SURAKSHA AUR BHAROSA DONO

Super Health Insurance

POLICY WORDING

PREAMBLE

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

A. DEFINITIONS

1.1 Standard Definitions

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

1. **Accident** means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.
2. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken.
3. **AYUSH Hospital** means an AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

   iii. Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;

   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

   i. Having qualified AYUSH Medical Practitioner in charge round the clock;

   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.
6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
7. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.

   a) Internal Congenital Anomaly which is not in the visible and accessible parts of the body.

   b) External Congenital Anomaly which is in the visible and accessible parts of the body

8. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
10. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under:

    i) has qualified nursing staff under its employment.

    ii) has qualified medical practitioner/s in charge;

    iii) has fully equipped operation theatre of its own where surgical procedures are carried out

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

11. **Day Care Treatment** means medical treatment, and/or surgical procedure which is

    i. Undertaken under General or Local Anesthesia in a hospital / day care center in less than 24 hrs because of technological advancement, and

    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

12. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital cash policies, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the sum insured.
13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and surgery.
14. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

15. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.
16. **Emergency Care** means management for an Illness which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
17. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.
18. **Hospital** means any institution established for In-patient Care and Day Care Treatment of diseases, injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:
    a) has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
    b) has qualified nursing staff under its employment round the clock,
    c) has qualified Medical Practitioner(s) in charge round the clock,
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out,
    e) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
19. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
20. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible, and evident means which is verified and certified by a Medical Practitioner.
21. **Illness/ Illnesses** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, Illness that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    2. it needs ongoing or long-term control or relief of symptoms
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4. it continues indefinitely
    5. it recurs or is likely to recur
22. **In-patient Care** means treatment for which the Insured Person must stay in a Hospital for minimum 24 hours or more than 24 hours for a covered event.
23. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
24. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
25. **Maternity Expenses** means
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
27. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
28. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.
29. **Medical Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:
    i. is required for the medical management of the illness or injury suffered by the Insured Person.
    ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.
    iii. must have been prescribed by a medical practitioner.
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
30. **Migration** means the right accorded to health insurance policyholders (including all members under Family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
31. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.
32. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the Network.

33. **New Borne Baby** means baby born during the Policy Period and is aged upto 90 days.

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

35. **OPD Treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

36. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:

    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

38. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:

    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

39. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

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

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

42. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

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

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

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

1.2 Specific Definitions

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

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

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

Def. 3. **Aggregate Deductible** means a cost-sharing requirement that provides that the Company will not be liable for a specified amount of the covered expenses in respect of all admissible claims made under the Policy in aggregate, and which will apply before any benefits are payable by the Company. The Aggregate Deductible does not reduce the Sum Insured.

Def. 4. **Ambulance** means a motor vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

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

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

Def. 7. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year, which shall be applied depending on the year in which a claim is due.

Def. 8. **Base Sum Insured** means the pre-defined limit specified in the Policy Schedule.

Def. 9. **Break in Policy** means the period of gap that occurs at the end of the existing Policy Period, when the premium due for renewal of the Policy is not paid on or before the premium renewal date specified in the Policy Schedule or within the subsequent Grace Period.

Def. 10. **Biological Attack** or **Weapons** means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 11. **Chemical attack** or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 12. **Commencement Date** means the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule.

Def. 13. **Dependents** means only the family members listed

below:

a) Your legally married spouse as long as continues to be married to You

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

c) Your natural parents or parents that have legally adopted You,

d) Your parent-in-law as long as Your Spouse continues to be married to You

Def. 14. **Family Floater** Members means any one or more of the following family members of the Insured Person:

i. Legally wedded spouse.

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

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

Def. 15. **HIV** means Human Immunodeficiency Virus

Def 16. **Home** means the Insured Person's place of permanent residence as specified in the Policy Schedule.

Def. 17. **Insured Person/You/Your** means persons named in the Policy Schedule who are insured under the Policy and are resident of India in respect of whom the applicable premium has been received.

Def. 18. **Life-threatening situation** shall mean a serious medical condition or symptom resulting from Injury or Illness which is not Pre-Existing Disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

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

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

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

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

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

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

The WHO definition is:

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

Def. 24. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.

Def. 25. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

Def. 26. **Policyholder means** person who has proposed the Policy and in whose name the Policy is issued.

Def. 27. **Policy Schedule** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 28. **Policy Year** means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Policy Schedule.

Def. 29. **Annual Health Check-up** means a package of the medical test(s) undertaken for a general assessment of health status, excluding any diagnostic or investigative medical tests for evaluation of Illness or a disease.

Def. 30. **E-Opinion** means a procedure whereby upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history. Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

Def. 31. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub- limit as applicable under the Policy is specified in the Policy Schedule against the relevant Cover in force under the Policy.

Def. 32. **Sum Insured** means the aggregate limit of indemnity consisting of the base sum Insured, Enhanced Cumulative Bonus/Loyalty Credit, ReInsure Benefit/Enhanced ReInsure Benefit, Health Multiplier, which represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

Def. 33. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

Def 34. **We/Our/Us/Company** means the SBI General Insurance Company Limited

B. SCOPE OF COVER

We will pay under below listed Covers On Medically Necessary Treatment of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured as specified in the Policy Schedule. Subject to otherwise terms and conditions of the Policy.

BENEFITS UNDER THE POLICY

The benefits available under this Policy are described below:

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

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

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

d. All claims paid under any benefit except for those admitted under Section C.2 (Shared accommodation Cash Benefit), Section C.16 (Recovery Benefit) and Section C.19 (Annual Health Check-up) shall reduce the Sum Insured for the Policy Year in which the Insured Event in relation to which the claim is made has been occurred, unless otherwise specified in the respective section. Thereafter only the balance Sum Insured after payment of claim amounts admitted shall be available for future claims arising in that Policy Year.

C. HOSPITALIZATION COVERS

C.1 In-patient Hospitalization Treatment

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

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

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

c) Nursing Expenses as provided by the Hospital

d) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees

e) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances

f) Consultation fees including Telemedicine by Medical Practitioner

g) Medicines, drugs, and consumables

h) Diagnostic procedures

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

Conditions

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

ii. If You are admitted in an ICU category those specified in the Policy Schedule of this Policy, then proportionate deductions shall not be applicable on the total Associated Medical Expenses in the proportion of the ICU Charges.

iii. In case of admission to a room at rates exceeding the limits as mentioned under 1.a and 1.b of Policy Schedule, the reimbursement of all other Associated Medical Expenses incurred at the Hospital, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of room rent charges.

iv. Proportionate deductions shall not apply in respect of the Hospitals which do not follow differential billings or for those expenses in respect of which differential billing is not adopted based on the room category.

v. Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.2 Shared accommodation Cash Benefit

The Company shall pay a daily cash amount as specified in Policy Schedule on per hospitalization basis for each continuous and completed 24 hours of Hospitalization during the Policy Year if the Insured Person is Hospitalised in shared accommodation in a Network Provider Hospital and such Hospitalization exceeds 48 consecutive hours.

