SURAKSHA AUR BHAROSA DONO

SBI GENERAL HEALTH ALPHA
POLICY WORDING

Section 1 Preamble

In consideration of payment of Premium by Policyholder 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 Policyholder. This Policy is subject to Policyholder/ Insured Person(s) statements in respect of all the Insured Person(s) in Proposal Form, declaration and/or medical reports, payment of Premium and the terms and conditions of this Policy.

Section 2 Definitions

The terms defined below and 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 and vice versa.

2.1. Standard Definitions

2.1(a). Accident/ Accidental means a sudden, unforeseen and involuntary event caused by external, visible and violent means

2.1(b). Act means the Insurance Act, 1938 (4 of 1938).

2.1(c). Anyone Illness means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/ Nursing Home centre where treatment was taken.

2.1(d). Authority means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999).

2.1(e). AYUSH Treatment means the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems.

2.1(f). 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 registered AYUSH Medical Practitioner(s) in charge,

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.

2.1(g). AYUSH Hospital is a healthcare facility wherein medical/ surgical/para-surgical treatment and procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

i. Central or State Government AYUSH Hospital; or

ii. Teaching Hospital attached to AYUSH colleges recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

iii. 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 with all the following criterion:

a. Having at-least 05 in-patient beds;

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

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

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

2.1(h). Break in Policy means the period of gap that occurs at the end of the existing Policy term/ installment premium due date, when the Premium due for renewal on a given Policy or installment Premium due is not paid on or before the Premium renewal date or Grace Period.

2.1(i). Cashless Facility means a facility extended by the Company 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 network provider by the Company to the extent pre-authorization is approved.

2.1(j). Complaint or Grievance means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a Complainant with respect to Solicitation or sale or purchase of an insurance Policy or related services by Insurer and /or by distribution channel

2.1(k). Complainant means a Policyholder or prospect or Nominee or assignee or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer and /or distribution channel

2.1(l). Condition Precedent means a Policy term or condition upon which the Company's liability under the policy is conditional upon.

2.1(m). Congenital Anomaly means a condition which is present since birth and which is abnormal with reference to form, structure or position.

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

ii. External Congenital Anomaly which is in the visible and accessible parts of the body.

2.1(n). Co-Payment means a cost sharing requirement under this 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.

2.1(o). Cumulative Bonus means any increase or addition in Base Sum Insured granted by the Insurer without an associated increase in premium.

2.1(p). Day Care Centre means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up 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 criteria as under.

i. Has qualified nursing staff under its employment.

ii. Has qualified Medical Practitioner/s in charge;

iii. Has a 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.

2.1(q). 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 hours because of technological advancement, and

ii. Which would have otherwise required Hospitalization of more than 24 consecutive hours.

iii. Treatment normally taken on an Out-Patient basis is not included in the scope of this definition.

2.1(r). 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.

2.1(s). Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

2.1(t). Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.1(u). 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.

2.1(v). Emergency/Emergency Care means management for an Illness or Injury 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.

2.1(w). Grace Period means the specified period of time, immediately following the Premium due date during which Premium payment can be made to renew or continue a Policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. Coverage need not be available during the period for which no Premium is received.

The Grace Period for payment of the Premium for all types of insurance policies shall be: fifteen days where Premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the Grace Period, if the Premium is paid in instalments during the Policy Period.

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

2.1(x). Home Care Treatment/Home Health Care means treatment availed by the Insured Person at home which in normal course would require care and treatment at a Hospital but is actually taken at home provided that:

i. The Medical Practitioner advices the Insured Person to undergo treatment at home.

ii. There is a continuous active line of treatment with monitoring of the health status of a Medical Practitioner for each day through the duration of the home care treatment.

iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

2.1(y). Hospital means any institution established for In-patient care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities, under the Clinical Establishments (Registration & Regulation) Act, 2010 or under enactments specified under the schedule of section 56(1) of the said Act or complies with all minimum criteria as under:

i. Has qualified nursing staff under its employment round the clock;

ii. 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;

iii. Has qualified Medical Practitioner(s)in charge round the clock;

iv. Has a fully equipped Operation theatre of its own, where Surgical Procedures are carried out;

v. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

2.1(z). 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 (Day Care Treatment).

