the Booster Benefit will be accrued for the newly added member from subsequent renewal

xii. Mid-term addition of member will be allowed up to first 6 months of the policy year only.

D.11 E-Opinion

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

Condition:

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

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

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

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

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

vi. The E-Opinion provided under this benefit is not for emergency care and shall not be valid for any medico legal purposes.

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

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

D.12 Women Care Benefit

D.12.1 Maternity Expenses

On availing this option, We will indemnify the Medical Expenses incurred up to the amount specified against this Benefit in the Policy Schedule for the Maternity Expenses incurred in respect of the Hospitalization of the female Insured Person for the delivery of the child during the Policy Period, subject to a waiting period of 48 months.

Condition:

i. The cover under this benefit shall include Pre-natal & Post-natal medical expenses.

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

iii. The insured person for whom the claim has been made under this benefit has to be the female insured covered under the policy and respective waiting periods as mentioned above shall apply.

iv. Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit except in case of life-threatening situation under the advice of Medical Practitioner For this purpose, 'week' shall constitute any consecutive 7 days.

v. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person.

vi. Medical Expenses for ectopic pregnancy are not covered under this Benefit but shall be covered under Section C.1

vii. Pre-natal medical expenses will be covered from the date of confirmation of pregnancy till the delivery and Post-natal medical expenses for a period up to eight (8) weeks after delivery.

D.12.2 New Born Baby Cover

On availing this option, the Company will indemnify up to the Sum Insured specified against this Benefit in the Policy Schedule for the Medical Expenses incurred in respect of a New Born Baby subject to Mother being covered under the policy.

Condition

i. The claim under this benefit shall be payable, if the Company has accepted the claim under Benefit-D.12.1 Maternity Expenses

ii. The coverage will be available in respect of a New Born Baby for 90 days from date of delivery.

iii. The Baby born during the policy period, will be covered from day one up to 90 days of age.

iv. New Born Baby older than 90 days and less than 1 year can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the additional premium

v. For Family Floater Policies, the amount under this benefit will be available on a floater basis.

vi. For Individual Policies, the amount under this benefit will be available with in Mother's In-patient Hospitalization Treatment cover under section C.1 in that Policy Year.

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

D.12.3 Assisted Reproduction Treatment:

On availing this option, the Company will reimburse medical expenses up to INR 1 Lakh incurred on Assisted Reproduction Treatment, where indicated, for sub-fertility subject to:

i. A waiting period of 48 months from the date of first inception of this policy with the Company for the insured person.

ii. Company will pay one Assisted Reproduction Treatment cycle for each eligible Insured Person undergoing treatment in a Policy Year.

iii. For the purpose of claiming under this benefit, in- patient treatment is not mandatory.

iv. Exclusion F.A.XIV (ii) will not be applicable under this section.

v. Benefits under this Section shall be available on an individual basis to each eligible Insured Person whose age is between 18 and above up to the limits specified in the Policy Schedule, irrespective of the type of Policy

Special Exclusions:

The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of:

i. Pre and Post treatment expenses

ii. Sub-fertility services that are deemed to be unproven, experimental or investigational

iii. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

iv. Reversal of voluntary sterilization

v. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery/ previous deliveries is/are not alive at the time of treatment.

vi. Payment for services rendered to a surrogate

viii. Selective termination of an embryo.

ix. Services done at unrecognized centre Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.

x. Exclusion F.A.XV of the Policy Terms & Conditions shall be not applicable to Section D.12

xi. This Benefit is over and above Base Sum Insured

D. 13 Global Treatment

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

	Name of Illness	Definition
1	Cancer Treatment Surgery	We will be covering expenses incurred in Surgery for Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. I. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high-grade dysplasia or severe dysplasia.
2	Heart Valve Replacement	I. 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. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.
3	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).
4	Pulmonary Artery Graft Surgery	We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
5	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. The following are excluded: Angioplasty and/or any other intra-arterial procedures.
7	Surgical Treatment for Stroke	I. 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. II. We will be covering surgical treatment of Stroke limited to: a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy;