What is not covered:

a. The Cover is not available for the time spent by the Insured Person in an Intensive Care Unit (ICU).

b. The claim for the same Hospitalization is not admissible under clause a) of Section C.1 (Inpatient Hospitalization Treatment).

C.3 Health Multiplier (Listed 37 Serious Illness)

If You are diagnosed and hospitalized for any of the Serious illness (listed and defined below) and claim is admissible under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.14 (Modern Treatments) or Section C.15 (AYUSH Treatments) then the Base Sum Insured for such serious Illness would be enhanced by a multiplier as mentioned in the Policy Schedule, provided that;

Condition:

a. Such enhancement in Sum Insured would be triggered only for treatment of the listed conditions, no other claim would be covered under the enhanced limit.

b. The enhanced limit provided under this benefit can only be utilized for the listed 37 Serious Illnesses and can be availed by any or all Insured Person(s) in the Policy.

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

i. Base Sum Insured followed by;

ii. Health Multiplier (if applicable) followed by;

iii. Enhanced Cumulative Bonus/Loyalty Credit (if any) followed by;

iv. ReInsure benefit

d. The enhancement of limit will happen only once in policy year even if multiple listed Serious Illnesses are diagnosed.

e. The enhanced Limit cannot be carried forward to next renewal.

List of Serious Illness			
S. No	Serious Illness	S. No	Serious Illness
1	Cancer	23	Open Chest Coronary Artery Bypass Grafting (CABG)
2	Kidney failure		
3	Multiple sclerosis with persisting symptoms	24	Pericardectomy
		25	Surgery to Place Ventricular Assist devices or Total Artificial Hearts
4	Benign brain tumor		
5	Parkinson's Disease		
6	Alzheimer's Disease	26	Myocardial Infarction
7	End stage liver failure	27	Implantation of Pacemaker of Heart
8	Motor neuron disease		
9	End stage lung failure	28	Implantable Cardioverter Defibrillator
10	Bacterial Meningitis		
11	Aplastic Anaemia	29	Stroke
12	Pulmonary Thromboembolism	30	Permanent paralysis of limbs
		31	Burns
13	Primary (idiopathic) pulmonary hypertension	32	Blindness
		33	Abdominal Aortic Aneurysm
14	Infective Endocarditis	34	Fulminant Viral Hepatitis
15	Major organ / bone marrow transplant	35	Severe Rheumatoid Arthritis
		36	Systematic Lupus Erythematous
16	Replacement / Repair of heart valves		
		37	Nephrotic syndrome
17	Aortic Dissection		
18	Cardiomyopathy		
19	Surgery for Cardiac Arrhythmia		
20	Angioplasty		
21	Balloon Valvotomy/ Valvuloplasty		
22	Carotid Artery surgery		

Serious Illness Definition (applicable to Health Multiplier)

1. Cancer

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

The following are excluded:

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

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

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

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

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

f. Chronic lymphocytic leukemia less than RAI stage 3

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

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

2. Kidney failure

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted, or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

3. Multiple sclerosis with persisting symptoms

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

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

b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

4. Benign brain tumor

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

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

5. Parkinson's Disease

The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication; and

b. Objective signs of progressive impairment; and

c. There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following five (6) "Activities of Daily Living" for a continuous period of at least 6 months

The Activities of Daily Living are:

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

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

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

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

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

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

Drug-induced or toxic causes of Parkinsonism are excluded.

6. Alzheimer's Disease

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

Activities of Daily Living are defined as:

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

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

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

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

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

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

The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Non-organic disease such as neurosis and psychiatric illnesses; and
- Alcohol-related brain damage.

7. End stage liver failure

I. End stage Liver Failure resulting in cirrhosis and irreversible failure of liver function that is evidenced by the following criteria and certified by Gastroenterologist:

a. Permanent jaundice

b. Uncontrollable Ascites

c. Hepatic encephalopathy

d. Oesophageal or Gastric Varices and portal hypertension

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

8.Motor neuron disease

Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico-spinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.

9. End stage lung failure

End stage Respiratory failure including Chronic Interstitial Lung disease. Following criteria must be met:

a. Requiring permanent oxygen therapy as a result of a consistent FEVI test value of less than one litre (Forced Expiratory Volume during the first second of forced exhalation)

b. Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less

c. This diagnosis must be confirmed by the chest/ Respiratory physician.

10. Bacterial Meningitis

I.Bacterial infection resulting in inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This diagnosis must be confirmed by:

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

b. A consultant neurologist.

11. Aplastic Anaemia

Chronic Irreversible persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least TWO of the following:

- Regular blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a Haematologist acceptable to the Company using relevant laboratory investigations, including bone marrow biopsy. Two out of the following three values should be present:

- Absolute neutrophil count of 500/ mm^3 per cubic millimetre or less;
- Absolute erythrocyte Reticulocyte count of 20,000/ mm^3 per cubic millimetre or less; and
- Platelet count of 20,000/ mm^3 per cubic millimetre or less.

Temporary or reversible aplastic anaemia is excluded.

12. Pulmonary Thromboembolism

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The pulmonary embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of lungs), angiography or electrocardiography, with evidence of right ventricular dysfunction and confirmation with D Dimer assay findings, and requiring medical or surgical treatment on an in-patient basis.

13.Primary (idiopathic) pulmonary hypertension

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

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

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

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

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

14. Infective Endocarditis

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

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

b. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of 20% or more) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) directly attributable to infective endocarditis and the severity of valvular disease/ risk factors and

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

15. Major organ /bone marrow transplant

I. The actual undergoing of a transplant of:

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

b. Human bone marrow using haematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of Langerhans are transplanted

16. Replacement / Repair of heart valves

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).

II. 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.

III. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty.

17. Aortic Dissection

The actual undergoing of surgery for aortic dissection, needing excision and surgical replacement of the diseased part of the aorta with a graft.

a. The term "aorta" means the thoracic and abdominal aorta but not its branches.

b. A cardiologist must confirm the diagnosis and realization of surgery.

c. Surgery performed using only minimally invasive or intra-arterial techniques are also covered.

18. Cardiomyopathy

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

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

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

19. Surgery for Cardiac Arrhythmia

I. Ablative procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electrophysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).

II. Pre-procedural evaluation prior to ablation procedures as below should be completely documented:

a. Strips from ambulatory Holter monitoring in documenting the arrhythmia.

b. Electrocardiographic and electrophysiologic recording cardiac mapping and localization of the arrhythmia during the ablative procedure.

20. Angioplasty

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

21. Balloon Valvotomy/ Valvuloplasty

I. The actual undergoing of Valvutomy and Valvuloplasty necessitated by the damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter-based techniques.

II. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or electrocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.

22. Carotid Artery surgery

I. The actual undergoing of the surgery to the Carotid Artery to treat Carotid artery stenosis of 50% and above, as proven by angiographic evidence, of one (1) or more carotid arteries.