2.1.(aa). Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i. Acute condition - Acute condition is a disease, Illness or Injury 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/ injury which leads to full recovery

ii. Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests".

b. It needs ongoing or long-term control or relief of symptoms.

c. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.

d. It continues indefinitely.

e. It recurs or is likely to recur.

2.1.(ab). 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.

2.1.(ac). In-Patient Care/ In-Patient Treatment means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.(ad). Intensive / Critical Care Unit (ICU/CCU) means an identified section, ward or wing of a Hospital which is under the constant supervision of 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.

2.1.(ae) ICU (Intensive Care Unit) 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.

2.1.(af). Maternity Expenses means

i. Medical Treatment Expenses traceable to childbirth

(including complicated deliveries and caesarean sections incurred during Hospitalization).

ii. Expenses towards lawful medical termination of pregnancy during the Policy Period.

2.1.(ag). Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

2.1.(ah). 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.

2.1.(ai). Medically Necessary Treatment means any treatment, tests, medication or stay in Hospital or part of a stay in Hospital which

i. Is required for the medical management of the illness/injury suffered by the Insured.

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.

2.1.(aj). 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 its scope and jurisdiction of license.

Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017.

The registered practitioner should not be the Policyholder/Insured or their close family member.

2.1.(ak). Migration means a facility provided to Policyholders (including all members under Family cover and group policies), to transfer the credits gained for Pre-Existing Diseases and Specific Waiting Periods from one health insurance Policy to another with the same Insurer.

2.1.(al). 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.

2.1.(am). Newborn baby means baby born during the Policy Period and is aged upto 90 days.

2.1.(an). Non-Network Provider/Hospital means any Hospital, Day Care center or other provider that is not part of the Network.

2.1.(ao). Notification of Claim means the process of intimating a Claim to the insurer or TPA through any of the recognized modes of communication.

2.1.(ap). OPD/Out-patient 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.

2.1.(aq). 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 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 Company

2.1.(ar). Portability means a facility provided to the health insurance Policyholders (including all members under family cover), to transfer the credits gained for, Pre-Existing Diseases and Specific Waiting Periods from one Insurer to another Insurer.

2.1.(as). Pre-Existing Disease means any condition, ailment, Injury or disease:

i. That is/are diagnosed by a physician not more than 24 months prior to the date of commencement of the Policy issued by the Insurer; or

ii. For which Medical Advice or treatment was recommended by, or received from, a physician, not more than 24 months prior to the date of commencement of the Policy.

2.1.(at). 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 Company

2.1.(au). Proposal form means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the Insurer in respect of a risk, in order to enable the Insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

2.1.(av). Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.1.(aw). Reasonable & 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.

2.1.(ax). 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.

2.1.(ay). Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

2.1.(az). Senior Citizen means any person, who has attained the Age of sixty years or above.

2.1.(aaa). Solicitation means the act of approaching a prospect or a Policyholder by an Insurer or by a distribution channel with a view to persuading the prospect or a Policyholder to purchase or to renew an insurance Policy.

2.1.(aab). Specific Waiting Period means a period up to 24 months from the commencement of a health insurance Policy during which period specified diseases/treatments (except due to an Accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

2.1.(aac). Surgery / Surgical Procedure / Surgical Operation 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 of suffering or prolongation of life, performed in a Hospital or Day Care centre by a Medical Practitioner.

2.1.(aad). Unproven/ Experimental Treatments means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.2. Specific Definitions

2.2.(a). Adventurous/ Hazardous Sports means any sport or activity involving a high level of inherent danger. These activities often involve speed, height, a high level of physical exertion and highly specialized gear in which an Insured Person participates or competes for entertainment whether he / she is trained or not.

2.2.(b). Age means Age as on last birthday" as determined on the date of first Policy issuance or at Renewal. In case of change in Age during the proposal stage then "Age" shall be determined on the date of Proposal Form submission would be considered for premium calculation.

