SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

SBI General Health Alpha

PROSPECTUS

Take Control of your health like never before with a revolutionary Health Insurance Product that puts you in the Driver's seat. SBI General Insurance Company Limited (herein after the "Company", "We", "Our", "Us") introduce the SBI General Health Alpha Product which protects you and your family, if you and your family members are Hospitalized during Policy Period.

Specifically designed for today's empowered customer, this customizable product lets you build your health Insurance your way – from choosing essential coverage to adding modern, lifestyle-specific benefits

A. Key Features of the Policy

i. Start with a solid foundation of core health coverage by opting either one or both out of 2 Optional Base Covers, Hospitalization Cover and Personal Accident, and enhance it with a wide range of 35 Optional covers.

ii. There is no one size fits all, design your own package by adding Critical Illness, Hospital Daily Cash, OPD and Global Cover sections to your Policy.

iii. Get a wide range of Sum Insured options to choose from including Unlimited Sum Insured.

iv. Endless Sum Insured benefit which covers Hospitalization benefit for one Claim without any limit on the Base Sum Insured.

v. Long-Term Policy options available from 1 year to 5 years.

vi. Get rewarded for no Claim by opting either Cumulative Bonus up to 1000% or Guaranteed Discount in Premium at the time of renewal.

vii. Have an active lifestyle? Insure yourself against injuries from gym and sports activities with industry first exclusive Gym and Sports Injury Cover. It offers a wide coverage including consultation from sports specialist, diagnostic tests, prescription drugs and physical therapy.

viii. Get varied coverage with benefits like Reconstructive Surgery, Prosthetics, Gender Reassignment, and Plan Ahead.

ix. Avail 10% discount by taking treatment in Preferred Partner Network Hospital.

x. Avail assured 5% Welcome discount, if Policy is purchased within 5 days of receiving quote.

B. Age Criteria and Eligibility

Minimum Entry Age	Adult: 18 years
	Dependent Child: 91 Days to 25 years
Maximum Entry Age	For Hospitalization Cover: No Limit
	For Personal Accident: 65 Years
Renewability	Lifelong
Policy Term	1 Year, 2 Years, 3 Years, 4 Years and 5 Years
Premium Payment Options	Single Premium, Annual, Half-yearly, Quarterly, and Monthly
How can You cover Yourself	Individual/Family Individual/Family Floater basis.
	Family Floater Basis: Maximum of 4 adults and any no. of children can be included in a single Policy.
Who are covered (Relationship with respect to the Proposer)	**For Family Individual (Hospitalization Cover):** Self, Legally Married Spouse/Live-in Partner, Son, Son-in-Law, Daughter, Daughter-in-Law, Father, Mother, Brother, Brother-in-Law, Sister, Sister-in-Law, Mother-in-Law, Father-in Law, Grandmother, Grandfather, Grandson, Granddaughter, Uncle, Aunt, Nephew, Niece, or Any other relationship having an insurable interest. **For Family Individual (PA, Critical Illness and Hospital Daily Cash):** Self, Legally Married Spouse, Dependent Children (Natural/Legally Adopted), Parents and/or Parents-in-Law. **For Family Floater:** Self, Legally Married Spouse, Dependent Children (Natural/Legally Adopted), Parents and/or Parents-in-Law.

C. Sum Insured (In Lacs)

In case of 'Hospitalization Cover' - 5, 7.5, 10, 12.5, 15, 20, 25, 30, 35, 50, 75, 100, 150, 200, 250, 300, Unlimited Sum Insured.

In case of 'Personal Accident' - 1 lac to 10 lacs (in multiples of 1 lac), 10 lacs to 100 lacs in (multiples of 5 lacs), 125, 150, 175, 200 Lacs.

Scope of Cover

We hereby agree subject to the terms, conditions and exclusions contained or expressed herein, to compensate the Insured Person, during the Policy Period, as per the covers and limits specified in the Policy Schedule.

All Sections mentioned under the Policy are Optional, but it is mandatory to opt D. Hospitalization Cover and/or E. Personal Accident Cover as mandatory Base Cover(s).

D. Hospitalization Cover

D.(a). In-Patient Treatment

Covers admission in Hospital beyond 24 hours. Room Rent can be covered up to actuals or Single Private AC Room or Twin Sharing Room as opted.

D.(b). Day Care Treatment

All Day Care Procedures will be covered even if the Insured Person is admitted for 2 hours or more. Also, treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer will be covered.

D.(c). AYUSH Treatment

Covers Medical Expenses for In-Patient Treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy.

D.(e). Domiciliary Treatment

Covers Medical Expenses for Domiciliary Hospitalization, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days.

D.(f). Pre-Hospitalization

Covers Medical Expenses incurred immediately before the Insured Person was Hospitalized for 30 or 60 or 90 days, as opted.

D.(g). Post-Hospitalization

Covers Medical Expenses incurred immediately after the Insured Person was Hospitalized for 60 or 90 or 120 or 180 days as opted.

D.(h). Bariatric Surgery

Covers Medical Expenses incurred towards surgical procedure for obesity for:-

i. Adults aged 18 years or older, presence of severe obesity 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:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnoea
- Uncontrolled Type 2 Diabetes

ii. This benefit shall become available only after the expiry of 24 months from the date of inception of the first Policy with Us.

Optional Covers (Available only with D. Hospitalization Cover)

All the benefits listed under D.1. to D.3 are optional covers and can be made available only with D. Hospitalization Cover under the Policy, for appropriate premium, subject to below mentioned terms, conditions, and exclusions.