II. Both of the following criteria must be met:

a. Either:

i. Actual undergoing of endarterectomy to alleviate the symptoms or,

ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms and

b. The diagnosis and medical necessity of the treatment must be confirmed by a cardiothoracic surgeon.

23. Open Chest Coronary Artery Bypass Grafting (CABG)

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by CABG. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

Any key hole or Laser surgery

24. Pericardiectomy

I. The undergoing of the pericardiectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consulting cardiologist. Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration are excluded.

II. The actual undergoing of pericardiectomy secondary to chronic constructive pericarditis.

III. The following are specifically excluded:

a. Acute pericarditis due to any reason

25. Surgery to Place Ventricular Assist devices or Total Artificial Hearts

I. This is an open chest procedure for implantation of Left ventricular Assist Device / Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use of the Refractory Heart Failure with reduced ejection fraction as defined below:

NYHA class IV symptoms who failed to respond to optimal medical management for >=45 fo the past 60 days, or have been intra-aortic balloon pump dependent for 7 days or IV inotrope dependent for 14 days.

II. The following are excluded:

a. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse.

26. Myocardial Infarction

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

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

b. New characteristic electrocardiogram changes

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

II. The following are excluded:

a. Non- ST- segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;

b. Any type of angina pectoris

c. Other acute Coronary Syndromes

27. Implantation of Pacemaker of Heart

I. Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field.

II. Following will be excluded:

a. Cardiac arrest secondary to alcohol, substance abuse or drug abuse.

28. Implantable Cardioverter Defibrillator

I. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness. Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter- Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

II. The insertion of permanent Cardioverter- Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

III. Following will be excluded:

a. Cardiac arrest secondary to alcohol, substance or drug abuse

29. 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 has to be produced.

II. 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.

30. Permanent paralysis of limbs

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery. Reconstruction surgeries required to attain best possible mobility will be included.

II. Rehabilitative treatment , prosthesis and supporting aids like

crutches/ vehicle/ home modification will be excluded.

31. Burns

I. Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

II. Burns arising due to self- infliction are excluded.

32. Blindness

I. The Blindness is evidenced by: (Either of the below condition is mandatory and to be treatment advised by certified specialist)

a. corrected visual acuity being 3/60 or less in both eyes or ;

b. the field of vision being less than 10 degrees in better eye with the best possible correction.

II. Treatments required for correction of blindness or improvement in visual acuity will be covered

III. Exclusion:

a. Low vision condition

b. Cost of enucleation related to tumors or other eye defects

c. Cosmetic correction and related prosthesis cost

d. Implantable or external visual implants

e. Cases of blindness with low vision before the inception of the policy

33. Abdominal Aortic Aneurysm

The actual undergoing of surgery for abdominal aortic aneurysm, needing excision and surgical replacement of the diseased part of the aorta with a graft.

a. The term "aorta" means the thoracic and abdominal aorta but not its branches.

b. A cardiologist must confirm the diagnosis and realization of surgery

c. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

34. Fulminant Viral Hepatitis

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

a. rapid decreasing of liver size as confirmed by abdominal ultrasound ; and

b. necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required) ; and

c. rapid deterioration of liver function tests; and

d. deepening jaundice; and

e. hepatic encephalopathy.

II. This excludes:

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

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

35. Severe Rheumatoid Arthritis

The unequivocal diagnosis of Severe Rheumatoid Arthritis with all of the following factors:

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

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

36. Systematic Lupus Erythematous

I. Multi-system, auto immuno disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Serious Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. There must be positive antinuclear antibody test.

II. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

III. Abbreviated ISN/RPS classification of lupus nephritis (2003):

a. Class I - Minimal mesangial lupus nephritis

b. Class II - Mesangial proliferative lupus nephritis

c. Class III - Focal lupus nephritis

d. Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

e. Class V - Membranous lupus nephritis

f. Class VI - Advanced sclerosis lupus nephritis the final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology

37. Nephrotic syndrome

I. Nephrotic syndrome is the onset of heavy proteinuria (>3.0 g/24 h), hypertension, hypercholesterolemia, hypoalbuminemia, edema/anasarca, and microscopic hematuria.

II. A confirmed diagnosis of glomerulonephritis with nephrotic syndrome must be made by an appropriate Medical Practitioner along with relevant reports and should confirm a treatment regimen appropriate to the clinical presentation has been followed throughout the period to which syndrome relates.

III. The syndrome must have continued for a period of at least 6 months from the date of confirmed diagnosis with or without intervening periods of remission.

C.4 Pre-hospitalization Medical Expenses

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

Conditions:

1. The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments)

b. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments).

c. The expenses are incurred after the inception of the First Policy

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

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

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

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

C.5 Post-hospitalization Medical Expenses

We will indemnify on Reimbursement basis only, the Insured Person's post-hospitalization Medical Expenses incurred following an Illness or Injury for duration as specified in the policy schedule

Conditions

1. The above coverage is subject to fulfilment of following conditions: apply in excess of this other policy and will not contribute with this other insurance.

a. We have accepted a claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments) ā

b. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments).

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

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

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

2. We shall not be liable to pay any Post-hospitalization Medical Expenses for more than the number of days specified in the Policy Schedule/Certificate of Insurance immediately following the Insured Person's discharge from Hospital under Inpatient Hospitalization Treatment or Day Care Treatment or AYUSH Treatments or Modern Treatments.

C.6 Day Care Treatment

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

Conditions -

The above coverage is subject to fulfilment of following conditions:

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

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

c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.4 and C.5.

What is not covered:

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

C.7 Domiciliary Hospitalization

We will indemnify on Reimbursement basis only, the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury.

Conditions

The above coverage is subject to fulfilment of following conditions:

a. The Domiciliary Hospitalization continues for at least 3 consecutive days, wherein We will make payment under this benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;

b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.

What is not covered:

Sections C.4 (Pre-hospitalization Medical Expenses) and Section C.5 (Post- hospitalization Medical Expenses) are not payable under this benefit.

C.8 Home Health Care

The Company shall indemnify the Medical Expenses incurred by the Insured Person on availing treatment at Home during the Policy Year, if prescribed in writing by the treating Medical Practitioner, provided that: a. The treatment in normal course would require In-patient Care at a Hospital, and be admissible under Section C.1 (Inpatient Hospitalization Treatment).

b. The treatment is pre-authorized by the Company as per procedure given under Section G. C.

c. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.

This Cover is not available on reimbursement basis.