2.2.(c). Ambulance means a road vehicle or an aircraft operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

2.2.(d). Annexure means document attached and marked as Annexure to this Policy.

2.2.(e). Assisted Reproduction Treatment: Assisted Reproduction Treatment means artificial insemination and advanced reproductive technologies but not limited to IVF, ZIFT, GIFT, ICSI, IUI.

2.2.(f). Base Sum Insured means the amount specified as Base Sum Insured in the Policy Schedule. Calculation of bonus and sub-limits mentioned under the Policy shall be on basis of the Base Sum Insured.

2.2.(g). Child means Insured Person's biological or legally adopted son or daughter, whose completed age is between day 1 to 25 years as on Policy Period start date, and who is financially dependent on the Insured Person and does not have an independent source of income.

2.2.(h). Claim means a demand made by the Policyholder or on his behalf, for payment of Medical Expenses under any other benefit, as covered under the Policy.

2.2.(i). Companion means Insured Person's Family Member/ relative/friend/colleague above 18 years of age who is accompanying the Insured Person during the Hospitalization.

2.2.(j). Dependent means only the family members listed below:

i. Your legally married spouse as long as she continues to be married to You.

ii. Your children (natural or legally adopted), aged between day 1 to maximum up to Age of 25 years and financially dependent on You.

iii. Your natural parents or parents that have legally adopted You.

iv. Your parent-in-law as long as Your Spouse continues to be married to You.

2.2.(k). Family means 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 Day 1 to Age 25 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.

2.2.(l). Insured Person/Insured/You/Your means persons named in the Policy Schedule who are Insured under the Policy and are Citizen of India in respect of whom the applicable Premium has been received.

2.2.(m). Life Threatening Medical Condition means a medical condition suffered by the Insured Person which has any of the following characteristics:

i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or

ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

iii. Critical care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or

iv. Critical Care being provided in critical care areas such as coronary care unit, Intensive Care Unit, respiratory care unit, or the Emergency department; and

v. Is certified by the attending Medical Practitioner as a Life Threatening Medical Condition.

2.2.(n). Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize 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 characterized by sub normality of intelligence.

2.2.(o). Medical Practitioner for Mental Illnesses means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized 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.

2.2.(p). 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, organization 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, organization 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.

2.2.(q). Nominee means the person whose name specifically appears as such in the Policy Schedule and is the person to whom the proceeds under this Policy, if any, shall become payable in the event of the death of the Policyholder.

2.2.(r). 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

2.2.(s). Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured Person.

2.2.(t). Policy Schedule means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Base 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.

2.2.(u). Policyholder means the person who has proposed the Policy and in whose name Policy is issued.

2.2.(v). Policy Period means the period commencing from the Policy Period start date as specified in Policy Schedule and ending on the Policy Period end date as specifically appearing in the Policy Schedule or on the date of cancellation of the Policy, whichever is earlier.

2.2.(w). Policy Year means a period of 12 consecutive months starting from the Policy Period start date and ending on the last day of such 12 month period. For the purpose of subsequent years, Policy Year shall mean a period of 12 months commencing from the end of previous Policy Year and lapsing on the last day of such 12month period, till the Policy Period end date, as mentioned in the Policy Schedule.

2.2.(x). Post-Natal Medical Expenses means medical expenses incurred for the Insured mother for a period of one month from the date of childbirth or termination.

2.2.(y). Pre-Natal Medical Expenses means medical expenses incurred for the Insured mother from the date of conception and up to childbirth.

2.2.(z). 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.

2.2.(aa). 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 benefit in force under the Policy.

2.2.(ab). Sum Insured means the pre-defined limit of each Section/Benefit specified in the Policy Schedule/ Certificate of Insurance. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person on Individual basis.

2.2.(ac). Telemedicine means medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

2.2.(ad). Time Excess means a cost sharing requirement that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the Insurer.

2.2.(ae). 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.

2.2.(af). We/Our/Us/Company/Insurer means the SBI General Insurance Company Limited.

2.2.(ag). You/Your/Yourself means the Insured Person shown in the schedule/Policy Schedule.