		b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke. III. The following are excluded: a. Transient ischemic attacks (TIA); b. Traumatic injury of the brain; c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
8	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases: a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 <55mmHg); and iv. Dyspnea at rest.
9	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases: I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
10	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to: a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy II. 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. d. The condition has to be confirmed by a specialist medical practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.
11	Surgery for Pheochrom ocytoma	I. We will be covering the actual undergoing of surgery to remove the tumour. II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.
12	Liver Transplant Surgery in case of End Stage Liver Disease	In case of End Stage Liver Disease We will be covering the actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following: I. Permanent jaundice; and ii. Ascites; and iii. Hepatic Encephalopathy. iv. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. Liver failure secondary to drug or alcohol abuse is excluded
13	Pneumonectomy - Removal of an entire lung	Removal of an entire lung The undergoing of surgery to remove an entire lung for disease or trauma. The following is not covered: i. Partial removal of a lung (lobectomy) or lung resection or incision. The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
14	Surgical removal of an eyeball	Surgical removal of a complete eyeball as a result of injury or disease. For the above definition the following is not covered: I. Self- inflicted injuries The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
15	Heart transplant surgery	Covers the actual undergoing of a transplant of human heart due to irreversible end- stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
16	Craniotomy for Cerebral Aneurysm	We will be covering the actual undergoing of Craniotomy for treatment of Cerebral aneurysm diagnosed by appropriate medical consultant supported with evidence of cerebral angiogram and/or

	magnetic resonance angiography and/or CT scan. For the above definition the following are not covered: i. Cerebral arteriovenous malformation.

Condition:

I. The above listed Illness must be diagnosed in India.

ii. The symptoms of the listed Illness first occur or manifest itself during the Policy Period and after completion of the applicable

Condition:

I. The above listed Illness must be diagnosed in India.

ii. The symptoms of the listed Illness first occur or manifest itself during the Policy Period and after completion of the applicable waiting periods as specified in the Policy Schedule.

iii. The planned treatment under this cover shall be claimed only on Reimbursement basis only.

iv. The treating Medical Practitioner must recommend the necessity of treatment abroad, considering the medical condition and availability of treatment at an international center of excellence which is best in class.

v. The Hospitalization is towards Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.

vi. For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and/or regulations applicable to the country where the treatment is taken.

vii. Claim amount will be paid in INR in Indian account of the Insured.

viii. The onus of procuring all the medical documents/requirements to adjudicate any claim will be on the Insured Person.

Section D.5 {Unlimited Refill (Related and Unrelated Illness both)} will not be applicable if claim is admissible under this section.

D.14 Wellness Benefit

On availing this option, The Insured Person may avail wellness services as mentioned in the Policy Schedule. The services may include any or all as specified in the policy schedule: **Services**	**Utilization Parameter (if applicable as per Policy Schedule)**
D.14.1 Health Assistance (A.I. Personal Fitness coaching)	Unlimited
D.14.2 Dietician and Nutrition E-consultation	Unlimited
D.14.3 Unlimited Gym Membership	**Option 1** - Eligible Customer must utilise Gym Services at least once every quarter (3 months periods from policy start date) to activate the next quarter. Once suspended, cannot be activated thereafter. **Option 2** - Eligible Customer must utilise Gym Services at least once in the first 6 months (from policy start date) to activate the next 6 months. Once suspended, cannot be activated thereafter.
D.14.4 Walk Healthy Benefit	Collect health benefits by taking steps counted on our App or Activity tracker of the vendor and get discount up to 30% onenewal premium.