D.1. Essential Covers

D.1.(a). Road Ambulance

Covers expenses on availing Road Ambulance services for transportation of Insured Person to the nearest Hospital or from one Hospital to another Hospital.

D.1.(b). Air Ambulance

Covers expenses on availing Air Ambulance services for transportation of Insured Person to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital.

D.1.(c). Radio Cab

Covers expenses on availing Radio Cab services for transportation of the Insured Person to the nearest Hospital and/or from Hospital to home.

D.1.(d). Organ Donor

Covers Medical Expenses up to 25% or 50% or 75% or 100% of Sum Insured (as opted) for any organ transplant surgery conducted on the Insured Person.

D.1.(e). Modern Treatments

Covers Medical Expenses up to 25% or 50% or 75% or 100% of Sum Insured (as opted) for In-Patient Treatment or Day Care Treatment or Domiciliary Treatment of Modern Treatments availed by the Insured Person.

D.1.(f). Home Health Care

Covers Medical Expenses up to 25% or 50% or 75% or 100% of Sum Insured (as opted) for In-Patient Treatment taken at home.

D.1.(g). Consumables Cover

Covers medically necessary expenses incurred in treatment of Insured Person for items listed in "Annexure II".

D.1.(h). Restore Benefit

Restoration of Base Sum Insured unlimited times during the Policy Year to an extent of claim amount immediately after settlement of a Claim for related or unrelated Illness/ Injury. Restored Sum Insured will be available for subsequent Claims. This benefit shall not be available if Unlimited Sum Insured has been opted under the Policy. In a given policy year, either Endless Sum Insured or Restore Benefit can be utilized. The sequence of utilization of the Sum Insured by the Insured Person at the time of making a Claim during the Policy Year will be as below:

i. Base Sum Insured

ii. Cumulative Bonus (if applicable)

iii. Restore Benefit (if opted)

D.2. Special Covers

D.2.(a). Convalescence

Lump sum payment to the Insured Person, if Hospitalized for a minimum period of 7 continuous and consecutive days. This benefit is payable once in a Policy Year, over and above the payment made under benefit D. Hospitalization Cover.

D.2.(b). Companion Cover

Covers payment of a fixed daily amount of Rs. 1000 or 2000 (as opted) for expenses of single companion towards accommodation, travel, food etc., if Insured Person is Hospitalized for minimum continuous and consecutive 72 hours. The amount under this benefit shall be payable for maximum up to 30 days in a Policy Year, over and above the payment made under benefit D.(a). In-Patient Treatment.

D.2.(c). Adventure Sports

Covers Medical Expenses incurred by Insured Person for treatment of Injury/Accident due to participation in below listed Adventure Sports up to 25%/ 50%/ 75% / 100% of Sum Insured (as opted). Available only if Insured Person is aged from 14 to 55 years.

i. Zip Lining

ii. Bungee Jumping

iii. Parasailing

iv. Water Scooter rides

v. Speed Boat rides (not as an operator)

vi. Rafting

vii. Scuba Diving

viii. Snorkelling

ix. Trekking

x. Biking including Cycling and Motor Biking

xi. Hot Air Ballooning (Tethered)

xii. All-Terrain Vehicle tours

xiii. Personal Light Electric Vehicle (Segway/PLEV) tours

xiv. River Canoeing/Kayaking

D.2.(d). Gym and Sports Injury Cover

Covers Medical Expenses incurred by Insured Person for treatment of below listed Injury due to participation in hobby sports or daily fitness activities. It includes coverage of consultation from orthopaedic sports specialist, diagnostic tests, prescription drugs and physical therapy.

Injuries Covered:

i. Fractures/Stress Fracture
ii. Shin splints
iii. Sprained ankle
iv. Muscle pull/Groin pull
v. Rotator cuff injury
vi. Tennis/Golf Elbow
vii. Concussion
viii. Sprains
ix. Strains
x. Joint dislocation
xi. Tendinopathy

D.2.(e). Reconstructive Surgery

Covers Medical Expenses incurred for treatment, if the Insured Person sustains bodily Injury/ Accident including third degree burns, which requires reconstructive surgery (for cosmetic purpose) within 6 months from the date of Accident/Injury.

D.2.(f). Prosthetics

Covers expenses incurred by Insured Person for installation of external prosthesis equipment to replace a limb or a body part (as specified in the Policy Wordings) due to an Injury/ Illness.

D.2.(g). Gender Reassignment

Covers Medical Expenses incurred by Insured Person for following Gender Reassignment Treatment/Procedures.

i. Hormone Therapy: The treatment involves hormone therapy (administered either on an In-patient or outpatient basis) like Testosterone (masculinizing hormones) for Trans Man (Female to Male) and estrogen (feminizing hormones) for Trans Woman (Male to Female).
ii. Surgical Intervention including but not limited to below listed procedures
a. Genital surgery for Male-to-Female transsexuals.
b. Genital surgery for Female-to-Male transsexuals.

D.2.(h). Vision Correction

Covers Medical Expenses incurred by Insured Person for undergoing Medically Necessary Treatment or any other advanced Surgical Procedures conducted to correct the refractive errors beyond +/- 4.5 diopter to rectify the refraction of one or both eyes.

