SURAKSHA AUR BHAROSA DONO

SBIG Health Super Top-Up

PROSPECTUS

Your greatest wealth is your health & everybody has differing levels of control over their own wellbeing. Life follows no fixed plan and sudden Illnesses, or Accidental injury can sometimes leave you financially hurt and highly stressed. SBI General Insurance Company Limited (herein after the "Company", "We", "Our", "Us") introduces the SBIG Health Super Top-Up product which protects you and your family. If you or your family members are Hospitalized during Policy Period and your base sum insured exhausts, this product helps you to reduce your financial stress.

A. KEY FEATURES OF THE POLICY

1. Comprehensive Policy with 9 Base Covers and 15 Optional covers
2. Multiple Sum Insured range from 5 Lacs to 4 Crores is available under the Policy.
3. Multiple Deductible range from 2 Lacs to 2 Crores is available under the Policy.
4. Long term Policy options are available up to 3 years.
5. Flexible plans options of Annual Aggregate Deductible and Long Term Aggregate Deductible are available.

B. AGE CRITERIA & ELIGIBILITY

Minimum Entry Age	Adult: 18 years
	Dependent Child: 91 Days to 25 years
Maximum Entry Age	No Limit
Renewability	Lifelong
Policy Term	1/2/3 Years
Premium Payment Options	Single Premium, Half-yearly, Quarterly and Monthly
How can You cover Yourself	Individual/Family Floater basis.
	In a family floater Policy, a maximum of 4 adults and 6 children can be included in a single Policy.
Who are covered (Relationship with respect to the Proposer)	Individual: Self, Spouse, Children, Parents and/ or Parents in Law, Brothers, Sisters, Grand Parents, Grand Children, Daughter in law and Son-in-law
	Family Floater: Self, Spouse, Children (max 6), Parents and/ or Parents in Law

C. SUM INSURED & DEDUCTIBLE

The sum insured that can be offered is from ₹ 5,00,000/- to ₹ 4,00,00,000/- subject to Deductible opted. Sum Insured and Deductible options available in the product are as below:

Deductible (in lacs)	Sum Insured (in lacs)							
2	5	8	13					
3	5	7	12	22				
4	6	11	16	21				
5	5	10	15	20	25	45	70	95
6	14	19	44	69	94			
7	8	13	18	23	43	68	93	
7.5	7.5	12.5	17.5	22.5	42.5	67.5	92.5	
8	7	12	17	22	42	67	92	
9	6	11	16	21	41	66	91	
10	10	15	20	30	40	50	65	90
12.5	7.5	12.5	17.5	27.5	42.5	62.5	87.5	
15	15	25	35	60	85			
20	20	30	55	80	105	130		
25	25	50	75	100	125			
30	70	120						
50	50	100	150	200	250			
75	75	125	175	225				
100	100	150	200	400				
200	300							

D. SCOPE OF COVER

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

D. A. Hospitalization Covers

D. 1. In Patient Treatment

If any of the Insured Person, during the Policy Year, is diagnosed with any Illness or suffers any Injury that requires Inpatient Treatment on the written advice of a Medical Practitioner, then We will indemnify the below Medical Expenses incurred by the Insured in excess of Deductible amount and up to the Sum Insured as specified in the Policy Schedule.

a. Room rent and boarding expenses as provided by the Hospital/Nursing home up to the Room Rent limit as specific in the Policy Schedule.
b. Intensive Care Unit Expenses/ Intensive Cardiac Care Unit (ICCU) expenses.
c. Nursing Expenses as provided by the Hospital
d. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees
e. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
f. Consultation fees including Telemedicine by Medical Practitioner
g. Medicines, drugs, and consumables
h. Diagnostic procedures
i. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

D. 1. 1. Pre- Hospitalization

We will indemnify the Insured for the Medical Expenses incurred in the 60 days immediately before the Insured was Hospitalized, provided that:

i. Such Medical Expenses are incurred in respect of the same condition for which Insured has taken Hospitalization, and
ii. We have accepted the Claim under Benefit-D.1 In Patient Treatment, Benefit-D.2 Day Care Treatment, Benefit-D.4 Modern Treatment, Benefit-D.5 AYUSH Treatment or Benefit-D.6 Domiciliary Hospitalization

D. 1. 2. Post Hospitalization

We will indemnify the Insured for the Medical Expenses incurred in 90/180 days (as specified in the Policy Schedule) immediately after the Insured Person was discharged post Hospitalization provided that:

i. Such costs are incurred in respect of the same condition for which the Insured has taken Hospitalization, and
ii. We have accepted the Claim under Benefit-D.1 In Patient Treatment, Benefit-D.2 Day Care Treatment, Benefit-D.4 Modern Treatment, Benefit-D.5 AYUSH Treatment or Benefit-D.6 Domiciliary Hospitalization

D. 2. Day Care Treatment

We will indemnify the Insured for the Medical Expenses on the written advice of the Medical Practitioner, if during the Policy Year, any of the Insured Person undergoes a Day Care Treatment as defined under this Policy.

Specific Condition applicable to Benefit-D.2 Day Care Treatment

i. The Day Care Treatment would be covered if the Insured is admitted for more than 2 hours.
ii. The Day Care Treatment would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer.
iii. Our maximum liability under this benefit is limited to Sum Insured, in excess of Deductible as specified in the Policy Schedule.