Condition:

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

ii. The above-mentioned optional covers (D.14.1 to D.14.4) can only be opted at inception of the policy and cannot be opted at subsequent renewals.

iii. This cover will be available on optional basis. D 14.1 [Health Assistance (A.I. Personal Fitness coaching)], D14.2[Dietician and Nutrition E-consultation], D14.3 [Unlimited Gym Membership]. Wellness benefit can be availed only as a combination i.e with or without D 14.4[Walk Healthy Benefit]

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

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

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

D.14.4. Conditions Applicable to Walk Healthy Benefit

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

Conditions - The above coverage is subject to fulfilment of following conditions:

a. Steps taken by the Insured Person, who is covered as an Adult under the policy, are recorded every day. Steps will be counted by the mobile App which is provided to use ONLY would be considered.

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

Note: For long term policies the discount grid as per table no.2 and 3 will be applied.

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

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

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

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

Table no.1 (Policy Period -1 year)

Policy duration	End of 9 months	Steps at the end of 9 months (A) This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount applicable on second year of Policy Period (1st Renewal)			
					NOTE: Discount applicable on Individual Policies and or Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
1 year	End of 9 months	1500000			0%	0%	0%	0%
		1500001-2250000			5%	2.50%	1.65%	1.25%
		2251000 – 3000000			15%	7.50%	5.0%	3.75%
		3000001 – 3750000			20%	10%	6.65%	5.00%
		>=3750001			30%	15%	10.0%	7.50%

Table no.2 (Policy Period -2 years)

Policy duration	End of 21 months	Steps at the end of 21 months (A). This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium			
					NOTE: Discount applicable on Individual Policies and or Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
Year 1 and 2 (2 years)	End of 21 months	3000000			0%	0%	0%	0%
		3000001 – 4500000			5%	2.50%	1.65%	1.25%
		4500001 – 6000000			15%	7.50%	5.0%	3.75%
		6000001 – 7500000			20%	10%	6.65%	5.00%
		>=7500001			30%	15%	10.0%	7.50%

Tale no.3 (Policy Period -3 years)

Policy duration	End of 33 months	Steps at the end of 33 months (A). This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium			
					NOTE: Discount applicable on Individual Policies and or Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
Year 1,2 and 3	End of 33 months	Upto 4500000			0%	0%	0%	0%
		4500001 – 6750000			5%	2.50%	1.65%	1.25%
		6751000– 9000000			15%	7.50%	5.0%	3.75%
		9000001 – 11250000			20%	10%	6.65%	5.00%
		>=1125001			30%	15%	10.0%	7.50%

SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products

SBI General Insurance Company Limited, Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai - 400099. | CIN: U66000MH2009PLC190546 | Tollfree: 18001021111 | customer.care@sbigeneral.in | www.sbigeneral.in | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Company Limited under license | IRDAI Reg No: 144 | Health Edge Insurance, UIN: SBIHLIP23173V012223 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

D.15 Co-payment

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

Note 1: This co-payment will be additive to any other co-payment in the Policy, if applicable.

Note 2: Co-payment will be applicable under any admissible claim under Section C.1 (In-patient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.6 (Bariatric Surgery Cover) or Section C.7 (Modern Treatment/Advanced Procedures) or Section C.8 (AYUSH Treatment)

E. WAITING PERIOD

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

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

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

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than 24 months.

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

Note: The above waiting period shall not be applicable for claims arising due to Critical Illness Cover, Hypertension, Diabetes and Cardiac Condition. Waiting period specific to these ailments are mentioned in E. IV, V.

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

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

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

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

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

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

1. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. Kidney stone, Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/Fistula in anus, Hemorrhoids including
Pilonidal sinus	Gout and Rheumatism
Benign tumors, Cysts, Nodules, Polyps including breast lumps	Osteoarthritis and Osteoporosis
Polycystic ovarian diseases	Fibroids (Fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate
Genetic Disorder	

2. Surgical Procedures

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

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

a) Expenses related to the treatment of a Pre-Existing Diseases (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us.