D.2.(i). Endless Sum Insured

Covers Medical Expenses in respect of Hospitalization of the Insured Person for any one Claim during lifetime of the Policy without any limits on the Base Sum Insured, provided:

i. This benefit can be opted at the time of Policy inception or at the time of first renewal.
ii. This benefit is available only with Sum Insured Rs. 10 Lakhs and above.
iii. This benefit shall not be available if Unlimited Sum Insured has been opted under the Policy.
iv. If the Insured Person opts out of this benefit during any renewal, the same cannot be opted again.
v. Once a Claim has been made under this benefit, it will cease to exist and cannot be opted again upon subsequent renewals.
vi. The benefit can be utilized upon exhaustion of sequence of utilization of the Sum Insured by the Insured Person at the time of making a Claim during the Policy Year will be as below:
a. Base Sum Insured
b. Cumulative Bonus (if applicable)
c. Endless Sum Insured (if opted)
vii. After utilization of all the above-mentioned Sum Insured, the Total Sum Insured shall be reduced to zero for that Policy Year following the payment of claim under Endless Sum Insured.
viii. In a given Policy Year, either Endless Sum Insured (if opted) or Restore Benefit (if opted) can be utilised.

D.2.(j). Plan Ahead

Provides continuity benefit for listed Waiting Periods served by the Policyholder (must be an Insured Person under the Policy) to the newly married spouse or newborn child, within 120 days of marriage/ birth. Only newly married spouse (age up to 35 years)/newborn child (maximum 2 living children) can be added under this benefit.

i. First 30 days Waiting Period
ii. Specific Illness Waiting Period
iii. Pre-Existing Disease Waiting Period

D.3. Maternity and Child Care Cover

D.3.(a). Maternity Expenses

Covers Maternity Expenses of female Insured Person in case of normal delivery, routine or elective Caesarean or Maternity related Complications incurred on In-Patient Treatment. This benefit covers medically recommended lawful pregnancy termination only in life-threatening cases, along with pre- and post-natal medical expenses. Available only if Insured Person is aged from 18 to 45 years.

D.3.(b). New Born Baby Care

Covers Medical Expenses of Newborn Baby subject to Mother being covered under the Policy. Newborn Baby will be covered up to 90 days from the date of delivery.

D.3.(c). Child Vaccination

Covers expenses of child vaccination till the child completes 12 years of age.

D.3.(d). Assisted Reproduction Treatment

Covers Medical Expenses incurred by Insured Person towards Medically Necessary Treatment of Assisted Reproduction Treatment not limited to reversal of sterilization, Assisted Reproduction services including artificial insemination and advanced reproductive technologies but not limited to IVF, ZIFT, GIFT, ICSI, IUI. Available only if Insured Person is aged from 18 to 45 years.

E. Personal Accident

This is the other Base Cover in the product, if this section is opted, then it is mandatory to opt either E.1. Accidental Death (AD) and/or E.2. Permanent Total Disablement (PTD) under this Policy.

E.1. Accidental Death (AD)

Lump sum payment to the Nominee/Legal Heir/Assignee on Accidental Death of Insured Person, within 12 months from the date of Accident.

E.2. Permanent Total Disablement (PTD)

Lump sum payment to Insured Person, if PTD occurs within 12 months from the date of Accident as per following:-

Permanent Total Disablement (PTD)	Percentage of Sum Insured
Permanent Total Loss of Sight in both eyes	100%
Permanent Total Loss of both hands above wrist	100%
Permanent Total Loss of both feet above ankle	100%
Permanent Total Loss of Sight of one eye and one hand above wrist or one foot above ankle	100%

E.3. Permanent Partial Disablement (PPD)

Lump sum payment as specified, if PPD occurs within 12 months from the date of Accident as per the following:-

Permanent Partial Disablement (PPD)	Percentage of Sum Insured
The sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.	50%
Use of a hand or a foot without physical separation	50%
Loss of toes – all	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of Hearing - one ear	30%
Loss of four fingers and thumb of one hand	50%
Loss of four fingers of one hand	40%
Loss of thumb - both phalanges	25%
Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%
Loss of index finger – two phalanges	10%
Loss of index finger - one phalanx	5%

Loss of middle finger or ring finger or little finger – three phalanges	10%
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger – one phalanx	3%

Provided that, such disablement shall be a direct consequence thereof permanently disables the Insured Person from resuming his/her normal occupation.

E.4. Temporary Total Disablement (TTD)

Provides a weekly benefit for opted number of weeks, in case Insured Person sustains an Injury in an Accident which completely incapacitates the Insured Person from engaging in any employment or occupation.

E.5. Home Modification Benefit

Lump sum amount payable, if an Insured Person sustains an Injury in an Accident and incurs expenses towards necessary improvements carried out in the residence. Modifications must be carried out within three months from the Insured Person's discharge from Hospital.

E.6. Child Education Benefit

Lump sum payment to Nominee/Legal Heir/Assignee for education of Insured Person's dependent children, if the Policyholder (must be an Insured Person under the Policy) suffers AD and/or PTD. The Dependent child(ren) is under the Age of 25 years and unmarried as on date of Accident. The limit is applicable per member, irrespective of number of Dependent child/ children.

E.7. Loan Protector Benefit

Payment of fixed limit or outstanding loan amount, whichever is lower, if Insured Person suffers AD or PTD.

F. OPD Cover

Covers Medical Expenses of OPD Treatment including consultation, diagnostic, pharmacy, surgical treatment, dental treatment and physiotherapy. Available only if an Insured Person is up to 65 years of age. Co-pay option of 0%/10%/25% on each and every claim is available under this benefit.

G. Global Cover

Covers Medically Necessary Expenses incurred for In-Patient Treatment or Day Care Treatment or OPD Treatment including Planned Hospitalization (for below listed critical illnesses) incurred outside India. Available only if an Insured Person is up to 65 years of age. This benefit shall become available only after the expiry of 24 months from the date of inception of the first Policy with Us except for Emergency Care.

