SURAKSHA AUR BHAROSA DONO

SAMPOORNA AROGYA - GROUP

PROSPECTUS

SBI General's Sampoorna Arogya – Group insurance policy is a comprehensive Health Insurance Plan that goes the extra mile to make Insured Person's life convenient. It is designed to meet the needs for today's health problems.

WHO CAN BUY THIS POLICY?

SBI General's Sampoorna Arogya – Group policy can be bought by Groups as defined by the Regulator and eligible member/employee of the group between the age of 18 Years to 65 Years and his/her family can be enrolled under the policy.

AGE CRITERIA

Sections	Minimum Entry Age- Adult	Maximum Entry Age- Adult	Maximum Entry Age- Children	Minimum Entry Age- Children
Hospitalization Cover	18 Years	65 Years	91 Days/1 Day	25 Years
Critical Illness	18 Years	65 Years	18 Years	25 Years
Hospital Daily Cash	18 Years	65 Years	91 Days/1 Day	25 Years
Personal Accident	18 Years	65 Years	5 Years	NA

Policy can be renewed for lifetime.

SCOPE OF COVER

We will pay under below listed Covers on Medically Necessary Hospitalization 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, co-payments and deductible, if applicable as specified on the Schedule of Coverage in the Policy Schedule / Certificate of Insurance. Subject to otherwise terms and conditions of the Policy.

SECTION I - HOSPITALIZATION COVER

I.A. Base Cover

I.A.1 – Hospitalization Medical Expenses

a. Room Rent, Boarding & Nursing Charges

b. Intensive Care Unit Charges

c. Medical Practitioner and Specialists Fees Including Teleconsultation

d. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances

e. Medicines, drugs and consumables

f. Diagnostic procedures

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

In case the Insured Person opts for a higher room category than his eligibility all "Incremental Expenses" pertaining to Room Rent, Medical Practitioners/ Specialist Medical Practitioners fees and other incidental Expenses to be borne by the Insured Person.

Note on Deriving Incremental expenses: "Hospital accommodation as stated under point (a) & (b) above and all other related charges as stated under point (c) till (g) are allowed in accordance with limits mentioned in Policy Schedule / Certificate or on actual basis, whichever is less. In the event of an Insured Person's accommodation during Hospitalization being higher than his eligible limit specified in Policy Schedule/ Certificate then the related charges will be allowed only in proportion of actual accommodation cost to corresponding eligible accommodation limit"

I.A.2 – PRE-HOSPITALIZATION MEDICAL EXPENSES

We will, pay for Pre-Hospitalization Medical Expenses of an Insured Person which are incurred due to an Accident, Injury or Illness immediately prior to the Insured Person's date of admission to the Hospital up to limits specified in the Policy Schedule/Certificate of Insurance, provided that a claim made by the Insured Person on Us has been admitted under In-patient Benefit under Section I.A.1 or I.A.5 or I.A.7 or I.A.8 and is related to the same Accident, Injury or Illness.

Note -For the purpose of calculating Our liability under this benefit in an event of multiple Hospitalization claims for any one Illness, Injury or Accident We shall consider date of admission to the Hospital for Insured Person's first Hospitalization in order of its occurrence, for such Illness Injury or Accident.

I.A.3 – POST-HOSPITALIZATION MEDICAL EXPENSES

We will, pay for Post-Hospitalization Medical Expenses of an Insured Person which are incurred due to an Accident, Injury or Illness immediately prior to the Insured Person's date of admission to the Hospital or in case of domiciliary hospitalisation up to limits specified in the Policy Schedule/Certificate of Insurance, provided that a claim made by the Insured Person on Us has been admitted under In-patient Benefit under Section I.A.1 or I.A.5 or I.A.7 or I.A.8 and is related to the same Accident, Injury or Illness.