D. 3. Organ Donor

We will indemnify the Insured for the Medical Expenses incurred during In Patient Treatment, in respect of donor for any organ transplant Surgery conducted on the Insured Person during the Policy Year, provided that:

i. The organ donated is for the Insured Person's use
ii. We have accepted the claim under Benefit-D.1 In Patient Treatment.
iii. We shall not pay the donor's Pre and Post Hospitalization Expenses
iv. Our maximum liability under this benefit is limited to Sum Insured, in excess of Deductible as specified in the Policy Schedule.

An organ donor is any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs Act, 1994 (amended).

D. 4. Modern Treatments

We will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Medical Expenses incurred during the

Policy Year on Inpatient Treatment or Day Care Treatment or Domiciliary Treatment of Modern Treatments and not limited to the following:

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy-Monoclonal Antibody to be given as injection
vi. Intra Vitreal injections
vii. Robot surgeries
viii. Stereotactic radio surgeries
ix. Bronchial Thermoplasty
x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neutro Monitoring)
xii. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

D. 5. AYUSH Treatment

We will indemnify the Insured Person for the Medical Expenses which are incurred on treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy up to the Sum Insured in excess of Deductible as specified in the Policy Schedule. The AYUSH Treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.

D. 6. Domiciliary Hospitalization

We will indemnify the Insured Person, to the extent of Sum Insured subject to Deductible for the Reasonable and Customary Charges for Medical Expenses incurred towards the Domiciliary Hospitalization during the Policy Year, provided that the condition for which the medical treatment is required for at least twenty-four hours.

The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

D. 7. Road Ambulance

We will indemnify the Insured up to an amount specified in the Policy Schedule, per Hospitalization for expenses incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider

i. We have accepted a Claim under Benefit D.1 In Patient Treatment or Benefit D.2 Day Care Treatment.
ii. Such life-threatening emergency condition is certified by the Medical Practitioner.
iii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital or from one Hospital to another Hospital, which is prepared to admit the Insured Person and provide the necessary medical services, provided that transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

D. 8. Home Health Care

We will indemnify the Reasonable and Customary charges towards Medical Expenses incurred by the Insured for Home Health Care Services during the Policy Year, up to the Sum Insured in excess of Deductible, provided that

i. The treatment in normal course would require In Patient Treatment at a Hospital and be admissible under Benefit-D.1 In Patient Treatment but is actually taken while confined at home.
ii. The benefit shall not be available for any emergency treatment/care.
iii. The Treatment is availed from Our empanelled service provider on Cashless basis
iv. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.

D. B. Optional Covers

The covers listed below are optional covers and are available to the Insured Persons, on payment of additional premium, subject to below mentioned terms, conditions, and exclusions.

D. 9. Maternity Expenses

We will indemnify towards the Maternity Expenses of female Insured Person incurred on Inpatient Treatment, to the extent of Sum Insured subject to Deductible, provided:

i. This benefit is available only to female members between the age group of 18 years to 45 years.
ii. The benefit also covers expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner
iii. This benefit shall become available only after the expiry of 36 months from the date of inception of the first Policy with Us.
iv. The payment under this cover is limited to maximum two deliveries or termination for the female Insured Person covered under this Policy. Those female Insured Persons who are already having two or more children will not be eligible for this benefit.

D. 10. New-born Baby Cover

We will indemnify up to the extent of Sum Insured in excess of Deductible specified in the Policy Schedule towards the Medical Expenses incurred in respect of a Newborn Baby subject to Mother being covered under the Policy.

Provided that,

i. The claim under this benefit shall be payable, if We have accepted the claim under Benefit-D.9 Maternity Expenses

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

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

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

v. Sum Insured available under this benefit shall be up to Mother's Sum Insured in case of an individual Policy and up to family floater Sum Insured in case of family floater Policy.

D. 11. Hospital Daily Cash

If We have accepted a claim under Benefit-D.1 In-Patient Treatment, then We will pay the Insured an amount equal to the Hospital Daily Cash amount specified in the Policy Schedule per day of Hospitalization, provided

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

ii. In a given Policy Year, the amount under this benefit shall be payable for a maximum of no. of days (as specified in the Policy Schedule) in a Policy Year.

iii. In case of ICU hospitalization, We will pay per day Hospital Daily Cash amount maximum of 2 times of Hospital Cash Limit as specified in the Policy Schedule

iv. Irrespective of Policy type, this benefit shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule.

v. The payment under this benefit shall not reduce the Base Sum Insured.

D. 12. Consumables

If We have accepted a Hospitalization claim, then the items which are not payable as per List I– 'Expenses not covered' under Annexure II of Policy Wordings related to that particular claim will become payable, provided

i. Such Non-Medical/Consumables items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In Patient Treatment or Day Care Treatment and

ii. We have accepted a claim under Benefit-D.1 to Benefit-D.6 and Benefit D.8 Home Health Care.

D. 13. Global Cover

We will indemnify the Medical Expenses incurred towards the Insured Person's In Patient Treatment or Day Care Treatment taken outside India during the Policy Year for below listed procedures that occurs or manifests itself during the Policy Year.

Listed Illness and Definitions:

Sr. No.	Name of Illness	Definition
1	Cancer Treatment Surgery	We will be covering expenses incurred in Surgery for Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. I. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high-grade dysplasia or severe dysplasia.
2	Heart Valve Replacement	I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist medical practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.
3	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).

Sr. No.	Name of Illness	Definition
4	Pulmonary Artery Graft Surgery	We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
5	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	We will be covering the actual undergoing of heart Surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. The following are excluded: Angioplasty and/or any other intra-arterial procedures.
7	Surgical Treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II. We will be covering surgical treatment of Stroke limited to: a. Intra cranial Surgery by the route of Burr Hole Procedure or Craniotomy; b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke. III. The following are excluded: a. Transient ischemic attacks (TIA); b. Traumatic injury of the brain; c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
8	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases: a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and iv. Dyspnea at rest.
9	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases: I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
10	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to: a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a. no response to external stimuli continuously for at least 96 hours; b. life support measures are necessary to sustain life; and c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. d. The condition has to be confirmed by a specialist medical practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.