Sno	Name of Illness	Sno	Name of Illness
1	Cancer Treatment Surgery	9	Kidney Transplant Surgery in case of End Stage Renal Failure
2	Heart Valve Replacement	10	Surgical Treatment of Coma
3	Bone Marrow Transplant	11	Surgery for Pheochromocytoma
4	Pulmonary Artery Graft Surgery	12	Liver Transplant Surgery in case of End Stage Liver Disease
5	Aorta Graft Surgery	13	Pneumonectomy - Removal of an entire lung
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	14	Surgical removal of an eyeball
7	Surgical Treatment for Stroke	15	Heart transplant Surgery
8	Lung Transplant Surgery in case of End Stage Lung Disease	16	Craniotomy for Cerebral Aneurysm

H. Benefit Based Covers

H.1. Critical Illness

Lump sum payment to the Insured Person/Nominee/Legal Heir/Assignee upon diagnoses of any below listed Critical Illness. A Waiting Period of 90 days is applicable at the commencement of the Policy. This benefit shall terminate in the event of Claim of a covered Critical Illness becoming accepted and paid.

Below is the List of Critical Illness
i. Cancer of Specified Severity
ii. Myocardial Infarction (First Heart Attack of Specific Severity)
iii. Open Chest CABG

iv. Open Heart Replacement or Repair of Heart Valves
v. Coma of Specified Severity
vi. Kidney Failure Requiring Regular Dialysis
vii. Stroke Resulting in Permanent Symptoms
viii. Major Organ /Bone Marrow Transplant
ix. Motor Neuron Disease with Permanent Symptoms
x. Permanent Paralysis of Limbs

H.2. Hospital Daily Cash

Payment of an amount equal to the specified Hospital Daily Cash amount as per day of Hospitalization, subject to deductible of no. of hours (as opted), for a maximum of 30 days. In case of ICU, 2 times the Hospital cash limit as opted shall be paid.

I. Preventive Care

I.1. Health Check Up

Covers expenses incurred by Insured Person for preventive Health Check Up tests (as per pre-defined packages). This benefit is available to all adult members above 18 years of age.

I.2. E-Opinion

Covers E-Opinion availed by Insured Person on medical condition from Medical Practitioner from our empanelled network.

J. Modifiers

J.1. Reduction in Room Rent Limits

Insured Person can reduce the Room Rent limit for Hospitalization from Actuals to Single Private A.C Room or Twin Sharing Room.

J.2. Reduction in Specific Disease Waiting Period

Insured Person can reduce the Specific Disease Waiting Period from 24 to 12 months.

J.3. Change in PED Waiting Period

Insured Person can change the PED Waiting Period from 24 to 12 or 36 months.

J.4. Change in Maternity Expenses Waiting Period

Insured Person can change the Maternity Expenses Waiting Period from 24 to 12 or 36 months.

J.5. Reduction in Global Cover Waiting Period

Insured Person can reduce the Global Cover Waiting Period from 24 to 12 months.

K. Voluntary Covers for Discounts

If this Section is opted, then Policyholder can opt either benefit K.1 or K.2 under this Policy.

K.1. Voluntary Deductible

The Insured has the following options: -
Option 1: Annual Aggregate Deductible- Insured Person shall bear an amount equal to the opted deductible for admissible Claims during the Policy Year.

Option 2: Per Claim Deductible- Insured Person shall bear an amount equal to the opted deductible for each and every admissible Claim during the Policy Year.

K.2. Voluntary Co-Payment

Insured Person to pay a pre-determined percentage, specified in Policy Schedule, as Voluntary Co-Payment on each and every Claim. This will be in addition to existing co-payment if any.

L. No Claim Bonus (Available only with D. Hospitalization Cover)

Under this Section, Policyholder/Insured Person can opt either L.1. Cumulative Bonus or L.2. Discount in Premium, if no Claim has been made under the expiring Policy by any of the covered Insured Person(s).

L.1. Cumulative Bonus

On Claim free renewal, 50% up to 100% to 1000% (in multiples of 100 as opted) of the Base Sum Insured shall be provided as Cumulative Bonus, at the end of each completed and continuous Claim free Policy Year.

OR

L.2. Discount in Premium

On Claim free renewal, a discount of 2.5% on Hospitalization Base Sum Insured shall be provided at the time of each renewal of the Policy.

M. 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:

M.1. Pre-Existing Diseases (Code-Excl01):

i. 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.

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

iii. 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.

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

M.2. Specified Diseases and Procedures Waiting Period (Code-Excl 02):

i. 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.

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

iii. If any of the specified disease / procedures falls under the Waiting Period specified for Pre-Existing Diseases (PED), then the longer of the two Waiting Periods shall apply.

iv. The Waiting Period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

v. 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

M.3. First Thirty Days Waiting Period (Code-Excl 03):

i. Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shall be excluded except Claims arising due to an Accident, provided the same are covered.

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

iii. 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.

M.4. Maternity and Child Care Cover

A Waiting Period of 24 months shall apply for all Claims under the benefit D.3. Maternity and Child Care Cover.

M.5. Vision Correction

A Waiting Period of 12/24 months (as opted) shall apply for all Claims under the benefit D.2(h). Vision Correction.

M.6. Global Cover

A Waiting Period of 24 months shall apply to all Claims under the benefit G. Global Cover except for Emergency Care.

M.7. Critical Illness

A Waiting Period of 90 days shall apply to all Claims under the benefit H.1. Critical Illness

M.8. Bariatric Surgery

A Waiting Period of 24 months shall apply to all Claims under the benefit D.(h). Bariatric Surgery.