Note -For the purpose of calculating Our liability under this benefit in an event of multiple Hospitalization claims for any one Illness, Injury or Accident We shall consider date of admission to the Hospital for Insured Person's first Hospitalization in order of its occurrence, for such Illness Injury or Accident.

I.A.4 – MENTAL HEALTHCARE

If an Insured Person is hospitalized for any Mental Illness contracted during the Policy period We will pay Medical Expenses under Section I in accordance with The Mental Health Care Act, 2017 provided that;

a. The Hospitalization is prescribed by a Medical Practitioner for Mental Illness
b. The Hospitalization is done in Mental Health Establishment

I.A.5 – DAY CARE SURGERY/PROCEDURES

We will pay for the Medical Expenses as listed under Section I.A.1 on Hospitalization of Insured Person in Hospital or Day Care Centre for Day Care Treatment

Indicative list of Day Care Treatment is attached in Annexure V (Please refer at the end of this document)

I.A.6 – AMBULANCE CHARGES

We will pay for expenses incurred on Road Ambulance Services if Insured Person is required;

a. to be transferred to the nearest Hospital following an emergency
b. or from one Hospital to another Hospital
c. or from Hospital to Home (within same City) following Hospitalization

provided that, claims under Section I.A.1 is admissible under the Policy.

I.A.7 – DOMICILIARY HOSPITALISATION

We will pay the Medical Expenses incurred on Domiciliary Hospitalization of the Insured Person provided that:

a. It has been prescribed by the treating Medical Practitioner and
b. the condition the Insured Person is such that he/she could not be removed to a Hospital or
c. the Medical Necessary Treatment is taken at Home on account of non-availability of room in Hospital.

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

a. Asthma, bronchitis, tonsillitis, and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
b. Arthritis, gout, and rheumatism,
c. Chronic nephritis and nephritic syndrome,
d. Diarrhoea and all type of dysenteries, including gastroenteritis,
e. Epilepsy
f. Pyrexia of Unknown Origin for less than 10 Days.

I.A.8 – ALTERNATIVE TREATMENTS

We will pay Medical Expenses in accordance with Section I.A.1 on Hospitalization of Insured Person for following Alternative Treatments prescribed by Medical Practitioner.

a. Ayurvedic
b. Unani
c. Siddha
d. Homeopathy

provided that;

a. The procedure performed on the insured Person cannot be carried out on Outpatient basis.
b. The treatment has been undertaken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board or authorised medical council of the respective country/state as applicable.

I.A.9 – ORGAN DONOR EXPENSES

We will pay Medical Expenses as listed under Section I.A.1 towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, provided that;

a. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011 and Transplantation of Human Organs and Tissues Rules, 2014

b. Hospitalization Claim under Section I.A.1 is admissible under the Policy.

We will not cover expenses towards the donor in respect of:

a. Any Pre or Post - Hospitalization Medical Expenses,

b. Cost towards donor screening.

c. Cost associated to the acquisition of the organ.

d. Any other medical treatment or complication in respect of the donor, consequent to harvesting

e. Expenses related to organ transportation or preservation.

f. Transplant of any organ/tissue where the transplant is experimental or investigational.

g. Hospitalisation or any other Medical Expenses if Insured Person is Hospitalised for donating organ.

This is an in-built cover for Sum Insured options Rs. 600,000.00 and above.

I.A.10 – REINSTATEMENT BENEFIT

We will automatically reinstate the Sum Insured immediately upon exhaustion of the limit of coverage, which has been defined, during the policy period.

Other conditions applicable to this benefit:

a. The reinstated Sum Insured will be triggered only after the Hospitalisation Sum Insured has been completely exhausted during the Policy Period;

b. If the claimed amount is higher than the balance Sum Insured under the Policy, then this Benefit will not be triggered for such claims.

c. The reinstated Sum Insured would be triggered only for subsequent claims made by the Insured Person and not arising out of any Illness/disease/ Injury or Accident (including its complications) for which a claim has been lodged in the current Policy year under Hospitalisation Expenses Section I.A.1

d. This benefit is applicable only once during each Policy Period & will not be carried forward to the subsequent renewals if the Benefit is not utilized.

e. The reinstated Sum Insured shall not be available for claims towards Alternative treatments I.A.9 and Maternity Expenses I.B.3 and New Born Baby Expenses I.B.4 and, if opted for

This is an in-built cover for Sum Insured options Rs. 600,000.00 and above.