Sr. No.	Name of Illness	Definition
11	Surgery for Pheochromocytoma	I. We will be covering the actual undergoing of Surgery to remove the tumour. II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.
12	Liver Transplant Surgery in case of End Stage Liver Disease	In case of End Stage Liver Disease We will be covering the actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following: i. Permanent jaundice; and ii. Ascites; and iii. Hepatic Encephalopathy. iv. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. Liver failure secondary to drug or alcohol abuse is excluded
13	Pneumonectomy - Removal of an entire lung	Removal of an entire lung The undergoing of surgery to remove an entire lung for disease or trauma. The following is not covered: i. Partial removal of a lung (lobectomy) or lung resection or incision. The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
14	Surgical removal of an eyeball	Surgical removal of a complete eyeball as a result of injury or disease. For the above definition the following is not covered: i. Self- inflicted injuries The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.
15	Heart transplant surgery	Covers the actual undergoing of a transplant of human heart due to irreversible end- stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
16	Craniotomy for Cerebral Aneurysm	We will be covering the actual undergoing of Craniotomy for treatment of Cerebral aneurysm diagnosed by appropriate medical consultant supported with evidence of cerebral angiogram and/or magnetic resonance angiography and/or CT scan. For the above definition the following are not covered: i. Cerebral arteriovenous malformation.

Provided that,

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

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

iii. This benefit is available on Reimbursement basis

iv. Our maximum liability under this benefit shall be limited to Sum Insured in excess of Deductible as specified in the Policy Schedule.

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

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

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

viii. The claim payment under this benefit shall be payable in Indian Rupees.

D. 14. Radio Cab

We shall indemnify the Insured up to the amount specified in the Policy Schedule, per Hospitalization, for the expenses incurred on availing registered Radio cab operator services, provided that:

i. We have accepted the claim under Benefit- D.1 In Patient Treatment and Benefit-D.2 Day Care Treatment

ii. The coverage includes the cost of the transportation of the Insured for whom claim has been accepted under under Benefit D.1 In Patient Treatment or Benefit D.2 Day Care Treatment to the nearest Hospital and/or from Hospital to home.

D. 15. Air Ambulance

We will indemnify the Insured to the extent of Sum Insured specified in the Policy Schedule for expenses incurred on availing Air Ambulance services during the Policy Year, provided.

i. The medical condition of the Insured requires immediate ambulance services from the place where the Insured is injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing.

ii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
iii. We have accepted a claim under Benefit D.1 In Patient Treatment or Benefit D.2 Day Care Treatment.
iv. Expenses under this benefit shall be payable on reimbursement basis subject to the original Ambulance bills and payment receipt submitted to Us.
v. The Origin and Destination of Air Ambulance Service are within the geographical boundaries of Republic of India.
vi. Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.
vii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.

D. 16. Recovery Benefit

We shall pay a lump sum amount as specified in the Policy Schedule to the Insured for the Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, during the Policy Year, provided.

i. We have accepted a claim under Benefit-D.1 Inpatient Hospitalization Treatment or Benefit D.5 AYUSH Treatment.
ii. This benefit is over and above the Sum Insured
iii. This benefit is available once for each Insured Person in a Policy Year.
iv. The Deductible shall not be applicable on this benefit.

D. 17. Personal Accident Cover

D. 17. 1. Accidental Death

If the Primary Insured Person, sustains an injury, from an Accident, during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the Insured, then we shall be liable to pay 100% of Sum Insured to Nominee /Legal Heir/Assignee as mentioned in the Policy Schedule.

D. 17. 2. Permanent Total Disability

If the Primary Insured Person, sustains an injury, from an Accident, during the Policy Period and if such injury shall within twelve calendar months of its occurrence be the sole and direct cause of Permanent Total Disablement of the nature specified below, then we shall be liable to pay 100% of Sum Insured to the Insured Person as specified in the Policy Schedule.

a. Total and irrecoverable loss of sight of both eyes or
b. Physical separation or loss of use of both hands or feet or
c. Physical separation or loss of use of one hand and one foot or
d. loss of sight of one eye and Physical separation or loss of use of hand or foot
e. If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever

Note:

1. Disappearance: In the event of Insured Disappearance, If such claim payment has been made and if after the payment of claim, it is found that the Insured Person has survived the Accident, then the Insured Person has to refund the payment back to Us in consideration of the obligatory guarantee as provided during the claim.
2. The claim under this benefit shall be payable either under Accidental Death or Permanent Total Disablement.
3. If we become liable to make payment under Accidental Death / Permanent Total Disability due to Accidental bodily injury, then this insurance will cease as far as the Insured is concerned.
4. Our maximum liability to pay the claim under this benefit is limited to Sum Insured as specified in the Policy Schedule.
5. The Deductible shall not be applicable on this benefit.