C.9 Emergency Road Ambulance Cover (per hospitalization)

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

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

ii. or from one Hospital to another Hospital

iii. or from Hospital to Home

Provided that claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments) is admissible under the Policy

Insured Person shall not bear specified percentage of admissible

Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.10 Air Ambulance Cover (Domestic)

The Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to the nearest Hospital. The claim is subject to a maximum of Sum Insured as specified in the Policy Schedule against this Cover, and subject to the following conditions:

a. The air Ambulance transportation is advised in writing by a Medical Practitioner.
b. Medically Necessary Treatment is not available at the location where the Insured Person is situated at the time of emergency.
c. The air Ambulance provider is a registered entity in India.
d. The Insured Person is in India and the treatment is taken in India only.
e. No return transportation to the Insured Person's Home or elsewhere by the air Ambulance will be covered under this Cover.
f. A claim for the same Hospitalization is admissible under Section C.1(Hospitalization Expenses)

C.11 Organ Donor Expenses

We will pay Medical Expenses up to the Sum Insured as specified in the Policy Schedule, towards organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, provided that

Condition

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and
ii. We have accepted an inpatient Hospitalization claim for the Insured Person under In-Patient Hospitalization Treatment (section C.1).
iii. The Organ Donor's Pre-Hospitalization and Post-Hospitalization expenses are excluded under the Policy
iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.12 ReInsure Benefit (Related and Unrelated Illness both) This benefit is triggered and becomes payable for each and every claim from the first claim itself in a policy year.

Conditions

The above coverage is subject to fulfilment of the following:

a. Single claim under this benefit will be payable up to 100%/200% of Base Sum Insured as specified in the Policy Schedule.
b. The sequence of utilization of Sum Insured will be as below:
   i. Base Sum Insured followed by;
   ii. Health Multiplier (if applicable) followed by;
   iii. Enhanced Cumulative Bonus (if any) followed by;
   iv. ReInsure benefit
c. Claims under this benefit will be payable only under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments) arising in that Policy Year for any or all Insured Person(s).
d. Any one Illness clause will not be applicable under this benefit.

C.13 Bariatric Surgery Cover

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

Eligibility:

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

Body Mass Index (BMI);

a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea
   iv. Uncontrolled Type 2 Diabetes

Conditions

v. Our maximum liability will be restricted to up to Sublimit mentioned in the Policy Schedule.
vi. Bariatric surgery performed for Cosmetic reasons is excluded.
vii. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured shall obtain prior approval for cashless treatment from the Company.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.14 Modern Treatments/Advanced Procedures

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Sections C.1 and C.6 respectively, in a Hospital:
   a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
   b. Balloon Sinuplasty
   c. Deep Brain stimulation
   d. Oral chemotherapy
   e. Immunotherapy- Monoclonal Antibody to be given as injection
   f. Intra vitreal injections
   g. Robotic surgeries
   h. Stereotactic radio surgeries
   i. Bronchical Thermoplasty
   j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   k. IONM - (Intra Operative Neuro Monitoring)
   l. Stem cell therapy: Hematopoietic stem cells for bone marrow

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.4 and C.5

C.15 AYUSH Treatment

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

C.16 Recovery Benefit

We will pay a lump sum amount as specified in the Policy Schedule upon Your Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, provided that, claim is admissible under Section C.1 (Inpatient Hospitalization Treatment) or Section C.6 (Day Care Treatment) or Section C.15 (AYUSH Treatments) or Section C.14 (Modern Treatments)

I. This Benefit is over and above base Sum Insured

ii. This Benefit amount will not reduce the Sum Insured

iii. This is available per Hospitalization of each Insured Person

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.17 Claims Shield

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

C.18 E-Opinion

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

Condition:

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. You may have 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 You are 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 of this benefit shall be requested through Our Website/App or through calling Our call center on the toll-free number specified in the Policy Schedule.

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

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.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

C.19 Annual Health Check-up

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

Conditions

The above coverage is subject to fulfilment of following conditions:

a. 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

b. The list of tests covered under this benefit will be Complete blood count, 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.

c. For Family Floater, this cover will be applicable only to adult members of the Family who are aged 18 years and above on the start date of Policy. For Individual, this cover will be applicable to each Insured Person who are aged above 18 years.

d. Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Enhanced Cumulative Bonus (C.22)/Loyalty Credit (C.23).

What is not covered:

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

C.20 Maternity and Related Expenses Cover

C.20.1 Maternity Expenses (including Pre and Post Natal check-ups)

We will indemnify the Medical Expenses incurred up to the amount specified against this Benefit in the Policy Schedule for the Maternity Expenses including Pre-natal Medical Expenses & Post-natal check-ups incurred in respect of the Hospitalization of the Insured Person for the delivery of the child during the Policy Period.

Conditions:

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

b. If the Insured person is covered as a single Adult on an individual basis under the policy, the company shall be liable to pay the claim under this benefit, after a waiting period of 48 months from the date of issuance of the first policy with Us, provided that the policy has been renewed continuously with us without any break and We have received at least 5 continuous annual premiums under the Policy.

c. For any other family combination under the policy, the company shall be liable to pay the claim under this benefit, after a waiting period of 24 months from the date of issuance of the first policy with Us, provided that the policy has been renewed continuously with us without any break and We have received at least 3 continuous annual premiums under the Policy.

d. Fresh waiting period as mentioned above under (b) and (c) would apply for all the policies which are issued with continuity under portability guidelines either from our existing Health Product or

any other Non-Health or Standalone Health Insurance Company

e. The insured person for whom the claim has been made under (b) & (c) above has to be the female insured covered under the policy and respective waiting periods [as mentioned above under (b) and ©] shall apply.

f. Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit.

g. For this purpose, 'week' shall constitute any consecutive 7 days.

h. Medical Expenses for ectopic pregnancy are not covered under this Benefit.

I. Pre-natal check-ups will be covered from the date of confirmation of pregnancy and Post-natal check-ups for a period up to eight (8) weeks from delivery.

C.20.2 New Born Baby Cover

The Company will indemnify up to the amount specified against this Benefit in the Policy Schedule for the Medical Expenses incurred in respect of a New Born Baby whose claim under Section - C.20.1 (Maternity Expenses) is admissible by the Company.

a. The coverage will be available in respect of a New Born Baby for 90 days from date of delivery and will be covered under Maternity Expenses Sum Insured as specified in the Policy Schedule.

b. 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.

Exclusion F.A.XV of the Policy Terms & Conditions shall be not applicable to Section C.20

C.21 Child Vaccination Cover

We will reimburse the expenses up to the limit specified in the Policy Schedule during the Policy Period on vaccination of the Child till he/she completes 12 year of Age.

Conditions:

a. Child has to be an Insured under the Policy.

b. Coverage of the New Born Baby on birth shall be subject to the addition of the New Born Baby older than 90 days and less than 1 year as an Insured Person under the Policy by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.

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

C.22 Enhanced Cumulative Bonus

Enhanced Cumulative Bonus (ECB) will be applied/ by /50% of the Base Sum Insured of immediate preceding Policy Year in respect of each claim free Policy Year (where no claims are reported), provided the Policy is renewed with the Company without a break, subject to maximum cap of 100%/200% (as specified in the Policy Schedule) of the Base Sum Insured under the current Policy Year. If a claim is made in any particular Policy Year, the ECB accrued shall be reduced at the same rate at which it has accrued.