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

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

d) Coverage under the Policy after expiry of 24 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

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

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

VII) Women Care Benefit: A waiting Period of shall apply for all claims under the Women Care Benefit as **Maternity Expenses**: 48 months, **Assisted Reproduction Treatment**: 48 months

F. GENERAL EXCLUSIONS

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

A. STANDARD EXCLUSIONS

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

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

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

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

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

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

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

III. 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.

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

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

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

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

VI. Breach of Law (Code- Excl 10)

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

VII. Excluded Providers (Code-Excl 11)

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

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

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

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

XI. Refractive Error (Code-Excl 15)

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

XII. Unproven Treatments (Code- Excl 16)

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

XIII. Sterility and Infertility (Code-Excl 17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI (Not applicable for Section D.12.3 - Assisted Reproduction Treatment)

iii. Gestational Surrogacy

iv. Reversal of sterilization

XIV. Maternity (Code-Excl 18) (Not Applicable for Section D.12 – Women Care Benefit)

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

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

B. SPECIFIC EXCLUSIONS

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

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

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

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

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

III. Treatment taken outside India (Not applicable for variants wherein D.14 – Global Treatment is applicable.

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

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

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

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

VIII. Expenses related to Domiciliary hospitalization shall not be covered.

IX. Non-payable items: Expenses against items mentioned in "List I" shall not be payable. This exclusion shall be waived off, if Optional Benefit-D.8 has been opted under the Policy.

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

XI. 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 such specified ICD codes.

XII. If as per any or all of the medical references herein below containing guidelines and protocols for evidence-based medicines, the Hospitalization for treatment under claim is not necessary or the stay at the Hospital is found unduly long:

a. Medical text books,

b. Standard treatment guidelines as stated in clinical establishment act of Government of India,

c. World Health Organization (WHO) protocols,

d. Published guidelines by healthcare providers,

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

XIII. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

G. CONDITIONS

A.I STANDARD TERMS AND CONDITIONS

1 Condition Precedent to the contract

a. Disclosure of Information

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

b. Condition Precedent to Admissible of Liability

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

c. Multiple Policies (applicable for Indemnity Section only)

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.

d. 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.

e. 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 Your death. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the Insured Person, the Company will pay the nominee (as named in the Policy Schedule) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

II. Conditions applicable during the contract

1. Cancellation:

a. Cancellation by you:

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

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

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

b. Cancellation by Us:

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

2. 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.

3. Addition of Insured during the policy period

Where an individual is added to this Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy with Us for that Insured Person.

Option of Mid-term inclusion of a Person in the Policy as an Insured will be only upon marriage or childbirth (inclusion of child only after

completed 90 days and less than 1 year of age), Additional differential premium will be calculated on a pro rata basis. Otherwise child addition can happen only in next renewal or at the start of next policy year in multi-year policies.

4. Withdrawal of the Product

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

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

5. Premium Payment in Installment

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

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

ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

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

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

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

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

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

Option	Instalment Premium Option
Option 1	Half yearly
Option 2	Quarterly
Option 3	Monthly
Option 4	Annual
Option 5	Single

6. 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.

B. SPECIFIC CONDITIONS

I. Condition Precedent to the contract

a. Age Limit

To be eligible to be covered under the Policy or get any benefits under the Policy, the Insured Person should have attained the age of at least 18 years on the date of commencement of the Policy. Dependent children can be covered from 91 days and up to 30 years of age.

b. Currency

The monetary limits applicable to this Policy will be in INR

c. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

d. Material Change

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

f. Notice and Communication

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

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

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

g. Premium

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

h. Records to be Maintained

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

i. Automatic change in Coverage under the policy

i. The coverage for the Insured Person(s) shall automatically terminate: In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

ii. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal

on the due date as per the applicable terms and conditions.

J. Territorial Jurisdiction

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

k. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

II. Conditions applicable during the contract

a. Alterations in the Policy

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

b. Conditions when a claim arises

On the occurrence of any Claim under this Policy, the claim procedures set out below shall be followed.