N. Exclusions (Applicable to all Benefits under the Policy)

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.

N.1. Standard Exclusions

N.1(a). Investigation & Evaluation (Code-Excl04):

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

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

N.1(b). Rest Cure, Rehabilitation and Respite Care (Code-Excl05):

i. 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.

N.1(c). Obesity/ Weight Control (CodeExcl06):

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

i. Surgery to be conducted is upon the advice of the Doctor.

ii. The surgery/Procedure conducted should be supported by clinical protocols

iii. The member has to be 18 years of age or older and

iv. 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:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type2 Diabetes.

N.1(d). Change-of-Gender Treatments (Code-Excl07):

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

N.1(e). Cosmetic or Plastic Surgery (Code-Excl08):

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

N.1(f). Hazardous or Adventure Sports (Code-Excl09):

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

N.1(g). Breach of Law (Code-Excl10):

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

N.1(h). Excluded Providers (Code-Excl11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete Claim (For updated and detailed list of Excluded Providers refer website- https://www.sbigeneral.in/).

N.1(i). Substance Abuse and Alcohol (Code-Excl12):

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

N.1(j). Wellness and Rejuvenation (Code-Excl13):

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

N.1(k). Dietary Supplements & Substances (Code-Excl14):

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization Claim or day care procedure.

N.1(l). Refractive Error (Cod-Excl15):

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

N.1(m). Unproven Treatments-Code (Code-Excl16):

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

N.1(n). Sterility and Infertility (Code-Excl17):

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization.

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

iii. Gestational Surrogacy.

iv. Reversal of sterilization.

N.1(o). Maternity (Code-Excl18):

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.

N.2. Specific Exclusions

N.2(a). 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.

N.2(b). Any charges incurred to procure any medical certificate, treatment/Illness related documents pertaining to any period of **Hospitalization/Illness.**

N.2(c). Any Medical Expenses which are not **Reasonable and Customary Charges.**

N.2(d). 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.

N.2(e). Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

N.2(f). Circumcision unless necessary for treatment of a disease, Illness or Injury not excluded hereunder, or, as may be necessitated due to an Accident.

N.2(g). Convalescence (if not opted), general debility, "run-down" condition, rest cure, external congenital anomaly.

N.2(h). 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:

i. Medical text books,

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

iii. World Health Organization (WHO) protocols,

iv. Published guidelines by healthcare providers,

v. Guidelines set by medical societies like Cardiological society of India, neurological society of India etc

N.2(i). 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.

N.2(j). Non-payable items: Expenses against Items mentioned in "Annexure II" shall not be payable. This exclusion shall be waived off, if optional benefit D.1.(g). Consumables Cover has been opted under the Policy.

N.2(k). 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:

i. 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.

ii. 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.

iii. 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.

N.2(l). Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy, unless otherwise agreed by Us.

N.2(m). Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

N.2(n). Stem cell storage/preservation

N.2(o). Treatment taken outside India, except for G. Global Cover.

N.2(p). Treatment taken from anyone not falling within the scope of definition of Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

N.2(q). Vaccination or inoculation except as part of post-bite treatment for animal bite.

N.2(r). 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.

N.2(s). Sanction Clause: Any Claim or benefit hereunder to the extent that the provision of such cover, payment of such Claim, or provision of such benefit would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of India, the European Union, United Kingdom or United States of America.

O. Terms and Clauses (Applicable to all benefits under the Policy)

O.1. Condition Precedent to the Contract

O.1(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 Policyholder.

(Explanation: "Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

O.1(b). Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

O.1(c). 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.

O.1(d). Premium Payment in Instalment

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

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

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

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

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

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

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

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

O.1(e). 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 affected.

O.1(f). Nomination

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

O.1(g). Currency

The monetary limits applicable to this Policy will be in Indian Rupees (INR).

O.1(h). 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.

O.1(i). Territorial Jurisdiction

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

O.1(j). Terms and Conditions of the Policy

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

O.2. Condition Applicable During the Contract

O.2(a). Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an Insurance Policy:

i. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

ii. The active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. Any other act fitted to deceive; and

iv. Any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the Claim and/or forfeit the Policy benefits on the ground of Fraud, if the Insured Person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention

to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

O.2(b). 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.

O.2(c). Free Look Period

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

ii. In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any Claim, he shall have the option to return the Policy to the Insurer for cancellation, stating the reasons for the same.

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

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

O.2(d). 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 if 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.

O.2(e). Change of Sum Insured

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

O.2(f). Notice and Communication

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

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

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

O.2(g). 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.

O.2(h). 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.

O.3. Condition When a Claim Arises

O.3(a). Claim Settlement (Provision for Penal Interest)

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

ii. In case the Claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment. Such interest shall be suo-moto paid by the Company.

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

O.3(b). Complete Discharge

Any payment to the Policyholder, Insured Person or his/her Nominees or his/her legal representative or assignee or to the Hospital, as the case maybe, for any benefit under the Policy shall be a valid discharge towards payment of Claim by the Company to the extent of that amount for the particular Claim.

O.3(c). Multiple Policies (Applicable for Indemnity Section only)

i. 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.

ii. Benefit based Policies:

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

O.3(d). 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.