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

D. 18. Unlimited Restore Benefit

We shall restore the Base Sum Insured unlimited times during the Policy Year after occurrence and payment of claim amount under the Policy, provided:

i. the Sum Insured shall be restored to full extent immediately after settlement of a claim under Benefits D.1 (In Patient Treatment), D.1.1 (Pre- Hospitalization), D.1.2 (Post Hospitalization), D.2 (Day Care Treatment), D.3 (Organ Donor), D.4 (Modern Treatments), D.5 (AYUSH Treatment), D.6 (Domiciliary Hospitalization) and D.8 (Home Health Care).
ii. The Restored Sum Insured shall be available only for all subsequent claims.
iii. The Restored Sum Insured can be utilized unlimited times for subsequent claims for related or unrelated illness/ injury.
iv. The Unlimited Restore benefit shall be available at each Policy Year and the Restored Sum Insured at given time shall not exceed the Sum Insured specified in the Policy Schedule.
v. Restored Sum Insured will be available on individual basis for individual policies and on floater basis for Family Floater Policies during a Policy Year.

vi. If the Unlimited Restore Benefit is not utilized in a Policy Year it shall not be carried forward to any subsequent Policy Year.

vii. Under the Policy, this benefit can be utilized in following sequence:

a. Sum Insured

b. Cumulative Bonus

c. Unlimited Restored Benefit (if opted)

D. 19. Reduction in Room Rent

If you avail this option, the Insured shall be allowed to opt the Room Rent category Actuals to Single Private A.C Room or Twin Sharing Room for hospitalizations allowable under Section D. A. of this Policy, if so, requested by the Insured and accepted by Us. The agreed Room Rent category shall be expressly specified in the Policy Schedule.

D. 20. Change in Pre-Existing Waiting Period

If you avail this option, the Insured shall be allowed to change the 24 months Waiting Period for Pre-Existing Diseases as specified in Section E to 36 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Policy Schedule.

D. 21. Change in Maternity Waiting Period

If you avail this option, the Insured shall be allowed to change the 36 months Waiting Period for Maternity Expenses as specified in Section E to 48 months, 24 months or 12 months. Such change, if allowed, shall be expressly mentioned in the Policy Schedule.

D. 22. Reduction in Specific Disease Waiting Period

If you avail this option, then We shall reduce the 24 months Waiting Period for Specific Diseases as specified in the Section E to 12 months. Such reduction, if allowed, shall be expressly specified in the Policy Schedule.

D. C. Value Added Services

D. 23. E-Opinion

Under this benefit, the Insured Person may avail E-Opinion on his/her medical condition occurring during the Policy Year from a Medical Practitioner from our empanelled network.

Provided,

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

i. The Insured Person may have an option to choose E-Opinion from the list of Specialist as provided by Us on Our Website/App.

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

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

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

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

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

vii. The Deductible shall not be applicable on this benefit.

D. 24. Stay Fit Health Check Up

The Insured may avail a health check-up, only for Preventive Test, up to a limit specified in the Policy Schedule, provided

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

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

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

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

v. Availing of Claim under this benefit will not impact the Sum Insured or the Cumulative Bonus.

vi. The Deductible shall not be applicable on this benefit.

vii. This benefit is over and above the Sum Insured.

D. D. Renewal Benefits

D. 25. Cumulative Bonus

At the end of each completed and continuous claim free Policy Year, We will provide Cumulative Bonus which will increase 10% of the Sum Insured of immediate preceding Policy Year provided the Policy is renewed with Us without a break, subject to maximum cap of 100% of the Sum Insured under the current Policy Year. If a claim is made in any particular Policy Year, the Cumulative Bonus accrued shall not be reduced and no Cumulative Bonus will be earned on the Policy Renewal.

Specific Condition Applicable to Benefit-D.25 Cumulative Bonus

i. In case where the Policy is on individual basis as specified in the Policy Schedule, the Cumulative Bonus shall be added and available individually to the Insured Person and in case where the Policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis.

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

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

iv. In case of floater policies where the Insured Persons renew their expiring Policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the Cumulative Bonus of the expiring Policy shall be apportioned to such renewed Policies in the proportion of the Sum Insured of each renewed Policy.

v. If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured in current Policy.

vi. If the Sum Insured under the Policy has been increased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

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

viii. In case of mid-term addition in floater policies, the accumulated Cumulative Bonus will be available among all the Insured Persons including the newly added member on floater basis.

ix. For a claim to be admissible under Cumulative Bonus it should be admissible under the Benefit D.1 to D.8 and D.13.

E. WAITING PERIOD

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

E. 1. 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 excepts 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 24 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, Hypertension, Diabetes and Cardiac Condition.

E. 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, 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

Internal Congenital diseases	Non infective Arthritis
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

E. 3. 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 is subject to the same being declared at the time of application and accepted by Us.

E. 4. Hypertension, Diabetes, Cardiac Condition: A waiting period of 90 days shall apply for all claims of Hypertension, Diabetes, Cardiac Condition except if these diseases are pre-existing and disclosed at the time of Policy.

E. 5. Global Treatment: Expenses related to the treatment taken abroad for any listed Illness under this benefit within 36 months from the first Policy Period Start Date shall be excluded.

F. 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:

F. 1. Standard Exclusions

1) Investigation & Evaluation (Code: Excl04)

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

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment, except under the Benefit-D.24-Stay Fit Health Check Up.

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:

- 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.
- 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);

- greater than or equal to 40 or

- 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: 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.
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 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/)
9) **Substance Abuse and Alcohol (Code: Excl12):** Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
10) **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.
11) **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
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 (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.
14) **Sterility and Infertility (Code: Excl17):** Expenses related to sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization
15) **Maternity (Code-Excl 18) (Not Applicable to Benefit-D.9 Maternity Expenses (if opted))**
    i. Medical treatment expenses traceable to child-birth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

F. 2. Specific Exclusions

1) 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.
2) Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
   a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
   b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
   c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
3) Treatment taken outside India, except for Benefit-D.13-Global Cover.

4) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an Accident
5) Convalescence, general debility, "run-down" condition, rest cure, external congenital anomaly.
6) Vaccination or inoculation except as part of post-bite treatment for animal bite.
7) Medical Practitioner's home visit expenses during Pre and Post hospitalization period, attendant nursing expenses.
8) Non-payable items: Expenses against items mentioned in "List I" shall not be payable. This exclusion shall be waived off, if Optional Benefit-D.12 (Consumables) has been opted under the Policy.
9) 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.

   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.
10) If as per any or all of the medical references herein below containing guidelines and protocols for evidence-based medicines, the Hospitalization for treatment under claim is not necessary or the stay at the Hospital is found unduly long:
    a) Medical text books,
    b) Standard treatment guidelines as stated in clinical establishment act of Government of India,
    c) World Health Organization (WHO) protocols,
    d) Published guidelines by healthcare providers,
    e) Guidelines set by medical societies like cardiological society of India, neurological society of India etc
11) Any Permanent Exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

G. DISCLOSURE OF INFORMATION

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure 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).

H. 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.

I. 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

J. 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://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

K. 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.

L. CLAIMS PROCEDURE

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

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

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

Covers	List of Claim Documents
Hospitalization Cover: Hospitalization Expenses, Pre and Post Hospitalization, Organ Donor Expenses, Modern Treatment, Road Ambulance, Domiciliary Hospitalization, Reduction in Room Rent, AYUSH Treatment, Home Health Care, Maternity Expenses	1. Duly filled and signed claim form 2. Certified copy of Hospital discharge Summary 3. Certified copy of final hospital bill, pharmacy bills, Investigation labs bills 4. All original reports of Investigations done 5. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form with KYC Form

Covers	List of Claim Documents
	6. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc. 7. Certified copy of Death certificate issued by municipal authority (in case of death of insured) 8. KYC details and Documents
Personal Accident Cover:	**Accidental Death Cover** 1. Duly completed and signed Claim Form, in original 2. Death certificate 3. Post mortem report if available and applicable 4. First Information Report/ Final Police Report, if applicable 5. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased. 6. Any other document as required by the Company to assess the Claim **Disability** 1. Duly completed and signed Claim Form, in original 2. Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel of the related speciality 3. Original Investigation Reports and copies of reports, X - Ray films supporting the Accidental injury. Post-Operative X-ray films, if any 4. Photographs of the Insured Person highlighting the injury / disability 5. Copy of FIR / MLC (if registered)/ Panchnama, wherever applicable
Global Cover	1. Duly completed and signed Claim Form, in original 2. Passport Copy with Visa Stamp 3. Medical Practitioner's referral letter advising Hospitalization 4. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation 5. Original bills, receipts and discharge card from the Hospital / Medical Practitioner 6. Original bills from pharmacy / chemists 7. Original pathological / diagnostic test reports and payment receipts 8. Indoor case papers 9. First Information Report/ Final Police Report, if applicable 10. Post mortem report, if available
Critical Illness Cover	1. Duly filled and signed claim form 2. Certified copy of first hospital consultation & first diagnostic report 3. Certified copies of hospital treatment records, investigation reports and follow up details with Medical assessment certificate (if applicable) 4. In case of death, certified copy of death certificate, Medical certificate of cause of death 5. Duly filled and signed Central KYC Registry form (applicable for benefit of Rs 1,00,000 & above) 6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable for benefit of Rs 1,00,000 & above) 7. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
Hospital Daily Cash	1. Duly filled and signed claim form 2. Certified copy of Hospital discharge Summary with Pre & Post Hospitalization consultation details (if any) 3. Certified copy of Diagnostic report confirming diagnosis. 4. Certified copy of final hospital bill with detailed break up 5. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable only in case of benefit above Rs 1 Lakh) 6. Beneficiary (Primary Insured) bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
Value Added Covers: E-Opinion, Stay Fit Health Check Up	As per case, if required

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 empaneled Service providers are available on Our Website and can be obtained by Contacting Our TPA.
  ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim.
  iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.
  iv. We will make payment for the Cashless authorized amount directly to the Network Provider.
  v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.
- **Claim documents submission:**

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

  We will scrutinize the claim based on submission of above claim documents by you and if any deficiency in document we will intimate You in writing within 7 days from the date of submission of claim documents. We will initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document.
- **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.
- **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 List II, List III and List IV of Annexure II of Policy Wordings are not covered, unless otherwise Specified in the Policy Schedule.
- **Payment of Claim**

  All claims under the Policy shall be payable in Indian currency only.
- **Claim Settlement (provision for Penal Interest)**
  i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
  ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
  iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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)

M. RENEWAL OF POLICY

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.

N. WITHDRAWAL OF THE POLICY

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. 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.

P. NOMINATION

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

Q. PREMIUM PAYMENT IN INSTALLMENTS (WHEREVER APPLICABLE)

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.

R. CHANGE OF SUM INSURED

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

S. 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.

T. 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.

U. 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.

V. 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.

W. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING 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.

X. 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.

Y. 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.

Z. 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.

AA. 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.

BB. MULTIPLE POLICIES

a. Indemnity Policies:

A Policyholder can file for Claim settlement as per his/her choice under any Policy. The Insurer of that chosen Policy shall be treated as the primary Insurer.