I.A.11 - GENETIC DISORDER OR DISEASES

We will pay the medical expenses under Section I. If the insured person is hospitalized for any condition related to Genetic Disorder upto the Limit as specified in the Policy Schedule.

I.A.12- INTERNAL CONGENITAL DISEASES

We will pay the medical expenses under Section I. If the insured person is hospitalized for any condition related to Internal Congenital Diseases upto the Limit as specified in the policy schedule.

I.A.13.- HIV/AIDS COVER

We will cover expenses incurred for Inpatient treatment due to any condition caused by or associated with human immunodeficiency virus or variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS upto the Limit as specified in the policy schedule except for the conditions which are permanently excluded.

I.A.14- ADVANCED TREATMENTS

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit as specified in the policy schedule, during the policy period and not limited to the following:

i. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)

ii. Balloon Sinuplasty

iii. Deep Brain Stimulation

iv. Oral Chemotherapy

v. Immunotherapy - Monoclonal Antibody to be given as injection

vi. Intra Vitreal Injections
vii. Robotic Surgeries
viii. Stereotactic Radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporisation of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

I.B. OPTIONAL COVERS

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay the expenses under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits and subject to co-payments/deductibles, if any, mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

I.B.1 – MATERNITY EXPENSES COVER

We will cover In-patient Maternity Expenses as listed in Section I.A.1. We shall allow Hospitalizations for maximum up to 3 live children or lawful termination of pregnancy/pregnancies (or either) of an Insured Person.

Claim in respect of delivery for only first 3 living children and/or operations associated therewith will be considered in respect of any one Insured Person. Those Insured Persons who are already having three or more living children will not be eligible for this benefit.

This is an optional cover for Sum Insured options Rs. 600,000.00 and above.

a. The Insured Person should have been continuously covered under this Policy for at least 24 months before availing this Benefit.
b. The payment towards any admitted claim for Insured Person under this cover for any complication arising out of or as a consequence of pregnancy or child birth will be restricted to limits specified in the Policy Schedule/Certificate of Insurance. However, any "reinstated Sum Insured" will not be available for coverage under this section.
c. Pre or post-natal Maternity Expenses will be covered within the maternity Sum Insured under this Cover. However, the Pre or post-natal Maternity Expenses cannot be claimed under Pre or Post – Hospitalisation Expenses under Section I.A.2 and I.A.3, respectively.
d. Any Pre and Post Hospitalization expenses will be covered under maternity Sum Insured

I.B.2 – NEW BORN BABY EXPENSE COVER

Subject to a claim being admitted under Maternity Expenses Cover under Section I.B.4, We will cover the following:

a. We will cover the New Born Babies of the Insured Person from the date of birth of the baby, for any disease/sickness/ailment/Injury up to 90 days from the date of delivery
b. Subject to the terms and conditions of the Policy, on request of the Policy Holder, We will cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby into the Policy by way of an endorsement or at Renewal, whichever is earlier.
c. Mandatory Vaccinations of the New Born baby up to 90 days, as recommended by the Indian Pediatric Association will be covered, subject to maximum of Rs 2500/-.

Other conditions applicable to this benefit

a. Can be opted only under Family Floater plans covering two or more members under the same Policy.
b. This cover cannot be opted independent of Maternity Expenses cover.

This is an optional cover for Sum Insured options Rs. 600,000.00 and above.