Scope of Cover

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

All Sections mentioned under the Policy are Optional , but it is mandatory to opt Section 3 Hospitalization Cover and/or Section 4 Personal Accident Cover as mandatory Base Cover(s).

Section 3 Hospitalization Cover

3(a). In-Patient Treatment

If the Insured Person, during the Policy Year, is diagnosed with any Illness or suffers any Injury that requires In-Patient Treatment on the written advice of a Medical Practitioner, then We will indemnify the Insured Person towards below mentioned Medical Expenses incurred by the Insured Person up to the limit as specified in the Policy Schedule.

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

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

iii. Nursing Expenses as provided by the Hospital.

iv. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees.

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

vi. Consultation fees including Telemedicine by Medical Practitioner.

vii. Medicines, drugs, and consumables.

viii. Diagnostic procedures.

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

3(b). Day Care Treatment

We will indemnify the Insured Person up to the limit as specified in the Policy Schedule, for the Medical Expenses on the written advice of the Medical Practitioner, if during the Policy Year, any of the Insured Person undergoes a Day Care Treatment as defined under this Policy, provided:

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

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

3(c). AYUSH Treatment

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, for the Medical Expenses, if during the Policy Year, any of the Insured Person undergoes In-Patient Treatment or treatment taken under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy in an AYUSH Hospital or an AYUSH Day Care Centre as defined under the Policy.

3(d). Domiciliary Treatment

We will indemnify the Insured Person up to a limit specified in the Policy Schedule, for the Medical Expenses incurred for Domiciliary Hospitalization during the Policy Year, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days, in which case We will pay the Reasonable and Customary Charges for the entire period.

3(e). Pre-Hospitalization

We will indemnify the Insured Person for the Medical Expenses incurred during the Policy Year, for the period as specified in the Policy Schedule, immediately before the Insured Person was Hospitalized, provided:

i. Such Medical Expenses are incurred in respect of the same condition for which Insured Person has taken Hospitalization, and

ii. We have accepted a Claim under any of the following benefits Section 3 Hospitalization Cover, 3.1(d). Organ Donor, 3.1(e). Modern Treatments or 3.1(f). Home Health Care.

3(f). Post-Hospitalization

We will indemnify the Insured Person for the Medical Expenses incurred during the Policy Year, for the period as specified in the Policy Schedule, immediately after the Insured Person was discharged following Hospitalization provided:

i. Such costs are incurred in respect of the same condition for which the Insured Person has taken Hospitalization, and

ii. We have accepted a Claim under any of the following benefits Section 3 Hospitalization Cover, 3.1(d). Organ Donor, 3.1(e). Modern Treatments or 3.1(f). Home Health Care

3(g). Bariatric Surgery

We will indemnify the Insured Person up to an amount specified in the Policy Schedule for the Reasonable and Customary Charges for Medical Expenses incurred during the Policy Year towards surgical procedure of the Insured Person, for obesity, provided:

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

Body Mass Index (BMI);

a. Greater than or equal to 40 or

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

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

ii. The indication for the procedure should be found appropriate by 2 qualified surgeons and the Insured

Person shall obtain prior approval for cashless treatment from Us.

iii. We have accepted a Claim under benefit 3(a). In-Patient Treatment.

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

v. Bariatric surgery performed for cosmetic reasons is excluded.

vi. This benefit waives the Standard Exclusion 13.1(c). Obesity/ Weight Control (Code: Excl06) to the extent mentioned under this benefit.

Optional Covers (Available only with Section 3 Hospitalization Cover)

All the benefits listed under 3.1. to 3.3 are optional covers and can be made available only with Section 3 Hospitalization Cover under the Policy, for appropriate premium, subject to below mentioned terms, conditions, and exclusions.