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

b. Benefit based Policies:

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

CC. PRE-POLICY MEDICAL CHECK-UP

- Medical Tests as indicated in the grid below are applicable to all insured person(s), Sum Insured chosen and Age of Insured Person:

Sum Insured Opted irrespective of Deductible opted	Age Band	Tests Applicable
Any SI	Up to 15 years of Age	STP
SI Up to 75 Lakhs	16-17 years	STP
>75 Lakhs	16-17 years	Tele MER
5-30 lakhs	18-50 years	STP
>30 - 75 Lakhs	18-50 years	CAT 1
>75 Lakhs	18-50 years	CAT 2
5-75 lakhs	> 50 to 65 years	CAT 3
>75 Lakhs to 1.5 Crore	> 50 to 65 years	CAT 4
>1.5 Crore	> 50 years	CAT 7
Sum insured up to 1.5Cr	> 65 years	CAT 4

- The above medical grid is applicable for clean proposal without any medical history/ adverse declaration and Normal BMI (18-35).
- BMI Criteria is not applicable for age below 18 years.
- For any Adverse declaration/ adverse BMI, proposal shall be referred to Underwriters and we may ask for additional tests (in addition to above grid)/ TELE MER/ Video MER/ Physical MER.
- Also in case of any adverse disclosure by insured member, underwriters may ask for additional information, medical test as per grid, additional medical test as suitable to take prudent underwriting decision.
- 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) or declined.
- The total premium including loading applied in any proposal (new business/ renewal/ portability) will not exceed the opted sum insured of the Policy.

Test Category	CAT 1	CAT 2	CAT 3	CAT 4	CAT 7
Tests applicable	MER	MER	MER	MER	MER
	ECG	ECG	ECG	ECG	ECG
	Urine Routine	Urine Routine	Urine Routine	Urine Routine	Urine Routine
	CBC	CBC	CBC	CBC	CBC
	ESR	ESR	ESR	ESR	ESR
	SGPT	Total Cholesterol	Urine Microalbumin	Urine Microalbumin	Urine Microalbumin
	HbA1C	HbA1C	HbA1C	HbA1C	HbA1C
	Serum Creatinine	Serum Creatinine	Lipid Profile	Lipid Profile	Lipid Profile
	Total Cholesterol	Serum Triglyceride	LFT	LFT	LFT
		SGPT	KFT	KFT	KFT
		Urine Microalbumin		2D echo	2D echo
				PSA (male)	PSA (male)
				PAP smear (Female)	PAP smear (Female)
					CEA
					Fasting Blood Sugar
					Chest Xray
					HBsAG

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.

If the proposal is accepted the Insurer will reimburse 50% of the cost incurred towards the medical tests (as per agreed Package rates with empaneled centres).

Reference for tests:

- MER- Medical Examination report
- HbA1C- Glycated Haemoglobin
- CBC- Complete Blood Count
- ECG- Electro Cardio Gram
- ESR - Erythrocyte Sedimentation Rate
- SGPT - Serum Glutamate Pyruvate Transaminase
- KFT- includes: Serum creatinine, BUN, Serum Uric Acid.
- LFT includes: SGOT, SGPT, Total Bilirubin, GGT, Total protein
- Lipid Profile Includes: Total cholesterol, Triglycerides, HDL, LDL, Total cholesterol/HDL, VLDL.
- PSA- Prostate Specific Antigen
- PAP Smear- Papanicolaou test.
- Hbs Ag: Hepatitis B Australian Antigen
- CEA: Carcinoembryonic antigen

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

DD. DISCOUNTS

Insured is eligible for discount on premium as below:

i. Term Discount

Applicable in case of single payment for Policy term of more than one year

Number of Years	Discount
1 year	Nil
2 years	6%
3 years	9%

ii. Online/ Direct business/ SBIG Employee Referral/ Tele-sales Discount

A discount of 10% shall be applicable if Policy is sourced directly from the Company's website or through SBIG Employee's referral or through leads generated via Tele sales channel.

iii. Floater discount

Applicable discount is as per following table:

Family combination	Discount
2 members	20%
3 members	25%
>3 members	30%

iv. No floater discount (>= 2 members)

5% Family discount in case of more than 2 insured members are covered under the same Policy on individual sum insured basis.

v. Employee discount (for SBI Group)

5% Employee discount shall be applicable if the proposals received from the individual employed with SBI General Insurance Co. Ltd., provided that the respective individual, at least till the date of issuance of the Policy cover, continues to be in such capacity.

Towards entitlement of the discount, the proposer shall have to submit a self-attested copy of the identification card or appointment letter or such document that may have been issued in favor of the proposer to evidence the relationship along with the Proposal Form.

vi. Cross-sell Discount

5% Cross-sell discount shall be applicable if:

- Insured has an active retail health insurance Policy (other than SBIG Health Super Top-Up/ Personal Accident/ Travel) or,
- Insured has an active retail non-health insurance Policy or,
- Proposer is covered under active Group Health Policy offered by SBI General Insurance Company Limited.

vii. Girl Child Discount

- 5% discount shall be applicable if you insure your girl child/ children in the same Policy.
- Discount will get applied only once, irrespective of the number of girl child.

viii. Paperless Policy Discount

5% Paperless discount shall be applicable if the Proposer opts for an e-Format (electronic) of SBIG Health Super Top-Up Insurance Policy

ix. Early Entry Discount
- 5% discount shall be applicable to all adult members aged 18 years to 28 years
- The discount shall be applicable if the Individual(s) is/ are covered on individual sum insured basis.
- The standard premium will be charged once the Insured moves to the next age band as per premium chart.

x. BMI Discount
- 5% discount shall be applicable for Policyholders whose Body Mass Index (BMI) is between 18 to 29.
- Irrespective of Individual or Family Floater, this benefit is available to all adult members above 18 years of age on individual basis.

xi. Welcome discount (new business only)

A one time welcome discount of 5% shall be applicable on all the policies provided the Proposer purchases the SBIG Health Super Top-Up insurance within 5 days of receiving the quote from the Company.

xii. Renewal Discounts (on renewals)

A renewal discount of 5% shall be applicable on all the policies.