I.B.3 – OUTPATIENT EXPENSES

We will, on reimbursement basis, pay the expenses if an Insured Person undergoes Out- Patient Treatment, on advice of a Medical Practitioner because of Illness/disease and/or injury sustained or contracted during the Policy period up to the limit specified in the Policy Schedule/Certificate, for the Expenses incurred on:

a. Medical Practitioner's consultation excluding Dental Treatment;
b. Pharmacy expenses;
c. Diagnostic procedures.
d. Teleconsultation

Other conditions applicable to this benefit

a. Pharmacy expense is supported with a valid medical prescription.
b. Expense for diagnostic procedure is on the advice of the Medical Practitioner.

c. Single claim is raised for all expenses incurred during the Policy Period, within 30 days from the date of the expiry of the Policy, reimbursement of the same will be done once during the Policy year.

This is an optional cover for Sum Insured options Rs. 600,000.00 and above.

I.B.4 – AGGREGATE DEDUCTIBLE

We will pay under Covers listed from I.A.1 to I.A.9 on Medically Necessary Hospitalization of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured and post the Aggregate Deductible is met.

I.B.5 –VOLUNTARY CO-PAYMENT

If You avail this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule / Certificate of Insurance will be applied on each and every admissible claim after Deductible/Excess if any, applicable under the Policy. Once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent Renewal.

Voluntary Co Payment is applicable for the sections I.A.1, I.A.2, I.A.3 & I.A.5.

I.B.6 – NON-NETWORK HOSPITALISATION CO-PAY

If You avail this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule / Certificate of Insurance will be applied on each and every admissible claim in Non-Network Hospital after Deductible/Excess if any, applicable under the Policy. Once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent Renewal

Non Network Hospitalisation Co-Pay is applicable for the sections I.A.1, I.A.2, I.A.3 & I.A.5.

In case if you avail both the options I.B.5 and I.B.6 then Voluntary Co-payment will be applied first followed by Non- Network Hospitalisation Co-pay on each and every admissible claim after Deductible/Excess if any, applicable under the Policy.

SECTION II – CRITICAL ILLNESS

If an Insured Person is diagnosed to be suffering from a Critical Illness (as defined below), while the Policy is in force then We will pay the Critical Illness Sum Insured specified in the Policy Schedule/Certificate provided that:

a. The Critical Illness, which the Insured Person is suffering from, occurs or first manifests itself during the Policy Period as a first incidence; and

b. The Insured Person survives for at least 28 days from the date of Diagnosis of the Critical Illness; and

c. Upon Our admission of the first claim under this Section II in respect of an Insured Person in any Policy Period, the cover under this shall automatically terminate in respect of that Insured Person;

d. Our total liability for an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured.

e. For the purpose of this Policy, Critical Illness means any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence at least 90 days after the commencement of the Policy Period.

f. This coverage applicable for Individual basis only.

List of Critical Illness Covered

1. Cancer of specific severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
3. Open Chest 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. Multiple Sclerosis with Persisting Symptoms
11. Blindness
12. Primary (Idiopathic) Pulmonary Hypertension
13. Aorta Graft Surgery
14. Benign Brain Tumor
15. Motor Neurone Disease with Permanent Symptoms

SECTION III – HOSPITAL DAILY CASH

III.A. BASE COVER

III.A.1 – SICKNESS HOSPITAL CASH BENEFIT

We will pay the Daily Hospital Cash Benefit, if the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Illness that occurred during the Policy Period

III.A.2 – ACCIDENT HOSPITAL CASH BENEFIT

We will pay the Daily Hospital Cash Benefit, if the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment due to an Injury resulting from an Accident that occurred during the Policy Period. We will pay 2 times the daily cash Benefit.

III.A.3 – ICU CASH BENEFIT

If the Insured Person is Hospitalized in an Intensive Care Unit (ICU) during the Policy Period for Medically Necessary treatment of an Illness or an Injury that occurred during the Policy Period, We will pay 3 times the daily hospital cash Benefit.

