SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

DIVYANGA SURAKSHA

PROSPECTUS

We think of full-proof protection for ourselves and loved ones, but health risks and uncertainties for disables are a part of life. During any sudden illnesses, accidental injury, or medical exigency, a comprehensive health insurance for persons with disability and HIV Aids becomes an integral part of your financial planning, it provides a much-needed financial backup. SBI General Insurance Company Limited (herein after the "Company", "We", "Our", "Us") introduce the Divyanga Suraksha, SBI General Insurance which protects you if you are Hospitalized during the policy period and helps you to reduce your financial stress.

A. AGE CRITERIA & ELIGIBILITY

Only one policy can be purchased for this product across all insurers.
The Eligibility Criteria, Benefits & Optional Covers mentioned in this Prospectus, form part of the health cover provided under the Policy.

Name	Divyanga Suraksha, SBI General Insurance
Coverage Basis	Individual basis only
Category of Cover	Indemnity
Sum insured	On Individual basis — SI shall apply to each individual member
Sum insured available(in INR)	4 lacs and 5 lacs
Policy Period	1 Year
Eligibility	Policy can be availed on Individual basis. Age eligibility for adults: 18 years to 65 years Age eligibility for Children: Newborn to 17 years
Grace Period	For monthly payment- 15 days Other modes of payment- 30 days
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. Time limit of 24 hrs shall not apply in respect of Day Care Treatment.
Pre-Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for Room/ Medical Practitioner`s fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to maximum of 1% of the sum per day. 2.1ntensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to maximum of 2% of the sum insured per day.
Cataract Treatment	Upto Rs.40,000/-, per each eye in one policy year
Modern Treatment	Covered for listed procedures up to 50% of sum insured available for Inpatient Hospitalisation Care
Emergency Ground Ambulance	Expenses covered up to Rs. 2000 per hospitalisation
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured, during each Policy year as specified in the policy schedule
Pre-Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered.
Initial Waiting period	30 days for all claims except resulting from Accident

PED waiting period	36 months (For pre-existing diseases other than the pre-existing Disability and HIV/AIDS covered)
Specific Disease/ illness waiting period	24 months
Waiting Period and specific Sublimit for HIV AIDS Cover	For HIV/AIDS cover: a. Initial waiting period of 30 days will be applicable for Indemnity basis cover b. Sum Insured would be available for Hospitalization Expenses as per terms and conditions of the policy.
Waiting Period and specific Sublimit for Disability Cover	For Disability Cover: a. 24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.
Co-pay	20% on all claims unless waiver for Co-pay is opted and premium is paid for the same

B. SCOPE OF COVER

a. HOSPITALIZATION COVER

Inpatient Care:

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

I. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.
II. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up maximum of to 2% of Sum Insured per day.
III. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the hospital
IV. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

A. Expenses incurred on treatment of cataract subject to the sub limits.
B. Dental treatment necessitated due to disease or injury (for inpatient care only).
C. Plastic surgery necessitated due to disease or injury.
D. All day care treatments

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.

b. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year, up to sum insured as specified in the policy schedule in any AYUSH Hospital.

c. Pre-Hospitalization Medical Expenses:

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care) or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments) in respect of that Insured Person.
ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

d. Post-Hospitalization Medical Expenses:

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 4.1 (Inpatient Care) or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments) in respect of that Insured Person.
ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

e. Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization as per the limit mentioned in Policy Schedule.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

i. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness 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 for management of the current Hospitalization.
ii. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.
iii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
iv. The original Ambulance bills and payment receipt is submitted to the Company.
v. The Company has accepted a claim under Section 4.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 4.2(AYUSH Treatment) or Section 4.7 (Modern Treatments).
vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

f. Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000/-, per each eye in one policy year.

g. Modern Treatment:

The following procedures will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period and not limited to the following:

i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection.
vi. Intra Vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM- (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

C. WAITING PERIOD

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

1. Pre-Existing Diseases (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for pre-existing disability/ 36 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

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

d. Coverage under the policy after the expiry of number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. First 30 days waiting period- Code- Excl03

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

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

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

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

a. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 24 months as (mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

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

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

24 months waiting period

1. **Benign ENT disorders**
2. **Tonsillectomy**
3. **Adenoidectomy**
4. **Mastoidectomy**
5. **Tympanoplasty**
6. **Hysterectomy**
7. **All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.**
8. **Benign prostate hypertrophy**
9. **Cataract and age-related eye ailments**
10. **Gastric/ Duodenal Ulcer**
11. **Gout and Rheumatism**
12. **Hernia of all types**
13. **Hydrocele**
14. **Non-Infective Arthritis**
15. **Piles, Fissures and Fistula in anus**
16. **Pilonidal sinus, Sinusitis and related disorders**
17. **Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.**
18. **Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.**
19. **Varicose Veins and Varicose Ulcers**

D. SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH DISABILITY

The Company will indemnify reasonable and customary charges for medical expenses incurred towards Inpatient Hospitalisation arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons with Disabilities Act, 2016 subject to the terms and limits mentioned below.

i. Any treatment for the pre-existing disability covered, will have a waiting period of 24 months from the first policy inception date.

ii. Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

E. SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH HIV/AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition

which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided:

Conditions

This cover will exclude cost for any Anti-Retroviral Treatment.