3.1. Essential Covers

3.1(a). Road Ambulance

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

i. We have accepted a Claim under any one of the benefits, Section 3 Hospitalization Cover, 3.1(d). Organ Donor or 3.1(e). Modern Treatments.

ii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital in case of an emergency Life Threatening Medical condition, or from one Hospital to another Hospital which is prepared to admit the Insured Person and provide the necessary medical services.

iii. Such Life-Threatening Medical Condition is certified by the Medical Practitioner.

iv. The transportation from one Hospital to another Hospital has been prescribed by a Medical Practitioner and is medically necessary.

v. The Ambulance service is offered by a healthcare or registered ambulance service provider.

3.1(b). Air Ambulance

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, for the expenses incurred on availing air ambulance services during the Policy Year, provided:

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

ii. The Ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

iii. We have accepted a Claim under Benefit 3(a). In-Patient Treatment or Benefit 3(b). Day Care Treatment.

iv. Expenses under this benefit shall be payable on reimbursement basis subject to the original Ambulance bills and payment receipt submitted to Us.

v. The Origin and Destination of Air Ambulance Service are within the geographical boundaries of Republic of India.

vi. Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.

vii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment vital to monitoring

and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECGs, monitoring units, CPR equipment and stretchers.

3.1(c). Radio Cab

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

i. We have accepted a Claim under any one of the benefits, Section 3 Hospitalization Cover, 3.1(d) Organ Donor or 3.1(e) Modern Treatments .

ii. The coverage includes the transportation cost of the Insured Person to the nearest Hospital and/or from Hospital to home.

3.1(d). Organ Donor

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, for the Medical Expenses incurred during In-Patient Treatment, in respect during the Policy Year, provided:

i. The organ donated is for the use of the Insured Person.

ii. We have accepted the Claim under benefit 3(a) In-Patient Treatment.

iii. We shall not pay the donor's Pre and Post Hospitalization Expenses

iv. Any donor screening charges or other Medical Expenses or Hospitalization consequent to the harvesting of organ for the donor is excluded under the Policy.

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

3.1(e). Modern Treatments

We will indemnify the Insured Person up to the limit specified in the Policy Schedule for the Medical Expenses incurred during the Policy Year on In-Patient Treatment or Day Care Treatment or Domiciliary Treatment of Modern Treatments and not limited to the following:

i. Uterine Artery Embolization and HIFU

ii. Balloon Sinuplasty

iii. Deep Brain Stimulation

iv. Oral Chemotherapy

v. Immunotherapy-Monoclonal Antibody to be given as injection

vi. Intra Vitreal injections

vii. Robotic surgeries

viii. Stereotactic radio surgeries

ix. Bronchical Thermoplasty

x. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)

xi. IONM- (Intra Operative Neutro Monitoring)

xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

3.1(f). Home Health Care

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, for the Reasonable and Customary charges towards Medical Expenses incurred during the Policy Year, for Home Health Care taken by the Insured Person, on the written advice of a Medical Practitioner, provided:

i. The treatment in normal course would require In-Patient Treatment at a Hospital and be admissible under benefit 3(a). In-Patient Treatment but is actually taken while confined at home.

ii. The benefit shall not be available for any Emergency Treatment/Care.

iii. The treatment is availed from Our empanelled service provider on Cashless basis

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

3.1(g). Consumables Cover

We will indemnify the Insured Person up to an amount as specified in the Policy Schedule, for the expenses incurred by the Insured Person, during the Policy Year, for items which are listed in 'Annexure II' of this Policy, provided:

i. Such consumables or items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In-Patient Treatment or Day Care Treatment or AYUSH Treatment or Domiciliary Treatment or Organ Donor or Modern Treatments or Home Health Care.

ii. We have accepted Claim under any one of the benefits, Section 3 Hospitalization Cover, 3.1(d)Organ Donor, 3.1(e). Modern Treatments, 3.1(f) Home Health Care.