Coverage under this benefit is limited to a maximum of 15 days in aggregate per Insured Person per Policy Year.

Other conditions applicable to this benefit

a. Where a benefit is admissible under ICU Cash benefit, no other benefit is payable for the same day/(s) of Hospitalisation under section III.A.1 and III.A.2.

b. In the event of transfer from ward to Intensive Care Unit and vice versa, the hospitalization would be regarded as continuous and the daily benefit payable would be as per the limits stated in III.A.1 or III.A.2

Provided Our maximum liability shall be restricted to the amount and period mentioned in the Schedule.

III.A.4 – CONVALESCENCE BENEFIT

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Illness or an Injury or Accident that occurred during the Policy Period and the continuation of such Hospitalisation is Medically Necessary for at least 10 consecutive days, then We will pay a lump sum amount equal to 5 times the daily hospital cash Benefit.

This Benefit is available only once per Insured Person, per Policy Period.

III.A.5 – COMPASSIONATE BENEFIT

If the Insured Person is Hospitalized for more than 24 hours for Medically Necessary treatment of an Injury due to an Accident that occurred during the Policy Period and the Insured Person dies during the course of such Hospitalisation, We will pay the Nominee of the Insured Person a lump sum amount equal to 10 times the daily hospital cash benefit amount, subject to admissibility of the claim under Section III.A.2

III.A.6 – DAY CARE TREATMENT BENEFIT

If the Insured Person requires and avails a Medically Necessary Day Care Treatment during the Policy Period, We will pay a lump sum benefit amount which is the lower of either 5 times the daily hospital cash Benefit or Rs. 10,000/- to the Insured Person for such Day Care Treatment provided the Insured Person is admitted in the Hospital/Day Care Centre for such Day Care Treatment for less than 24 hours.

The Benefit under this Section shall be available for a maximum of 2 Day Care Treatments per Insured Person per Policy Period. For list of Day Care treatments refer Annexure V of the Policy.

SECTION IV – PERSONAL ACCIDENT

IV.A.1 – ACCIDENTAL DEATH

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the death of the Insured Person within 365 days from the date of the Accident, We will pay the Sum Insured as specified against this benefit in the Policy Schedule/Certificate

IV.A.2 – PERMANENT TOTAL DISABLEMENT

If during the Policy Period a Primary Insured Person sustains Bodily injury which directly and independently of all other causes results in disablement within 12 months of the date of loss, then the company agrees to pay the insured person the compensation stated in the specific table of benefits below.

Table of Benefits	
Permanent Total Disability	**% of Sum Insured**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%

One Hand and One Foot	100%
Either Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

Other conditions applicable to this benefit

a. If an Insured person dies as a result of bodily injury any amount claimed and paid to an Insured person under this section will be deducted from any payment under Accidental Death (IV.A.1)

IV.A.3 – FUNERAL EXPENSES

If We have accepted a claim for Accidental Death in accordance with Section IV.A.1. in respect of an Insured Person, then in addition to any amount payable under Section IV.A.1, We will make a onetime lump sum payment of the amount specified in the Policy Schedule/Certificate, towards transportation of mortal remains and funeral/cremation in respect of that Insured Person.

PERIOD OF INSURANCE

The policy can be issued for Annual Period Only

WHAT ARE THE WAITING PERIODS UNDER THE POLICY?