F. EXCLUSIONS

1. Standard Exclusions

a. **Investigation & Evaluation- Code- Excl04**

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

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

b. **Rest Cure, rehabilitation, and respite care- Code- Excl05**

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

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

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

c. **Obesity/ Weight Control: Code- Excl06**

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

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

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

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

iv. Body Mass Index (BMI).

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. coronary heart disease

iii. Severe Sleep Apnoea

iv. Uncontrolled Type2 Diabetes

d. **Change of Gender Treatments (Code- Excl 07)**

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

e. **Cosmetic or plastic Surgery: Code- Excl08**

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

f. **Hazardous or Adventure sports: Code- Excl09**

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

g. **Breach of law: Code- Excl10**

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

h. **Excluded Providers: Code- Excl11**

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

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

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

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

l. **Refractive Error: Code- Excl15**

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

m. **Unproven Treatments: Code- Excl16**

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

n. **Sterility and Infertility: Code- Excl17**

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

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

iii. Gestational Surrogacy

iv. Reversal of sterilization

o. **Maternity: Code Excl18**

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

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

2. Specific Exclusions

I. Any medical treatment taken outside India.

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

III. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
   a. any nuclear fuel or from any nuclear waste; or
   b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission; or
   c. nuclear weapons material; or
   d. nuclear equipment or any part of that equipment.

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

V. Injury or Disease caused by or contributed to by nuclear weapons/materials.

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

VII. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.

VIII. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

IX. Vaccination or inoculation except as post bite treatment for animal bite.

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

XI. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.

XII. Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.

XIII. Venereal/ Sexually Transmitted disease

XIV. Stem cell storage.

XV. Any kind of service charge, surcharge levied by the hospital.

XVI. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

XVII. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II

XVIII. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

G. GENERAL TERMS AND CONDITIONS

1. **Standard terms & Conditions Condition Precedent to the contract**

a. **Disclosure of Information**

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

b. **Condition Precedent to Admission of Liability**

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

c. **Claim Settlement (provision for Penal interest)**

i The Company shall settle or reject a claim as the case may be, 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.

(Explaination: 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.)

d. **Complete Discharge**

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

e. **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.

f. **Fraud**

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all 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:

a. the suggestion, as a fact of that which is not true and which the Insured person does not believe to be true;
b. the active concealment of a fact by the Insured person having knowledge or belief of the fact;
c. any other act fitted to deceive; and
d. any such act or omission as the law specially declares to be fraudulent

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

g. **Cancellation**

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

i. refund proportionate premium for unexpired Policy Period, if the term of Policy upto one year and there is no Claim (s) made during the Policy Period.
ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

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

h. **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

i. **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 45 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.
For Detailed Guidelines on Portability, kindly refer the link-
https://content.sbigeneral.in//uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

j. **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.

k. **Premium Payment in Instalments**

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.

l. **Withdrawal of the Product-**

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.

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.

m. **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.

n. **Possibility of Revision of terms of the Policy including the Premium Rates**

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three (3) months before the changes are affected.

o. **Loading as per Medical Condition/ Pre-existing condition:**

i. **Medical UW loading**

Please note Medical Age Band cases or cases with medical history will be subject to medical UW and will attract medical Loading on the premium, the maximum loading % will not exceed 150%.

Please note Medical Age Band cases or cases with medical history will be subject to medical UW and will attract medical Loading on the premium, the maximum loading % will not exceed 150%.

Irrespective of age and sum insured UW's may call for additional documents including radiology report, pathology report, specific report, if any and medical test for insured members.

Medical Tests as indicated in the grid below are applied to those proposed insured person/s whose age is >18 years of age & Where the proposed insured person/s is/are suffering from an existing medical condition (as mentioned in the proposal form or is identified so in the reports from the medical tests applied), additional medical test/s (depending upon the type of medical condition) may be applied for understanding the complete health condition.