3.1(h). Restore Benefit

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

i. The Sum Insured shall be restored to an extent of claim amount immediately after settlement of a Claim under benefits, Section 3 Hospitalization Cover, 3.1(d) Organ Donor, 3.1(e) Modern Treatments, 3.1(f). Home Health Care.

ii. This benefit shall be available at each Policy Year and the restored Sum Insured at given time shall not exceed the Base Sum Insured specified in the Policy Schedule.

iii. The Restored Sum Insured shall be available only for all subsequent Claims

iv. The Restored Sum Insured can be utilized unlimited times for subsequent Claims for related or unrelated Illness/ Injury.

v. This benefit shall not be available if Unlimited Sum Insured has been opted under the Policy.

vi. Restored Sum Insured will be available on individual basis for individual policies and on floater basis for family floater policies during a Policy Year.

vi. If this benefit is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

vii. The sequence of utilization of the Sum Insured by the Insured Person at the time of making a Claim during the Policy Year will be as below:

a. Base Sum Insured

b. Cumulative Bonus(if applicable)

c. Restore Benefit(if opted)

viii. In a given policy year, either Endless Sum Insured or Restore Benefit can be utilized.

ix. Benefit 10.1 Voluntary Deductible or benefit 10.2 Voluntary Co-Payment, if opted shall be applicable.

x. This benefit shall not be applicable to optional covers 3.2(i), 3.3 and to Sections 4, 5,6,7,8,9,10.

3.2. Special Covers

3.2(a). Convalescence

We shall pay a lump sum amount as specified in the Policy Schedule to the Insured Person, if the Insured Person is

Hospitalized for a minimum period of 7 continuous and consecutive days, during the Policy Year, provided that:

i. We have accepted a claim under benefit 3(a) In-Patient Treatment.

ii. This benefit is payable once in a Policy Year.

iii. The benefit shall be available on individual basis for individual policies and on floater basis for floater policies.

iv. The payment under this benefit will be over and above the payment made under benefit Section 3 Hospitalization Cover.

3.2(b). Companion Cover

We will pay the Insured Person a fixed daily amount, specified in the Policy Schedule, towards the expenses of single Companion during the In-Patient Treatment of the Insured Person, provided:

i. We have accepted the Claim under benefit 3(a). In-Patient Treatment.

ii. The claim under this benefit shall be payable if the Hospitalization of the Insured Person is for minimum continuous and consecutive 72 hours.

iii. If above condition no. (ii) is met, then daily amount shall be payable for each 24 hours of continuous and completed In-Patient Hospitalization of the Insured Person, from the first day of Hospitalization of the Insured Person.

iv. The amount under this benefit shall be payable for maximum up to 30 days in a Policy Year.

v. The amount shall be payable towards expenses incurred by the Companion towards accommodation, transportation, food or any other miscellaneous expenses.

vi. For a Claim to be payable under this cover, the Companion/ Insured Person shall submit at minimum, the receipts of paid accommodation, travel, food and other miscellaneous expenses incurred by the Companion to assist the Insured Person during Hospitalization.

vii. The payment under this benefit will be over and above the payment made under benefit 3(a). In-Patient Treatment.

3.2(c). Adventure Sports

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, if during the Policy Year, the Insured Person is Hospitalized and sustains bodily Injury/ Accident due to participation in below listed Adventurous Sports:

i. Zip Lining

ii. Bungee Jumping

iii. Parasailing

iv. Water Scooter rides

v. Speed Boat rides (not as an operator)

vi. Rafting

vii. Scuba Diving

viii. Snorkelling

ix. Trekking

x. Biking including Cycling and Motor Biking

xi. Hot Air Ballooning (Tethered)

xii. All-Terrain Vehicle tours

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

xiv. River Canoeing/Kayaking

Specific Exclusions applicable to benefit 3.2(c). Adventure Sports

We shall not be liable to make any payment under this benefit in connection with or in respect of any expenses whatsoever incurred by the Insured Person for:

i. Participation in any Adventure Sports whilst being under influence of Alcohol or any other narcotic drugs or abuse of prescription drugs or any hallucinates.

ii. Whilst being under any medication or treatment which slows down response and alertness or makes the Insured Person unfit for participating in such sports

iii. Participation against Medical Advice or against the advice of the professional instructor or any representative of the Adventure Sport Centre or Organiser.

iv. Insured Person going against instructions, guidelines or rules of participation issued by the Adventure Sport Centre or Organiser

v. Any training or participation in a semi-professional or professional capacity.