All claims payable will be subject to the waiting periods specified below

1. **Pre-Existing Diseases (Code- Excl01)**
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
   d. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.
2. **Specific Waiting Period: (Code- Excl02)**
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
   d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
   f. List of Diseases excluded for 12 months:
      i. Any types of gastric or duodenal ulcers;
      ii. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;
      iii. Surgery on all internal or external tumor /cysts/nodules/polyps of any kind including breast lumps;
      iv. All types of Hernia and Hydrocele;
      v. Anal Fissures, Fistula and Piles;
      vi. Cataract;

vii. Benign Prostatic Hypertrophy;
viii. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;
ix. Noninfective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;
x. Surgery of Genitourinary tract;
xi. Calculus Diseases;
xii. Sinusitis, nasal disorders and related disorders;
xiii. Surgery for prolapsed intervertebral disc unless arising from accident;
xiv. Vertebro-spinal disorders (including disc) and knee conditions;
xv. Surgery of varicose veins and varicose ulcers;
xvi. Chronic Renal failure;
xvii. Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by Accidental Bodily Injury.

g. List of Diseases excluded for 90 days:
i. Hypertension, Heart Disease and related complications
ii. Diabetes and related complications

3. First Thirty Days Waiting Period (Code- Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

WHAT ARE THE EXCLUSIONS UNDER THE POLICY?

The Company is not liable to 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:

1. Investigation & Evaluation (Code- Excl04)

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

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

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

3. Obesity/ Weight Control (Code- Excl06)

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

a. Surgery to be conducted is upon the advice of the Doctor
b. The surgery/Procedure conducted should be supported by clinical protocols
c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI)
i. greater than or equal to 40 or
ii. 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

4. 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.

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

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

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

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

7. **Breach of law: Code- (Excl10)**

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

8. **Excluded Providers: Code- (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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

10. **Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13)**

11. **Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl14)**

12. **Refractive Error:(Code- Excl15)**

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

13. **Unproven Treatments:(Code- Excl16)**

14. 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.

15. **Sterility and Infertility: (Code- Excl17)**

    Expenses related to sterility and infertility this includes:

    i. Any type of sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

16. **Maternity: (Code- Excl18)**

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

    b. Expenses towards miscarriage (unless due to accident) and lawful termination of pregnancy during the policy period.

    If the Insured Person has opted Maternity Cover under this Policy, then the above exclusions stand deleted.

17. Treatment taken outside geographical limits of India.

18. In respect of the existing diseases, disclosed by the insured and mentioned in the Policy Schedule / Certificate of Insurance (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes and the same are permanently excluded.

19. Dental treatment or surgery of any kind unless required because of Accidental Bodily Injury to natural teeth requiring hospitalization treatment.

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

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

22. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an Accident.

23. Venereal disease or any sexually transmitted disease or sickness.

24. Any Deductible amount or percentage of admissible claim under Co-Payment if applicable and as specified in the Policy Schedule / Certificate of Insurance.

25. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident.
26. Surgery to correct Deviated Nasal septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to our satisfaction that the condition is a result of an accidental injury.
27. Act of self-destruction or self-inflicted injury or suicide
28. Outpatient Diagnostic, Medical and Surgical procedures or treatments, unless specifically covered and specified in the Policy Schedule / Certificate of Insurance.
29. Costs of donor screening or treatment including organ extraction, unless specifically covered and specified in the Policy Schedule / Certificate of Insurance.
30. Medical Practitioner's or Private Nurse home visit during pre and post Hospitalization period, attendant nursing expenses
31. **Chemical & Nuclear Exposure**

    We will not pay for the treatment costs directly or indirectly caused by or contributed to or arising from nuclear weapons/materials, radiations of any kind, contamination by radioactive material, nuclear waste, nuclear fuel or from the combustion of nuclear fuel, nuclear, chemical or biological weapons/attack.

    a. 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.

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

    We will not pay for the treatment related to and arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation.

WHAT IS THE PREMIUM RATE?

As per Rating Chart attached

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.

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

ALTERATIONS IN THE POLICY

The Proposal Form, Certificate, and Policy Schedule / Certificate if Insurance 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.

CANCELLATION

1. Cancellation

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

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

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

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

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.

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.

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.

HOW CAN I CLAIM UNDER THIS POLICY?