O.3(e). 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 Pre-Authorization	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. KYC Form and KYC Documents 11. Any other relevant information as required	Not Applicable
Process for obtaining Pre-Authorization	1. 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 2. On receipt of duly filled preauthorization form from the Network Provider along with other sufficient details to assess the request, We may;	Not Applicable

	i. Issue the authorization letter specifying the sanctioned amount any specific limitation on the Claim and non-payable items, if applicable or ii. Reject the request for preauthorization specifying reasons for the rejection.	
List of Documents	Not Applicable	As listed below

O.3(f). List of Documents for Claims:-

Section Name	Cover Name	Claim Documents
Hospitalization Cover	In-Patient Treatment Day Care Treatment AYUSH Treatment Domiciliary Hospitalization Pre-Hospitalization Post Hospitalization Bariatric Surgery Cumulative Bonus	1. Duly filled and signed Claim form 2. Medical Practitioner's referral letter advising Hospitalization 3. Certified copy of Hospital Discharge Summary 4. Certified copy of final Hospital bill, pharmacy bills, Investigation labs bills 5. All original reports of Investigations done 6. Ambulance/Cab receipt/ bill 7. Pre and Post consultation bills 8. First Information Report/ Final Police Report, if applicable 9. Postmortem report, if available 10. 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 11. 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. 12. Certified copy of Death certificate issued by municipal authority (in case of death of insured) 13. KYC details and Documents
Essential Covers	Road Ambulance Air Ambulance Radio Cab Organ Donor Modern Treatments Home Health Care Consumables Cover Restore Benefit	1. Same Documents as mentioned in Section-Hospitalization Cover
Special Covers	Convalescence Companion Cover Adventure Sports Gym and Sports Injury Reconstructive Surgery Prosthetics Gender Reassignment Surgery	1. Same Documents as mentioned in Section-Hospitalization Cover 2. All consultation bills and prescriptions of Sports Specialist/Medical Practitioner 3. Diagnostic test bills along with copy of reports 4. Physiotherapy bills 5. Travel, food and accommodation proof(bills), if applicable

	Vision Correction	
	Endless Sum Insured	
	Plan Ahead	
Maternity and Child Care Cover	Maternity Expenses (including Pre and Post Natal Care)	1. Same Documents as mentioned in Section-Hospitalization Cover 2. Medical Practitioner's written recommendation in case of medical termination of pregnancy 3. Newborn baby Vaccination bills and receipts
	Newborn Baby Care	
	Child Vaccination	
	Assisted Reproduction Treatment	
Personal Accident	Accidental Death (AD)	1. Duly completed and signed Claim Form, in original 2. Death certificate 3. Postmortem report if available and applicable 4. First Information Report/ Final Police Report, MLC (if registered)/ Panchama, wherever 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. Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel of the related speciality 7. Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any 8. Photographs of the Insured Person highlighting the injury / disability 9. Bills for home modification 10. Proof of Full-time education at an accredited Education Institution 11. Loan Disbursement letter and proof of outstanding loan amount.
	Permanent Total Disablement (PTD)	
	Permanent Partial Disablement (PPD)	
	Temporary Total Disablement (TTD)	
	Home Modification Benefit	
	Child Education Benefit	
	Loan Protector	
OPD Cover	OPD Cover	1. Duly completed and signed Claim form 2. All consultation bills 3. Diagnostic test bills along with copy of reports 4. Bills of Surgical Treatment
Global Cover	Global Cover	1. Duly completed and signed Claim Form 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. Postmortem report, if available

Benefit Based Covers	Critical Illness	1. Same Documents as mentioned in Section-Hospitalization Cover 2. Certified copy of first Hospital consultation & first diagnostic report
	Hospital Daily Cash	
	Hospital Daily Cash	3. Same Documents as mentioned in Section-Hospitalization Cover
Preventive Care	Health Check Up	1. Duly completed and signed Claim Form 2. Health Check up bills and Receipts 3. Consultation Bills
	Second opinion/ E- Opinion	
Modifiers	Reduction in Room Rent Limits	1. Same Documents as mentioned in Section-Hospitalization Cover
	Reduction in Specific Waiting Period	
	Change in PED Waiting Period	
	Change in Maternity Period	
	Change in Global Waiting Period	
Voluntary Covers for Discounts	Voluntary Deductible Voluntary Co-Payment	1. Same Documents as mentioned in Section-Hospitalization Cover

Note:

1. Case specific additional documents may be requested if required for justified Claim decision & processing.
2. The Company at its discretion may revise the list of documents mentioned above.
3. 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 need to be sent to below address.

  Please do mention appropriate Claim number on Claim documents dispatched.

  Accident & Health Claims team

  SBI General Insurance Company Limited

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

  Pune, Maharashtra – 411 045.

- Conditions for Obtaining Cashless Facility:

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

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

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

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

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

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

- Claim Assessment

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

- Condonation of Delay:

  If the Claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the

delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the Claimant's control.

O.3(g). Proportionate Deduction (In case higher Room Category opted)

Subject to the other Terms and Conditions of this Policy, the Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

i. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula.

ii. (Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges. Proportionate deductions may apply based on the room category.

iii. The proportionate deductions and relevant Associated Medical Expenses specified above under point (i) and (ii) shall not be applicable for Hospitalization in an ICU.

iv. The expenses related to or subsumed into room charges / procedure charges / costs of treatment as Specified in Annexure II are not covered, unless otherwise Specified in the Policy Schedule.

O.3(h). Payment of Claim

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

O.3(i). Sequence of Sum Insured Applicability under Benefit-D

In case of an admissible claim, the sequence of Sum Insured applicability shall be:

i. Base Sum Insured

ii. Cumulative Bonus (If Applicable)

iii. Endless Sum Insured (If Opted)/Restore Benefit (If Opted)

O.3(j). Overriding Effect of the Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

O.4. Conditions For Renewal of The Contract

O.4(a). 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

O.4(b). 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

O.4(c). 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.