Conditions:

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

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

c. ECB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

d. 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 ECB 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 ECB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.

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

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

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

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

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

C.23 Loyalty Credit (Sum Insured enhancement irrespective of claim)

If the Insured Person's cover under the Policy is renewed with Us without a break We will increase the Base Sum Insured applicable under the Policy by 50% of Base Sum Insured of immediate preceding Policy Year for each successive renewal. The Sum Insured increase will be subject to the maximum of 100% of Base Sum Insured.

Condition:

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:

a. In case where the policy is on individual basis as specified in the policy schedule, the loyalty credit shall be added and will be available individually to the insured person.

b. In case where the policy is on floater basis, the loyalty credit shall be added and available to the family on floater basis.

c. Loyalty credit shall be available only if the policy is renewed/ premium paid within the grace period.

d. 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 loyalty credit 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 loyalty credit to be carried forward for credit in such renewed policy shall be the lowest one that is applicable among all the insured persons.

e. 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 30years, the loyalty credit of the expiring policy shall be apportioned to such renewed policies in the proportion of the sum insured of each renewed policy

f. If the sum insured has been reduced at the time of renewal, the applicable loyalty credit shall be reduced in the same proportion to the sum insured in current policy.

g. If the sum insured under the policy has been increased at the time of renewal, the loyalty credit shall be calculated on the sum insured of the last completed policy year.

h. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the sum insured.

C.24 Medical Treatment abroad (Listed Major illness, Diagnosis in India)

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

Listed Illness/Procedures and Definitions:

S. No	Name of Major 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 moreheart valves, as a consequence of defects in, abnormalities of, or disease affectedcardiac 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 valvotom / valvuloplasty are excluded.
3	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).
4	Pulmonary Artery Graft Surgery	We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
5	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
6	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. The following are excluded: Angioplasty and/or any other intra-arterial procedures.
7	Surgical Treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II. We will be covering surgical treatment of Stroke limited to: a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy; b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke. III. The following are excluded: a. Transient ischemic attacks (TIA); b. Traumatic injury of the brain; c. Vascular disease affecting only the eye or optic nerve or vestibular
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

		I. We will be covering Lung Transplant
9	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases: I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
10	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to: a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a. no response to external stimuli continuously for at least 96 hours; b. life support measures are necessary to sustain life; and c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. d. The condition has to be confirmed by a specialist medical practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.
11	Surgery for 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.

Conditions:

1) The above listed Illness must be diagnosed in India.
2) The symptoms of the listed Illness first occur or manifest itself during the Policy Period and after completion of the applicable waiting periods as specified in the Policy Schedule.
3) Expenses can be claimed under this Section on a Reimbursement basis only.
4) For availing treatment abroad, it should be a 'Planned Medical treatment abroad'.
5) The treating medical Practitioner must recommend the necessity of treatment abroad, considering the medical condition and availability of treatment at an international centre of excellence which is best in class.
6) The Hospitalization is towards Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.
7) 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.
8) Claim amount will be paid in INR in Indian account of the Insured.
9) The onus of procuring all the medical documents/requirements to adjudicate any claim will be on the Insured Person.
10) Section C.3 (Health Multiplier) and Section C.12 {ReInsure Benefit (Related and Unrelated illness both)} will not be applicable if claim is admissible under Section C.24 (Medical Treatment abroad).

C.25 Out Patient (OPD) Cover (Including Diagnostics and Pharmacy Expenses)

We will indemnify the Medical Expenses incurred up to the per member amount specified (subject to per family limit) against this Benefit in the Policy Schedule for the allopathic OPD expenses including Diagnostics and Pharmacy.

What all is covered under this:

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

Conditions:

a. 20% co-payment will be applicable on Professional Fees
b. 30% co-payment will be applicable on Diagnostics and Pharmacy Expenses to be borne by the Insured
c. The cover excludes expenses incurred towards Spectacles, Contact Lenses, Physiotherapy, Cosmetic Procedures, Ambulatory Devices like Walkers, any type of Dental treatment,

BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

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

C.26 Out Patient (OPD) - Dental and Vision Cover

We will indemnify the Medical Expenses incurred up to the limit specified against this Benefit (if applicable) in the Policy Schedule for the OPD- Dental and Vision Cover.

Conditions:

a. Out-patient dental treatment is covered for, limited to below:

For the immediate relief of dental pain; taken by you from a dentist, provided that We will pay only for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents.

b. The cover excludes for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer and Replacing any dental appliance which is lost or stolen.

c. Diagnostics and Pharmacy Expenses are not covered

d. 50% co-payment will be applicable for each and every admissible claim under this benefit.

e. The cover excludes expenses incurred towards Spectacles, cost of frame, any type of lenses like Contact Lenses, etc. and Sunglasses.

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

C.27 Out Patient and Prescribed Diagnostic test (Cancer Diagnosed Patients)

We will indemnify the Medical Expenses incurred up to the limit specified against this Benefit (if applicable) in the Policy Schedule for the Out Patient and Prescribed Diagnostic test.

a. Insured must be a Cancer diagnosed patient. This diagnosis must be evidenced by histological evidence of malignancy and confirmed by a pathologist

b. The cover will not cover for any type of Pharmacy/Treatment either prescribed or OTC.

c. Out-patient consultation to be taken only by a registered and qualified specialist Medical Practitioner.

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

D. OPTIONAL COVERS

D.1 Enhanced ReInsure Benefit

On availing this option, We will refill up to 200% Basic Sum Insured instead of up to 100% (as mentioned in Section C.12 - **ReInsure Benefit**) on complete or partial utilization of Your existing Policy Sum Insured including Enhanced Cumulative Bonus (if applicable) during the Policy Year. The total amount (Basic Sum Insured and Enhanced Cumulative Bonus and Enhanced ReInsure) will be available to all Insured Person for all claims under Section C.1 during the current Policy Year.

Rest all terms and conditions remain same as that of Section C.12 - **ReInsure Benefit**.

D.2 Enhanced Cumulative Bonus Safeguard (if claim amount is 1Lac or less, No reduction in Enhanced Cumulative Bonus)

On availing of this option, We will protect the percentage of Enhanced Cumulative Bonus (Section C.20) as specified in the Policy Schedule at subsequent renewal.

Provided that,

a. Claim amount shall not be exceeding 100,000 in expiring Policy.

b. You are eligible to avail this option only at inception of the Policy.

D.3 Co-payment

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

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

D.4 Aggregate Deductible

On availing this option, The Insured Person shall bear on his/her own account an amount equal to the opted deductible specified in the Policy Schedule for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year. The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted.