1. Claims Intimation

   If You meet with any Accidental bodily Injury or suffer an Illness that may result in a claim, then as a Condition Precedent to Our liability, You must comply with the following claim procedures

S No	Type of Hospitalization	Notify Us or Our TPA (either at Our call centre or in writing)
1	Planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier.
2	Emergency Hospitalization	within twenty-four (24) hours of Your admission to hospital or before discharge whichever is earlier
3	Diagnosis or actual undergoing of procedure	within 10 days from the date of occurrence of such event

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

- Health Card ID number
- Policy Number
- Name of the Policyholder

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

3.A Claim Cashless Process

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

3.A.1 For Planned Hospitalization

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

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

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

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

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

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

g. The authorisation letter shall be valid only for a period of fifteen (15) days from the date of issuance of authorization

In the event that the cost of Hospitalization exceeds the authorized limit as mentioned in the authorization letter:

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

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

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

At the time of discharge:

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

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

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

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

3.A.2 For Emergency Hospitalization

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

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

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

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

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

The Network Provider will send the claim documents to TPA within fifteen (15) days from the date of discharge from Hospital.

List of necessary claim documents to be submitted for Cashless are as following:

- Claim Form duly filled and signed
- Original signed pre-authorisation request

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

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

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

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

3.B Claim Reimbursement Process

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim to Our / TPA office not later than thirty (30) days from the date of discharge from the Hospital. You can obtain a Claim Form from any of Our / TPA Offices or download a copy from Our website https://www.sbigeneral.in

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

Sr No	List of Documents / Information	Hospitalization Cover	Critical Illness	Hospital Daily Cash	Personal Accident
1	Duly Filled and Signed Claim Form	Y	Y	Y	Y
2	Discharge Summary	Y	Y	Y	Y
3	Medical Records (Indoor Case Papers, OT notes, PAC Notes etc.)	Y	Y	Y	Y
4	Original Hospital Main Bill	Y	Y	Y	Y
5	Original Hospital Bill Break-up	Y	N	N	N
6	Original Pharmacy Bills	Y	N	N	N
7	Prescriptions for the medicines purchased (except hospital supply) and investigations done outside the hospital	Y	N	N	N
8	Consultation Papers	Y	Y	Y	Y
9	Investigation Reports	Y	Y	Y	Y
10	Digital Images/CDs of the Investigation Procedures (if required)	Y	Y	N	N
11	MLC/FIR Report (If applicable)	Y	N	N	Y
12	Original Invoice/Sticker (If applicable)	Y	N	N	N
13	Post Mortem Report (If applicable	Y	N	Y	Y
14	Disability Certificate (If applicable)	Y	N	N	Y
15	Attending Physician Certificate (If applicable)	Y	Y	N	Y
16	Ante-natal Record (If applicable)	Y	N	N	N
17	Birth Discharge Summary (If applicable	Y	N	N	N
18	Death Certificate (If applicable)	Y	Y	Y	Y
19	KYC (Photo ID card, If applicable)	Y	Y	Y	Y
20	Bank Details with Cancelled Cheque (If applicable)	Y	Y	Y	Y

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

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

REDRESSAL OF GRIEVANCES

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

Stage 1: Bima Bharosa

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

Stage 2: Head – Customer Care

Alternatively, if you wish to register your grievances directly with us, you may write to the Head – Customer Care. We aim to respond to all Grievances within 7 days. In our initial 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

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

For Senior Citizens:

Senior citizens can reach us through the following dedicated channels:

Email:Seniorcitizengrivences@sbigeneral.in

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

Stage 3: Grievance Redressal Officer (GRO)

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

Email: gro@sbigeneral.in

Phone: 022-45138021

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

Stage 4: Escalation to Insurance Ombudsman

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

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

ANTI REBATING WARNING

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

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing (or continuing) a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer
2. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to Ten Lakh rupees

DISCLAIMER

THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. PROSPECTS ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING THERETO BEFORE CONCLUDE THE SALE.

IRDAI Reg No. 144