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

- **List of Documents for Reimbursement Claims:**

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

- **List of Documents for Accidental Death Cover for Primary Insured:**

1. Duly completed and signed Claim Form, in original
2. Death certificate
3. Post mortem report if available and applicable
4. First Information Report/ Final Police Report, if applicable
5. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.
6. Any other document as required by the Company to assess the Claim

- **List of Documents for Global Treatment:**

1. Duly completed and signed Claim Form, in original
2. Passport Copy with Visa Stamp
3. Medical Practitioner's referral letter advising Hospitalization
4. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
5. Original bills, receipts and discharge card from the Hospital / Medical Practitioner
6. Original bills from pharmacy / chemists
7. Original pathological / diagnostic test reports and payment receipts
8. Indoor case papers
9. First Information Report/ Final Police Report, if applicable
10. Post mortem report, if available

- **List of Documents for Critical Illness Cover:**

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

- **List of Documents for Hospital Daily Cash**

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

Note:

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

- **Claim Document Submission Address**

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

Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team

SBI General Insurance Company Limited

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

Pune, Maharashtra – 411 045

- **Conditions for obtaining Cashless Facility:**

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

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

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

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

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

- **Claim documents submission:**

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

- **Claim Assessment**

We will pay fixed amounts as specified in the applicable Sections in accordance with the terms of this Policy. We are not liable to make any payments that are not specified in the Policy.

- **Condonation of delay:**

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

- **Standard Condition for Claim Process**

▶ **Claim Settlement**

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

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of claim submission to the date of payment of claim at a rate 2% above the bank rate.

▶ **Fraud**

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all Insured Person who has made that particular claim, who shall be jointly and severally liable for such repayment to Us.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or

by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

c) Any other act fitted to deceive; and

d) Any such act or omission as the law specially declares to be fraudulent The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Company.

- Complete Discharge Any payment to the Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.
- Payment of Claim All claims under the Policy shall be payable in Indian currency only.

C. Conditions for renewal of the contract

1. Renewal Conditions:

i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.

ii. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

iii. Renewal shall not be denied on the ground that the Insured Person had made a Claim or Claims in the preceding Policy years.

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

v. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

vi. No loading shall apply on Renewals based on individual Claims experience.

2. 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

3. 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

D. Grievances Redressal Procedure

Stage 1:

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

For Senior Citizens:

Senior citizens can reach us through the following dedicated channels:

Email: Seniorcitizengrievances@SBIGeneral.in

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

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

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

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

Stage 2 : Escalation to Insurance Ombudsman

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

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

SURAKSHA AUR BHAROSA DONO

ANNEXURE A

Names of Ombudsman and Addresses of Ombudsmen centers

Office Details	Ofhce of the Insurance Ombudsman
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	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
Karnataka	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
Madhya Pradesh, Chattisgarh	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
Odhisa	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
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Mr Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	Shri Segar Sampathkumar Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana- Gurugram, Faridabad, Sonepat & Bahadurgarh.	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
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	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
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	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
Rajasthan	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
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	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
West Bengal, Sikkim, Andaman & Nicobar Islands.	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

SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products

SBI General Insurance Company Limited, Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai - 400099. | CIN: U66000MH2009PLC190546 | Tollfree: 18001021111 | customer.care@sbigeneral.in | www.sbigeneral.in | SBI Logo displayed belongs to State Bank of India and used by SBI General Insurance Company Limited under license | IRDAI Reg No: 144 | Health Edge Insurance, UIN: SBIHLIP23173V012223 | SBI General Insurance and SBI are separate legal entities and SBI is working as Corporate Agent of the company for sourcing of insurance products.

Districts of Uttar Pradesh: Lalitpur, 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.	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
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	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
Bihar, Jharkhand.	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
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).	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
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.SBI Generaleneral.in	

Annexure II – Non -Medical Expenses

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 charges
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