The discount shall be applicable at renewals only, irrespective of any claim, provided the Policy is renewed with Us within the grace period.

Note: All discounts in the Policy shall be capped to a maximum of 40% only, excluding Floater and Non-floater discount.

EE. LOADING FOR LONG TERM DEDUCTIBLE

In case Pro Plan is opted, there will be loading as per Deductible option chosen as mentioned below:

Deductible option/ Policy term	2-Year	3-Year
2 Lakh	20.00%	30.00%
3 Lakh	25.00%	35.00%
4 Lakh	30.00%	40.00%
5 Lakh	35.00%	45.00%
6 Lakh and above	40.00%	50.00%

FF. LOADING FOR PREMIUM PAYMENT IN INSTALMENTS

Premium Payment facility on instalment basis is available. Given below are the loadings applicable on Standard premiums in case of instalments:

Option	Instalment Premium Option	Loading Applicable
Option 1	Monthly	3%
Option 2	Quarterly	2.5%
Option 3	Half yearly	1.5%
Option 4	Single Premium	0%

GG. 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.

HH. CANCELLATION

a) Cancellation by you:

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

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

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

b) Cancellation by Us

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.

II. REDRESSAL OF GRIEVANCE

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 7 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

Designation: Grievance Redressal Officer

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

JJ. CONTACT US

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

Contact details for Policy Servicing	Contact details for Claim Servicing
Address: **SBI General Insurance Company Limited,** 9th Floor, Wing A & B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099 Email: **customer.care@sbigeneral.in** ; **seniorcitizengrievances@sbigeneral.in** (for Senior Citizens) **Toll Free number:** 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7) Website: **www.sbigeneral.in**	**Address:** **Accident & Health claims team,** **SBI General Insurance Company Limited,** 9th Floor, Westport, Pan Card Club Road, Baner Pune, Maharashtra – 411 045 Email: **sbig.health@sbigeneral.in** Toll Free number: 1800 210 3366, 1800 210 6366 Website: **www.sbigeneral.in**

ANNEXURE – I – BENEFIT ILLUSTRATION IN RESPECT OF INDIVIDUAL AND FAMILY FLOATER BASIS

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any Family member discount)	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	1,018	500000	1,018	5%	967	500000	10,208	3,062	7,146	5,00,000
30 yrs	1,018	500000	1,018	5%	967	500000				
15 yrs	771	500000	771	5%	732	500000				
10 yrs	771	500000	771	5%	732	500000				
60 yrs	3,315	500000	3,315	5%	3,149	500000				
56 yrs	3,315	500000	3,315	5%	3,149	500000				
Total Premium for all members of the Family is ₹10,208/- when each member is covered separately. Sum Insured available for each individual is ₹5,00,000/- and Deductible is ₹5,00,000/-			Total Premium for all members of the Family is ₹9,698/- when they are covered under a single Policy. Sum Insured available for each family member is ₹5,00,000/- and Deductible is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹7,146/- Sum Insured of ₹5,00,000/- and Deductible of ₹5,00,000/-is available for the entire family.			

ANNEXURE – II- CLAIM PAYMENT

Applicable for Plan 'Plus' & Plan 'Pro' Sum Insured of 25 L & Deductible of 5 L									
Policy Year	Claim No.	Sum Insured availability				Sum Insured utilization			Remarks
		Base Sum Insured	Deductible	Cumulative Bonus	Unlimited Restore Benefit	Claim Amount	Claim Payable		
							Plan 'Plus' (Annual Aggregate Deductible)	Plan 'Pro' (Long Term Aggregate Deductible)	
1	1	25 L	5 L	NA	NA	5 L	0	Not Applicable as Plan 'Pro' is available for 2 and 3 year Policy Period	Not Payable as Deductible under the Policy is ₹5 L
	2	25 L	NA	NA	NA	7 L	7 L		₹7 L from Base Sum Insured
	3	18 L	NA	NA	7 L	20 L	20 L		₹18 L from Base Sum Insured and ₹2 L from Restore
	4	0	NA	NA	25 L	5 L	5 L		Restore the Sum Insured by ₹20 L as ₹5 L balance was available
	5	0	NA	NA	25 L				
In the above scenario, the total claim amount was ₹37 L and claims paid amount is ₹32 L and the Sum Insured available with Insured is ₹25 L for both related and unrelated illness/injury for the remaining Policy Period									

Applicable for Plan 'Plus' (Annual Aggregate Deductible) Sum Insured of 5 L & Deductible of 2 L								
Policy Year	Claim No.	Sum Insured availability				Sum Insured utilization		Remarks
		Base Sum Insured	Deductible	Cumulative Bonus	Unlimited Restore Benefit	Claim Amount	Claim Payable	
1	No Claim	5 L	2 L	NA	NA	NA	NA	
2	1	5 L	2 L	50000	NA	5 L	3 L	₹3 L paid from Base Sum Insured as Deductible is ₹2 L
	2	2 L	0	50000	3 L	3 L	3 L	a) As there is a claim, CB shall remain intact b) ₹2 L is paid from Base Sum Insured, ₹50,000 from Cumulative Bonus and ₹50,000 from Unlimited Restore
	3	0	0	0	5 L	2 L	2 L	₹2 L paid from Unlimited Restore
3	1	5 L	2 L	NA	NA	5 L	3 L	₹3 L paid from Base Sum Insured, Deductible Reconstituted
	2	2 L	NA	NA	3 L	4 L	4 L	₹2 L paid from Base Sum Insured, and ₹2 L from Unlimited Restore
	3	0	NA	NA	5 L	3 L	3 L	Restore the Sum Insured by ₹4 L as ₹1 L balance was available
	4	0	NA	NA	5 L			
In the above scenario, the total claim amount was ₹22 L and claims paid amount is ₹18 L and the Sum Insured available with Insured is ₹5 L for both related and unrelated illness/ injury for the remaining Policy Period								