Conditions:

a. This Cover can be opted only at inception of the Policy or during subsequent Renewals.

b. Once the Aggregate Deductible option is opted by the Insured Person, it cannot be opted out or reduced at any time during the Policy Year or at subsequent Renewals. Deductible however can be increased at the time of Renewal.

c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted before the Company pays for claims of any Family Member covered under the Policy.

d. Deductible under this section shall not apply to any claim under Section C.2 (Shared Accommodation Cash Benefit), C.9 (Emergency Road Ambulance Cover), C.13(Bariatric Surgery Cover),C.10(Air Ambulance Cover (Domestic), C.18 (E-Opinion), C.19(Annual Health Check-up), C.16(Recovery Benefit).

e. A Deductible does not reduce the Sum Insured.

D.5 Domestic Help/Staff Indemnity

On availing of this option, We will indemnify the Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person i.e. Domestic help in this case, during the Policy Period for an Illness, Injury or condition as mentioned in the Policy Schedule and described in the Section C.1(Inpatient Hospitalization Treatment), Section C.6(Day Care Treatment), Section C.15(AYUSH), Section C.14(Modern Treatments/Advanced Procedures), Section C.9(Emergency Road Ambulance Cover) and Section C.13(Bariatric Surgery Cover) of the base policy and contracted or sustained during the Policy Period

Conditions:

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

b. The Sum Insured under this cover is independent of the Sum

Insured of the base policy.

c. This will be an individual coverage.

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

e. The terms and conditions will remain the same as that of covered sections under this optional cover as described in the Section C.1(Inpatient Hospitalization Treatment), Section C.6(Day Care Treatment), Section C.15(AYUSH), Section C.14(Modern Treatments/Advanced Procedures), Section C.9(Emergency Road Ambulance Cover) and Section C.13(Bariatric Surgery Cover).

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

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

D.6 Additional Basic Sum Insured for Accident related hospitalization

On availing this option, We will provide an additional 2 times of base Sum Insured towards Medical Expenses incurred for In- Patient Hospitalization Treatment as given in Section C.1, as specified in the Policy Schedule. This cover applicable only an Emergency caused solely and directly due to an Accident-causing Injury, of the Insured Person who is Hospitalized for the treatment of such Injury.

Conditions:

a. This Benefit shall be utilized only after base Sum Insured has been completely exhausted.

b. This benefit shall be available only once during the Policy Year.

c. This benefit shall be available only for such Insured Person for whom Accidental Hospitalization claim is accepted under this Policy.

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

   a. Base Sum Insured followed by;

   b. Enhanced Cumulative Bonus/Loyalty Credit (if any) followed by;

   c. Additional Basic Sum Insured for Accident related hospitalization followed by;

   d. ReInsure benefit

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.3 is opted and specified in the Policy Schedule.

D.7 Wellness Benefit

On availing this option, The Insured Person may avail wellness services as mentioned in the Policy Schedule. The services may include any or all as specified in the policy schedule:

Services	Utilization Parameter (if applicable as per Policy Schedule)
D.7.1 Health Assistance (A.I. Personal Fitness coaching)	Unlimited
D.7.2 Dietician and Nutrition E-consultation	Unlimited
D.7.3 Unlimited Gym Membership	**Option 1** - Eligible Customer must utilise Gym Services at least once in the first 6 months (from policy start date) to activate the next 6 months. Once suspended, cannot be activated thereafter. **Option 2** - Eligible Customer must utilise Gym Services at least once every quarter (3mth periods from policy start date) to activate the next quarter. Once suspended, cannot be activated thereafter.
D.7.4 Walk Healthy Benefit	Collect health benefits by taking steps counted on our App or Activity tracker of the vendor and get discount up to 30% on renewal premium.

Condition:

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

b. The above-mentioned optional covers (D.7.1 to D.7.4) can only be opted at inception of the policy and cannot be opted at subsequent renewals.

c. This cover will be available on optional basis. D 7.1 [Health Assistance (A.I. Personal Fitness coaching)], D7.2[Dietician and Nutrition E-consultation],D7.3 [Unlimited Gym Membership] can be availed only as a combination with or without D 7.4[Walk Healthy Benefit] and D 7.4 [Walk Healthy Benefit] can be given on standalone optional basis also.

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

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

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

D.7.4.1 Conditions Applicable to Walk Healthy Benefit

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

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

a. Steps taken by the Insured Person, who is covered as an Adult under the policy, everyday are recorded. Steps counted by the mobile App We provide you to use ONLY would be considered.

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

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

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

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

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

Policy duration	End of 9 months	Steps at the end of 9 months (A) This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st Jan 2023 NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater			
					Individual sum insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2022	1500000			0%	0%	0%	0%
		1500001-2250000			5%	2.50%	1.65%	1.25%
		2251000 – 3000000			15%	7.50%	5.0%	3.75%
		2251000 – 3000000			15%	7.50%	5.0%	3.75%
		3000001 – 3750000			20%	10%	6.65%	5.00%
		>=3751000			30%	15%	10.0%	7.50%

Policy duration	End of 21 months	Steps at the end of 21 months (A).This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st Jan 2024 NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater			
					Individual sum insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2023	3000000			0%	0%	0%	0%
		3000001 – 4500000			5%	2.50%	1.65%	1.25%
		4500001 – 6000000			15%	7.50%	5.0%	3.75%
		6000001 – 7500000			20%	10%	6.65%	3.75%
		>=7501000			30%	15%	10.0%	7.50%

Policy duration	End of 33 months	Steps at the end of 33 months (A).This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium (Renewal policy start date 1st Jan 2025 NOTE: Discount applicable on the member's premium in Individual sum insured policies and on the Policy premium in case of Floater			
					Individual sum insured policy and Floater policies with - 1 Adult	Floater policies with 2 Adult	Floater policies with 3 Adult	Floater policies with 4 Adult
1st Jan 2022	30th September 2024	Up to 4500000			0%	0%	0%	0%
		4500001 – 6750000			5%	2.50%	1.65%	1.25%
		6751000– 9000000			15%	7.50%	5.0%	3.75%
		9000001 – 11250000			20%	10%	6.65%	5.00%
		>=11251000			30%	15%	10.0%	7.50%

E. WAITING PERIOD

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

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

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

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

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

d) Note: The above waiting period shall not be applicable for claims arising due to Hypertension, Diabetes and Cardiac Condition and for claims under Section C.24 – Medical Treatment abroad. Waiting period specific to these ailments are mentioned in E. IV and V.