Benefits			**Health Edge Insurance**	
Entry Age of Insured Adult			Min – 18 years and Max -65 years	
Entry Age (Child)			91 days to 30 years	
Sum Insured (SI)			3L, 5L,7L,10L, 15L,20L and 25Lacs	
Base Covers				
Eligibility	**Family Combination**		Up to 4ANC	
	Premium Type (Zone Agnostic Premium)		Age Banded	
	No. of Days of Hospitalization covered		5 days, 10 days and Unlimited	
In-patient Hospitalization	**Inpatient Hospitalization Treatment**	**Room Rent**	Actuals up to Sum Insured	Basis of Payment - Indemnity
		ICU Charges	Actuals up to Sum Insured	Basis of Payment - Indemnity
	Pre-hospitalization Medical Expenses (up to Sum Insured)		30 days	Basis of Payment - Indemnity
	Post-hospitalization Medical Expenses (up to Sum Insured)		60 days	Basis of Payment - Indemnity
	Day Care Treatment (up to Sum Insured)		All day care covered	Basis of Payment - Indemnity
	Emergency Road Ambulance Cover (per hospitalization)		INR 3000	Basis of Payment - Indemnity
	Bariatric Surgery Cover		up to 50,000	Basis of Payment - Indemnity
	Modern Treatments/Advanced Procedures		Covered up to SI	Basis of Payment - Indemnity
	AYUSH		Covered up to SI	Basis of Payment - Indemnity
	Stay Fit Health Check-Up		Up to INR 5,000	Basis of Payment - Indemnity

Optional			
Base Cover Modifiers	**Domestic Help/Staff Indemnity** [Room Rent - 2%, ICU - 4%, Bariatric - INR 50,000, (Day Care Treatment, AYUSH, Modern Treatment-up to Sum Insured), Emergency Road Ambulance - INR 3000/Hospitalization] [Min - 18 years/Max - 65 years]	INR 50K/1Lac	Basis of Payment - Indemnity
	Hospital Daily Cash	INR 1000 for 10 days or INR 2000 for 10 days	Basis of Payment - Benefit
	Accidental Death Cover (Primary Insured only)	INR 10 Lacs/20Lacs	Basis of Payment - Benefit
	Healing Benefit (>5 days of Hospitalization)	INR 5000/10,000	Basis of Payment - Benefit
	Unlimited Refill (Related and Unrelated Illness both)	Unlimited Refill up to 100% of BSI	Basis of Payment - Indemnity
	Vector Borne Fixed Benefit	INR 50K/1Lac	Basis of Payment - Benefit
	Critical Illness Cover	INR 300000/-	Basis of Payment - Benefit
	Claims Safeguard	Non-payable items covered	Basis of Payment - Indemnity
OPD	**Out Patient (OPD) Cover**	INR 5000/member	Basis of Payment - Indemnity
Renewal Benefits	**Booster Benefit** (reduction is same proportion in case claim is settled)	50% of Base Sum Insured up to 200% of Base Sum Insured	Basis of Payment - Indemnity
	E-opinion	Unlimited	Basis of Payment - Indemnity
Women Care	**Maternity Expenses**	Up to INR 25,000 for Normal Delivery and INR 50,000 for C-section.	Basis of Payment - Indemnity
	New Born Baby Cover	Actuals up to Sum Insured	Basis of Payment - Indemnity
	Assisted Reproduction Treatment	INR 1 Lacs	Basis of Payment - Indemnity
Co-Pay	**Co-payment**	10%/20%	NA
Global Cover	**Global Treatment**	Covered up to SI	Basis of Payment - Indemnity
Wellness	**Health Assistance** (A.I. Personal Fitness coaching) **Dietician and Nutrition E-consultation Unlimited Gym Membership** [Option 1 – 3+3+3+3 option and Option 2 – 6+6 Option]	Covered	NA
	Walk Healthy Benefit	Covered	NA
Waiting Period			
Waiting Period	**Pre Existing Waiting Period**	24 months	
	Specific Disease waiting period	24 Months	
	Initial Waiting Period (Excluding Accidental Hospitalization)	30 Days	
	Hypertension, Diabetes, Cardiac Condition	90 days	
	Critical Illness Cover	90 Days	
	Global Treatment	36 Months	
	Maternity Expenses	48 Months	
	Assisted Reproduction Treatment	48 Months	