O.4(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.

O.5. Conditions for Cancellation of the Contract

O.5(a). Cancellation

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 up to 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.

Cancellation by Us:

We 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.

O.6. Conditions For Grievance Redressal

O.6(a). Redressal of Grievances

Stage 1: Bima Bharosa

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

Stage 2: Head – Customer Care

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

Email: head.customercare@sbigeneral.in
Phone: 1800 102 1111

For Senior Citizens:
Senior citizens can reach us through the following dedicated channels:

Email: Seniorcitizengrivences@sbigeneral.in

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

Stage 3: Grievance Redressal Officer (GRO)

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

Email: gro@sbigeneral.in

Phone: 022-45138021

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

Stage 4: Escalation to Insurance Ombudsman

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

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

P. Pre-Policy Medical Check Up

i. Medical Tests are applicable to all insured person(s), as per Plan, Sum Insured chosen and Age of Insured Person as mentioned below. Also, in case of any adverse disclosure by insured member, underwriters may ask for additional medical test as suitable to take prudent underwriting decision.

ii. If both Hospitalisation & CI cover is opted, then test as per below Grid for NSTP cover to be applicable.

iii. In case of acceptance or rejection of the proposal, 50% of the medical test costs shall be borne by Us.

iv. All Pre-Policy health checkup and medical tests should be performed at our empanelled diagnostic center or our service providers empanelled diagnostic centers only.

v. The underwriter, at their discretion, may modify or relax the above-mentioned conditions depending on the details and declarations provided in the Proposal form

vi. Diseases not part of the medical underwriting manual or non-standard risks, may be accepted as standard risk or the exclusion and / or a loading in premium (maximum up to 150% per member)

Pre Policy Medical Check-up in case of Hospitalization Cover	For SI 5 lakh, 7.5 lakh, 10 lakh- 56 Years and above
	For SI 12.5 lakh, 15 lakh, 17.5 lakh, 20 lakh, 22.5 lakh, 25 lakh - 46 Years & above
	For SI 30 lakh, 35 lakh, 40 lakh, 45 lakh, 50 lakh - 18 Years & above
	For SI Above 50 lakhs to 1 Cr - 16 years & above
	For SI 1 Cr to 3 Cr - 16 Years & above
	For SI Above 3 Cr - 18 Years & above
Pre Policy Medical Check-up in case of Critical Illness Cover	For SI 2.5 lakh – 10 lakh - 18 years & above For SI 15 Lakhs & above - 16 years & above

Validity of reports: These test reports shall be considered valid for a period of 60 days from the date of conduct of tests. Exceptional call for change in validity of duration for medical reports will be taken by senior underwriter as per the Underwriting Authority Matrix.

Q. Discounts

Insured is eligible for discount on premium as below:

Q.1. Term Discount

Please note that long term discounts are not applicable in case instalment options are selected

Term	Discount
1-Year	0.00%
2-Years	6.00%
3-Years	9.00%
4-Years	11.00%
5-Years	14.00%

Q.2.	**Online/Direct Business Discount/SBIG Employee Referral/ Telesales**	10.00%

Q.3. Floater Discount

Family combination	Discount
2 members	25.00%
3 members	30.00%
>3 members	35.00%

Q.4.	**No Floater Discount (>= 2 Members)**	5.00%
Q.5.	**Employee Discount (For SBI Group)**	5.00%
Q.6.	**Cross-Sell Discount**	5.00%
Q.7.	**Welcome Discount**	5.00%

Applicable for New Business. Applicable only if the Proposer purchases the policy within 5 days of receiving the quote from the Company

Q.8.	Girl Child Discount	5.00%

Q.9.

Zone	Discount
Zone A	0.00%
Zone B	-20.00%

Zone B to Zone A: 20% Co-pay applicable where,
Zone A: Delhi, New Delhi & NCR including Faridabad, Noida, Ghaziabad, Gurugram, Noida, Gautam Buddha Nagar, Mumbai & Suburbs, MMR (Mumbai Metropolitan Region), Navi Mumbai & Suburbs, Thane City & Suburbs, Mira Road, Bhayandar, Panvel, Kalyan & Dombivli, Surat, Ahmedabad, Haryana.
Zone B: Rest of India

Q.10.

Hospital Type	Discount
Preferred Partner	10.00%
Non-Preferred Partner	0.00%

Preferred Partner to Non-Preferred Partner: 10% Co-pay is applicable

Q.11.	Loyalty Discount	5.00%

Applicable for Renewal Policies

Q.12.	Discount in Lieu of Acquisition Cost	Up to 15%

Aggregate discount for the below mentioned shall be capped at 15.0%

1. Online/Direct Business Discount/SBIG Employee Referral/ Telesales
2. Cross-Sell Discount
3. Discount in Lieu of Acquisition Cost
4. Employee Discount (For SBI Group)

Note: Maximum discount excluding floater/non-floater discount and change in waiting period should be capped at 45%.