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

a) Expenses related to the treatment of listed Conditions; Surgeries/treatments shall be excluded until the expiry of 24/12 months (as specified in the 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 / procedures falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

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

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

I. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. Kidneystone, Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/fistula in anus, Hemorrhoids including
Pilonidal sinus	Gout and rheumatism
Benign tumors, cysts, nodules, polyps including breast lumps	Osteoarthritis and osteoporosis
Polycystic ovarian diseases	Fibroids (fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate
Genetic Disorder	

ii. Surgical Procedures

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

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

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

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

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

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

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

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

VI) Maternity and Related Expenses cover: Single Adult – 48 months and All other Family Combinations – 24 months

F. General Exclusions

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

A. STANDARD EXCLUSIONS

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

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

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

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

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

a) Custodial care either at home or in a nursing facility for personal

care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

III. Obesity / Weight Control (Code- Excl 06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) 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 Apnea
      iv. Uncontrolled Type 2 Diabetes

IV. 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.

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

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

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

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

VII. Breach of Law (Code- Excl 10)

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

VIII. Excluded Providers (Code-Excl 11)

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

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

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

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

XII. Refractive Error (Code-Excl 15)

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

XIII. Unproven Treatments (Code- Excl 16)

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

XIV. Sterility and Infertility (Code-Excl 17)

Expenses related to sterility and infertility. This includes:

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

XV. Maternity (Code-Excl 18) (Not Applicable for Section C.20 – Maternity and Related Expenses Cover)

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

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

B. SPECIFIC EXCLUSIONS

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

II. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
   a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
   b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

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

III. Treatment taken outside India (Not applicable for product plan variants wherein C.24 – Medical Treatment Abroad is covered)

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

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

VI. Vaccination or inoculation except as part of post-bite treatment for animal bite or for Section C.21 for product plan variants wherein Child Vaccination cover is covered.

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

VIII. 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.

IX. 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 specified ICD codes.

X. 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 Organisation (WHO) protocols,

d. Published guidelines by healthcare providers,

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

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

G. CONDITIONS

A. Standard Conditions

I. 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. Multiple Policies (applicable for Indemnity Section only)

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

v. In case of multiple policies which provide fixed benefits, on the occurrences of insured event in accordance with the terms & conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies.

d. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

e. Nomination

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

II. Conditions applicable during the contract

1. Cancellation:

a. Cancellation by you:

The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Refund of Premium (Basis Policy Period) in %			
Month	**Policy Tenure 1 Year**	**Policy Tenure 2 Year**	**Policy Tenure 3 Year**
Up to 1 Month	85.00%	92.50%	95.00%
Up to 3 Month	70.00%	85.00%	90.00%
Up to 6 Month	45.00%	70.00%	80.00%
Up to 12Month	0.00%	45.00%	60.00%
Up to 15 Month	NA	30.00%	50.00%
Up to 18 Month	NA	20.00%	45.00%
Up to 24 Month	NA	0.00%	30.00%
Up to 27 Month	NA	NA	20.00%
Up to 30 Month	NA	NA	12.50%
Up to 36 Month	NA	NA	0.00%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

i. When annual payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable.

ii. For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months into the policy year. For instalment after 6 months, no refund will be payable.

iii. In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by You under this Policy.

b. Cancellation by Us:

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

2. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

I a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

3. Addition of Insured during the policy period

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

Option of Mid-term inclusion of a Person in the Policy as an Insured will be only upon marriage or childbirth (inclusion of child only after completed 90 days and less than 1 year of age), Additional differential premium will be calculated on a pro rata basis. Otherwise child addition can happen only in next renewal or at the start of next policy year in multi-year policies.

4. Withdrawal of the Product-

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

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

5. Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis as mentioned below, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days for Monthly Payment and 30 days for Single premium, Annual premium, Half yearly and Quarterly would be given to pay the instalment premium due for the policy.

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

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" 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 claim, all subsequent premium instalments shall immediately become due and payable.

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

viii. For long term policy if any of the below mentioned option is opted then single payable premium will be divided into opted payment instalments.

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

6. Possibility of Revision of terms of the Policy including the Premium Rates

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

B. Specific Conditions

I. Condition Precedent to the contract

a. Age Limit

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

b. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two Arbitrators **who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended).**

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

c. Currency

The monetary limits applicable to this Policy will be in INR.

d. Change of Sum Insured

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

c. Currency

The monetary limits applicable to this Policy will be in INR.

d. 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.

e. Material Change

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

f. Notice and Communication

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

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

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

g. Premium

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

h. Records to be Maintained

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

i. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. 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.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date

as per the applicable terms and conditions.

j. Territorial Jurisdiction

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

II. Conditions applicable during the contract

a. Alterations in the Policy

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

b. Conditions when a claim arises

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

Procedures	Cashless Hospitalization	Reimbursement Claims
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website.	
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 / Certificate of Insurance 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 discharg 7. Approximate Claim Expenses 8. Treatment Details 9. Claim Form / Pre-Authorization Request form	Not Applicable
	10. Any other relevant information as required 11. cKYC Form and KYC Documents	
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 Procedure for Cashless Claims in case of Home Health Care	Not Applicable On receipt of duly filled pre-authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may: a. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or b. reject the request for pre-authorization specifying reasons for the rejection.	As listed below Not Applicable

• <u>List of Documents for Reimbursement Claims:</u>

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 cKYC Form
6. Beneficiary bank account / NEFT details: Cancelled cheque or copy

of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.

7. Certified copy of Death certificate issued by municipal authority (in case of death of insured)
8. KYC details and Documents

• Claim Document Submission Address

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

Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team

SBI General Insurance Company Limited

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

Pune, Maharashtra – 411 045

• Conditions for obtaining Cashless Facility:

I. Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers and empanelled Service providers are available on Our Website.

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.

• Standard Condition for Claim Process

✦ Claim Settlement

i. The Company shall settle or reject a claim 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 Insured Person 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 Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

✦ Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

✦ Complete Discharge

Any payment to the Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may

be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

✦ Payment of Claim

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

C. Standard Conditions for renewal of the contract

1. Renewal Conditions:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for Renewal. however, We are not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.

iii. Request for renewal along with requisite premium shall be received by Us before the end of the Policy Period

iv. At the end of the policy period the policy shall terminate and can be renewed within the grace period of 15 days/30 days (as per the Premium Payment in Installments - Section G.A.II.5) to maintain continuity of benefits without break in policy. Coverage in not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

2. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast3O 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 will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link- https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

D. Grievances Redressal Procedure

If You may have a grievance that requires to be redressed, You may contact Us with the details of the grievance through:

For Queries / Service request Registration

Call SBI General Insurance on Toll Free - 1800 22 1111 / 1800 102 1111 Monday to Saturday (8 am - 8 pm).

Fax us at 1800 22 7244

Email us at customer.care@sbigeneral.in

Visit us at any of our Branches

We will acknowledge receipt of your concerns & will respond to you within 72 hours.

Level 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

Level 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 Chairman of the Grievance Redressal Committee at : gro@sbigeneral.in. The Committee will look into the appeal and decide the same expeditiously on merits.

Level 3

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

Level 4

If Your issue remains unresolved You may approach IRDAI by calling on the Toll-Free no. 155255 or You can register an online complaint on the website http://igms.irda.gov.in

ANNEXURE I – OMBUDSMAN DETAILS

Office Details	Jurisdiction of Office
Shri Kuldip Singh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL - Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office,	Madhya Pradesh, Chhattisgarh.