Applicable for Plan 'Pro' (Long Term Aggregate Deductible) Sum Insured of 5 L & Deductible of 2 L								
Policy Year	Claim No.	Sum Insured availability				Sum Insured utilization		Remarks
		Base Sum Insured	Deductible	Cumulative Bonus	Unlimited Restore Benefit	Claim Amount	Claim Payable	
1	No Claim	5 L	2 L	NA	NA	NA	NA	
2	1	5 L	2 L	50000	NA	5 L	3 L	₹3 L paid from Base Sum Insured as Deductible is ₹2 L
	2	2 L	NA	50000	3 L	3 L	3 L	a) As there is a claim, CB shall remain intact b) ₹2 L from Base Sum Insured, ₹50,000 from Cumulative Bonus and ₹50,000 from Unlimited Restore
	3	0	NA	NA	5 L	3 L	3 L	₹3 L paid from Unlimited Restore
3	1	5 L	NA	NA	NA	5 L	5 L	₹5 L from Base Sum Insured, No Deductible Reconstituted
	2	0	NA	NA	5 L	4 L	4 L	₹4 L paid from Unlimited Restore
	3	0	NA	NA	5 L	6 L	5 L	Restore the Sum Insured by ₹4 L as ₹1 L balance was available
	4	0	NA	NA	5 L			
In the above scenario, the total claim amount was ₹26 L and claims paid amount is ₹23 L and the Sum Insured available with Insured is ₹5 L for both related and unrelated illness/injury for the remaining Policy Period								

ANNEXURE – III- RATE CHART

For premium rates & applicable discounts and loadings please refer to the premium chart attached herewith.

ANNEXURE – IV – PRODUCT BENEFIT TABLE

Policy Period	1/2/3 years		
Plans	There are 2 Plans. Plus and Pro. Plus: Annual Aggregate Deductible Pro: Long Term Aggregate Deductible (applicable to 2 and 3 years Policy period)		
Room Rent Category	Actuals		
Covers	Plan 'Plus' - Annual Aggregate Deductible	Plan 'Pro' - Long Term Aggregate Deductible	Sum Insured Applicability
Base Covers			
Inpatient Treatment	Actuals up to Sum Insured		Within Sum Insured
Pre-Hospitalization	60 Days		Within Sum Insured
Post-Hospitalization	90 Days/180 Days		Within Sum Insured
Day Care Treatment	All day care procedures covered		Within Sum Insured
Organ Donor	Covered		Within Sum Insured
Modern Treatments	Covered		Within Sum Insured
AYUSH Treatment	Covered		Within Sum Insured
Domiciliary Hospitalization	Covered		Within Sum Insured
Road Ambulance	Up to INR 5000 per Hospitalization		Within Sum Insured
Home Health Care	Covered		Within Sum Insured

Optional Covers			
Maternity Expenses	Upto INR 2 Lacs for Deductible 5 L and above		Within Sum Insured
New-born Baby Cover	Covered		Within Sum Insured
Hospital Daily Cash	INR 500 per day upto 10 days maximum ICU- 2 times of Hospital Daily Cash	INR 500/ 1000 per day upto 10 days maximum ICU- 2 times of Hospital Daily Cash	Over and Above Sum Insured
Global Cover	Covered for Deductible options INR 20 Lacs & above.		Within Sum Insured
Radio Cab	Upto INR 3000 per Hospitalization		Within Sum Insured
Air Ambulance	up to INR 5 Lacs		Within Sum Insured
Recovery Benefit	INR 5000	INR 5000/ 10000/ 25000	Over and Above Sum Insured
Personal Accident Cover	INR 10 Lacs	INR 10 Lacs/ INR 20 Lacs	Over and Above Sum Insured
Unlimited Restore Benefit	On subsequent Claim Unlimited restore up to 100% of Sum Insured, for related and unrelated Illness/ Injury		Over and Above Sum Insured
Reduction in Room rent	Actuals to Single Private A.C Room or Twin Sharing Room		Within Sum Insured
Change in Pre-existing waiting period	3/ 1 years		Not Applicable
Change in Maternity Waiting period	1/ 2/ 4 years		Not Applicable
Reduction in Specific disease waiting period	1 year		Not Applicable
Value Added Services (Optional Covers)			
E-Opinion	Unlimited		Not Applicable
Stay Fit Health Check Up	Upto INR 5000(Annual). No Deductible applicable		Over and Above Sum Insured
Renewal Benefits (Base Cover)			
Cumulative Bonus	10% increase of Sum Insured up to 100% for each claim free Policy year. There will be no reduction in case there is a Claim.		Over and Above Sum Insured

SURAKSHA AUR BHAROSA DONO

DISCLAIMER

This is only a summary of the product features. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please seek the advice of our insurance advisor if you require any further information or clarification.

STATUTORY WARNING

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

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 life or property in India any rebate of the whole or part of the commission payable or any rebate of 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 prospectus or tables of the insurers.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.