R. Loadings

R.1. Instalment Premium Loading

Instalment Option	Loading
Monthly	3.00%
Quarterly	2.50%
Half-yearly	1.50%
Single	0.00%

S. Illustrations

Illustration 1 - Application of Endless Sum Insured

Policy Period	1 year
Sum Insured	10 lakhs
Cumulative Bonus	5 lakhs
Base cover	Hospitalization Cover
Optional cover	Endless Sum Insured

Claim Details			Sum Insured Available			Sum Insured Utilization			Total Claim Amount Paid (in Rs.)	Remarks
Claim No.	Treatment taken for disease/ illness/ injury	Claim Amount (in Rs.)	Base Sum Insured (in Rs.)	Cumulative Bonus (in Rs.)	Endless Sum Insured (in Rs.)	Base Sum Insured (in Rs)	Cumulative Bonus (in Rs.)	Endless Sum Insured (in Rs.)		
Claim No.1	Stroke	1,200,000	1,000,000	500,000	Available	1,000,000	200,000	0	1,200,000	10 Lacs will be paid from Base Sum Insured 2 Lacs will be paid from CB
Claim No.2	Accident	500,000	0	300,000	Available	0	300,000	0	300,000	3 lacs paid from balance CB amount and remaining claim amount of Rs. 2 Lacs will be paid by the Insured Person from his pocket.
Claim No.3	Cancer	2,500,000	0	0	Available	0	0	2,500,000	2,500,000	Base Sum Insured and CB has been exhausted therefore, Insured Person is eligible to Claim under Endless Sum Insured and since this benefit can be used in once in lifetime of the Policy. The Insured Person chose to avail the Claim under this benefit being a high-ticket size claim.
Claim No.4	Dengue	100,000	0	0	0	0	0	0	0	All the Sum Insured under the Policy has been exhausted, therefore

										Insured Person will not get any Claim for the remaining Policy Year.

Illustration 2 - Application of Restore Benefit

Policy Period	1 year
Sum Insured	10 lakhs
Cumulative Bonus	5 lakhs
Base cover	Hospitalization Cover
Optional cover	Restore Benefit

Claim Details			Sum Insured Available			Sum Insured Utilization			Total Claim Amount Paid (in Rs.)	Remarks
Claim No.	Treatment taken for disease/ illness/ injury	Claim Amount (in Rs.)	Base Sum Insured (in Rs.)	Cumulative Bonus (in Rs.)	Restore Benefit (in Rs.)	Base Sum Insured (in Rs)	Cumulative Bonus (in Rs.)	Restore Benefit (in Rs.)		
Claim No.1	Stroke	900,000	1,000,000	500,000	0	9,00,000	0	0	900,000	9 Lacs will be paid from Base Sum Insured
Claim No.2	Accident	500,000	100,000	500,000	900,000	1,00,000	4,00,000	0	500,000	1 lac paid from Base Sum Insured and 4 lacs from CB.
Claim No.3	Stroke	1,000,000	0	100,000	1,000,000	0	100,000	900,000	1,000,000	Base Sum Insured and CB has been exhausted therefore, Insured Person is eligible to Claim from Restore Benefit which can Claim both for related/unrelated illness or Injury
Claim No.4	Dengue	100,000	0	0	1,000,000	0	0	100,000	100,000	Since Restore can be claimed for related/unrelated illness or Injury,

										therefore 1 lac is paid from Restore benefit
Claim No.5	Malaria	100,000	0	0	1,000,000	0	0	100,000	100,000	Insured Person has Restore benefit to pay future Claims upto 10 lacs per Claim amount

Illustration 3- Benefit Illustration in respect of Individual and Family Floater Basis

Age of the members insured	Coverage opted on Individual Basis covering each member of the family separately (at a single point in time)		Coverage opted on Individual Basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of the family)				Coverage opted on Family Floater Basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any (Non-Floater Discount – 5%) (Rs.)	Premium after Discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
30 yrs	7,219	10L	7,219	361	6,858	10L	21,984	6,595	15,389	10
35 yrs	7,872	10L	7,872	394	7,478	10L				
08 yrs	6,893	10L	6,893	345	6,548	10L				
Total Premium for all members of the Family is Rs. 21,984/- when each member is covered separately. Sum Insured available for each individual is Rs. 10,00,000/-.			Total Premium for all members of the Family is Rs. 20,884/- when they are covered under a single Policy. Sum Insured available for each family member is Rs. 10,00,000/-.				Total Premium when Policy is opted on floater basis is Rs. 15,389/- Sum Insured of Rs. 10,00,000/- is available for the entire family.			

How to Maximize Your Health Insurance Policy

General Points:

Opting the Right Policy: Every health insurance policy is designed with specific customer needs in mind. Opting the right policy which suits individual coverage needs is crucial for optimum financial risk protection at times of health crisis.

Higher Coverage: Opting for a higher Sum Insured provides a larger safety net for medical expenses alleviating financial burden during times of health crisis. It also helps mitigate the impact of these rising costs.

Increase Sum Insured at Renewal: Opting a higher Sum Insured at renewal helps adjust the insurance coverage against rising medical costs due to steep medical inflation.

Long Term Policy: According to multiple reports, the medical inflation in India is over 10% annually. Opting for a long-term policy helps beat rising costs due to this steep medical inflation.

Network Hospital List: Opting for a health insurance policy which has preferred hospital in its network lists helps in smooth and easy cashless settlement of health claims and additional discount can be availed for preferred network hospital.

Take Advantage of Preventive Care: Most health insurance products offer preventive care coverages like annual health check-up etc. One must fully utilize these coverages for early detection of potential health issues.

Personal Health Insurance: Purchasing a health insurance policy over and above employer provided policy is recommended. Employer health insurance is good. However, they may be limited in coverages. Also, the policy is tied to employment status, adding another layer of uncertainty in continuous coverage.

Consumables: It is recommended to have consumables covered under the health insurance policy as they may add up significantly to the hospital bill. This minimizes out-of-pocket expenses during hospitalization and also provides more comprehensive financial protection.

Note: The information in this document is indicative in nature. For more complete details on Terms, conditions and exclusions, please refer to the Policy Wordings.