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Annexure III - Product Benefit Table

Benefits			Elite	Premier	Platinum	Platinum Infinite
Entry Age (Adult)			Min - 18 years Max - No capping	Min - 18 years Max - No capping	Min - 18 years Max - No capping	Min - 18 years Max - No capping
Entry Age (Child)			91 days to 30 years	91 days to 30 years	91 days to 30 years	91 days to 30 years
Sum Insured (SI)			3 Lacs, 5 Lacs, 7 Lacs, 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs	3 Lacs, 5 Lacs, 7 Lacs, 10 Lacs	10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs, 30 Lacs, 40 Lacs, 50 Lacs	50 Lacs, 75 Lacs 1 Crore and 2 Crores
Base Covers						
Eligibility	**Family Combination**		Up to 4ANC	Up to 4ANC	Up to 4ANC	Up to 4ANC
	Premium Type [Zone Agnostic]		Age Banded	Age Banded	Age Banded	Age Banded
In-patient Hospitalization	**Inpatient Hospitalization Treatment**	**Room Rent**	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
		ICU Charges	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	Shared accommodation Cash Benefit		500 per day, maximum INR 4000	500 per day, maximum INR 4000	500 per day, maximum INR 8000	1000 per day, maximum INR 15000
	Health Multiplier		For SI:3 Lacs to 10 Lacs - 2X of SI For SI:15 Lacs and above - 3X of SI	2X of Base Sum Insured	For SI:10 Lacs – 2X of SI For SI: 15 Lacs and above - 3X of SI	3X of Base Sum Insured
	Pre-hospitalization Medical Expenses (up to Sum Insured)		60 Days	60 Days	60 Days	60 Days
	Post-hospitalization Medical Expenses (up to Sum Insured)		90 Days	90 Days	90 Days	180 Days
	Day Care Treatment (up to Sum Insured)		All day care covered	All day care covered	All day care covered	All day care covered
	Domiciliary Hospitalization		Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	Home Health Care		Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	Emergency Road Ambulance Cover (up to Sum Insured)		INR 3000	INR 4000	INR 5000	Covered up to SI
	Air Ambulance Cover (Domestic)		Up to 2 Lacs	Up to 2 Lacs	Up to 2 Lacs	Up to 10 Lacs
	Organ Donor Expenses		Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	ReInsure Benefit (Related and Unrelated illness both)		Unlimited up to 100%	Unlimited up to 100%	Unlimited up to 100%	Unlimited up to 200%
	Bariatric Surgery Cover		Up to INR 50,000	Up to INR 50,000	Up to INR 2 Lacs	Up to INR 2 Lacs
	Modern Treatments/Advanced Procedures		Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	AYUSH (In-patient hospitalization)		Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured	Actuals up to Sum Insured
	Recovery Benefit		NA	INR 2500	INR 5000	INR 10,000
	Claims Shield		Non-payable Items (paid up to Sum Insured)	Non-payable Items (paid up to Sum Insured)	Non-payable Items (paid up to Sum Insured)	Non-payable Items (paid up to Sum Insured)
Value Added Services	**E-Opinion**		NA	NA	4 - Per Member	Unlimited

	Annual Health Check-up	Up to INR 2500 (1st renewal onwards/year)	Up to INR 2500 (1st renewal onwards/year)	Up to INR 5000 (since inception)	Up to INR 10,000 (since inception)
Maternity	**Maternity Expenses**	NA	Up to INR 25,000 (N)/ INR 50,000(C-sec)	Up to INR 50,000 (N)/ INR 75,000(C-sec)	Up to 2 Lac
	New Born Baby Cover	NA	Up to Maternity SI	Up to Maternity SI	Up to Maternity SI
	Child Vaccination (Up to 12 years of age)	NA	NA	5000 per annum	10,000 per annum
Renewal Benefits	**Enhanced Cumulative Bonus** (reduction is same proportion in case claim is settled)	50% of Base Sum Insured up to 100%	50% of Base Sum Insured up to 100%	50% of Base Sum Insured up to 200%	NA
	Loyalty Credit (SI enhancement irrespective of claim)	NA	NA	NA	50% of Base Sum Insured up to 100%
Global Cover	**Medical Treatment abroad** (Listed illness, Diagnosis in India)	NA	NA	Actuals up to Sum Insured	Actuals up to Sum Insured
Out Patient Cover	**Out-Patient (OPD) Cover**	NA	NA	Single Adult – INR 5,000 All other family combinations - Up to INR 10,000/Family	Single Adult – INR 10,000 All other family combinations - Up to INR 20,000/Family
	Out-Patient Dental / Vision Cover	NA	NA	NA	Up to INR 5000/Family
	Out-Patient and Prescribed Diagnostic test (Cancer Diagnosed Patients)	NA	INR 5000/Policy	INR 10000/Policy	INR 15000/Policy
Optional Covers					
Base Cover Modifiers	**Enhanced ReInsure Benefit**	Unlimited up to 200%	Unlimited up to 200%	Unlimited up to 200%	NA
	Enhanced Cumulative Bonus Safeguard (if claim amount is 1Lac or less, No reduction in Enhanced Cumulative Bonus)	Covered	Covered	Covered	NA
	Co-payment	10/20%	10%/20%	10%/20%	10%/20%
	Aggregate Deductible	1 Lac / 2 Lacs / 3Lacs	1 Lac / 2 Lacs / 3Lacs	3 Lacs / 5 Lacs	5 Lacs/10 Lacs
	Domestic help/staff Indemnity [Room Rent - 2%, ICU - 4%, Bariatric - INR 50,000, (Day Care Treatment, AYUSH, Modern Treatment-up to Sum Insured), Emergency Road Ambulance - INR 3000/Hospitalization] [Min - 18 years/Max - 65 years]	Up to INR 50,000/ 1 Lac	Up to INR 50,000/ 1 Lac	Up to INR 50,000/ 1 Lac	Up to INR 50,000/ 1 Lac
	Additional Basic Sum Insured (for Accident related hospitalization)	2x	2x	2x	2x
Wellness	**Health Assistance (A.I. Personal Fitness coaching)**	Covered	Covered	Covered	Covered
	Dietician and Nutrition E-consultation	Covered	Covered	Covered	Covered
	Walk Healthy Benefit (Collect health benefits by taking steps counted on our App and get discount up to 30% on renewal premium)	Covered	Covered	Covered	Covered
	Unlimited Gym Membership	Covered (3+3+3+3 option)	Covered (3+3+3+3 option)	Covered (6+6 option)	Covered (6+6 option)

Waiting Period					
Waiting Period	Pre-Existing Waiting Period	2 years	2 years	2 years	2 years
	Specific Disease waiting period	2 years	2 years	1 years	1 years
	Initial Waiting Period (Excluding Accidental Hospitalization)	30 days	30 days	30 days	30 days
	Maternity Expenses	NA	Single Adult – 48 Month All other Family Combination - 24 Months	Single Adult – 48 Month All other Family Combination - 24 Months	Single Adult – 48 Month All other Family Combination - 24 Months
	Medical Treatment Abroad	NA	NA	36 Months	36 Months
	Hypertension, Diabetes, Cardiac Condition	90 Days	90 Days	90 Days	90 Days