Tests applicable- CAT 3	
MER	ESR
ECG	Urine Microalbumin
Urine Routine	HbA1C
CBC	Lipid Profile
LFT	KFT
MER- Medical Examination report	ESR - Erythrocyte Sedimentation Rate
HbA1C- Glycated Hemoglobin	KFT- includes: Serum creatinine, BUN, Serum Uric Acid.
CBC- Complete Blood Count	LFT includes: SGOT, SGPT, Total Bilirubin, GGT, Total protein
ECG- Electro Cardio Gram	

50% will be reimbursed in case of acceptance of Proposal, where PPMC has been conducted.

p. **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.

m. **Redressal of Grievance**

Stage 1: If you are dissatisfied with the resolution provided above or for lack of response, you may write to head.customercare@sbigeneral.in We will look into the matter and decide the same expeditiously within 14 days from the date of receipt of your complaint.

For Senior Citizens: Senior Citizens can reach us at seniorcitizengrievances@sbigeneral.in; Toll free number 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7)

Stage 2: In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may send your Appeal addressed to the Grievance Redressal Officer at : gro@sbigeneral.in or contact at 022-45138021.

Address: Grievance Redressal Officer, 9th Floor, A & B Wing, Fulcrum Building, Sahar Road, Andheri (East), Mumbai 400 099. List of Grievance Redressal Officers at Branch:

https://content.sbigeneral.in/uploads/0449cac1bcd144bbb160d3f6b714fbbd.pdf/

Stage 3: In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may Register your complaint with IRDAI on the below given link https://bimabharosa.irdai.gov.in/Home/Home

Stage 4: If your grievance remains unresolved from the date of filing your first complaint or is partially resolved, you may approach the Insurance Ombudsman falling in your jurisdiction for Redressal of your Grievance. The details of the Insurance Ombudsman can be accessed at (https://www.cioins.co.in/Ombudsman)

n. **Nomination**

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

2. Specific Conditions

A. **Condition Precedent to the contract**

(i) **Change of Sum Insured**

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

(ii) **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.

(iii) **Notice and Communication**

1. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
2. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
3. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule/certificate of insurance.

(iv) **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.

(vi) **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.

(vii) **Eligibility Criteria**

All Persons with Disability who have at least one of the disabilities as defined under Specified Disability under The Rights Of Persons With Disabilities Act, 2016 with valid disability certificate are eligible to enroll this product.

B. Conditions applicable during the contract

a. **Alterations in the Policy**

The Proposal Form, Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. 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 Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

b. **Revision and Modification of the Policy Product-**

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

c. **Terms and conditions of the Policy**

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

H. CLAIM PROCEDURE

a. **Procedure for Cashless claims**

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,

ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,

vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

b. **Procedure for reimbursement of claims**

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

S. No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

c. **Notification of Claim**

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

d. **Documents to be submitted**

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form.
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission.
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/invoices of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable.
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

- Claim Document Submission Address

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

Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team

SBI General Insurance Company Limited

9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person
4. In case of lumpsum payment for HIV/AIDS, Insured will need to submit the below mentioned documents for the processing of Claim:
   a. Identity proof of the claimant
   b. Dully filled Claim form
   c. Copy of Hospital summary/Discharge card/treatment advise / medical reference
   d. Copy of Medical reports/records
   e. Copy of Investigation reports
   f. Medical Practitioner's certificate
   g. Any other relevant document as requested by the Insurer.
   h. On receipt of claim documents from Insured

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

e. **Co-payment**

   Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

This co-payment can be waived of by paying an additional premium (optional).

f. **Services Offered by TPA**

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

i. Claim settlement and claim rejection.

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

g. **Payment of Claim**

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

I. SECTION 41 OF INSURANCE ACT 1938 (PROHIBITION OF REBATES)

i. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of 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.

ii. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees

IRDAI Regulation no 5- This Policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation Disclaimer: the above is descriptive only. The actual terms and conditions can be found in the policy document. Insured's are advised to read the policy document completely for a full description of the terms and conditions of coverage and the exclusions relating thereto.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

DISCLAIMER

The above is descriptive only. The actual terms and conditions can be found in the policy document. Prospects are advised to read the policy document completely for a full description of the terms and conditions of coverage and the exclusions relating thereto before conclude the sale.

IRDAI Reg No. 144

Annexure I- Benefit Illustration in respect of individual and family floater basis

Age of the member insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after Discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
35	43979	5,00,000	Not Applicable				Not Applicable			
Total Premium for a Insured Member aged 35 years is Rs.43979/-			Not Applicable				Not Applicable			

Note: Premium rates specified in the above illustration are standard premium rates excluding taxes for moderate risk without considering any loading.