vi. Participation in any other Adventure Sports not listed under the above list.

vii. If the Insured is suffering from a Pre-Existing Injury that limits their participation in the selected Adventure Sports.

viii. Regardless of the Age definition (refer Entry Age under General Conditions), Insured is aged above 55 years or if the Insured is less than 14 years.

ix. If the Insured is already pregnant as on the date when the Insured undertook participation.

x. If there is a public weather advice or prevailing weather conditions which are not suitable for undertaking participation in such activities.

xi. Participation in any Adventure Sports within 2 weeks or before the end of recouping period as per the advice by the attending Physician, whichever is maximum.

xii. Participation in any water-based Adventure Sports without knowledge of swimming by the Insured.

xiii. Participation in any Adventure Sports which is undertaken without direct supervision of a professionally trained guide for that specific Adventure Sports.

xiv. Participation in any Adventure Sports which is undertaken at a Centre or under an Organiser who do not have required certifications as per the rules of the prevailing Jurisdiction or internationally accepted norms.

xv. Insured Person is receiving any monetary/ non-monetary reward/ benefit/ consideration for participating in Adventure Sports

xvi. Unlimited Sum Insured shall not be available under this benefit, the maximum liability under this benefit shall be limited to Sum Insured as specified in the Policy Schedule.

xvii. Standard Exclusion no. 13.1(f). Hazardous or Adventure Sports: Code- Excl09 shall not be applicable to the extent mentioned under this benefit if opted.

Specific Conditions applicable to benefit 3.2(c). Adventure Sports

We shall make any payment under this benefit on adherence of below conditions

Sr. No	Activity	Conditions
1	Zip Lining	1. The participants must wear helmet and prescribed Personal Protection Equipment consisting of rock-climbing sit harness, Additional Chest Harness with two-point attachment to the safety systems confirming to the Union International de Alpine Association (UIAA) or EN/Conformité Européenne (CE) standards or ISI 2. Only zip liners with arrival Speed lesser than 50 KpH or 31 miles per hour are covered under this Policy.

		3. Only zip line courses having lesser than 20% of the course distance over a water body like river, lake is covered under this Policy.
2	Bungee Jumping	1. Bungee Jumping operations are carried out in conformation to the guidelines issued by the government Participation during night times (after local sunset) or low visibility conditions are not covered.
3	Parasailing	1. Parasailing wing and Harness must have been certified by reputed organisation 2. Parasail drivers / instructors to be certified in Power Boat Handling from recognised organisation and in First Aid / Cardiopulmonary resuscitation (CPR) techniques from appropriate recognised organisation 3. Participation during night times (after local sunset) or low visibility conditions are not covered.
4	Water Scooter rides or Personal Watercraft	1. The instructors to be certified in Power Boat Handling from recognised organisation and in First Aid / Cardiopulmonary resuscitation (CPR) techniques from appropriate recognised organization. 2. Equipment was to be certified by reputed institutions. 3. Participation during night times (after local sunset) or low visibility conditions are not covered.
5	Speed Boat rides (not as an operator)	1. The instructors to meet the applicable Maritime Standards to operate the type of vessel and the limits they operate in. 2. The vessel is also to meet the appropriate Maritime Standards as applicable. The Crew Ratios must also be complied with the applicable Maritime Standards. 3. No rides beyond the coastal waters of the destination Jurisdiction would be covered.
6	Rafting	1. Helmet and Lifejackets must be worn by the participants at all times during the rafting activity. 2. Rafting activity should be only on area falling under Grade I and Grade II of International Scale of River Difficulty, also known as White Water Scale 3. The guide must be certified in First Aid / Cardiopulmonary resuscitation (CPR) techniques from appropriate recognized organization and must be certified as a White-Water Rescue Technician from appropriate institutes.
7	Scuba Diving	1. The Dive Master and the Diving Instructor must be holding requisite qualification from international/Indian associations Equipment used should be certified by appropriate agencies and of high quality. 2. Diving more than 20 meters are not covered
8	Snorkeling	1. The activity to be undertaken under guidance of experienced and qualified guides / supervisors only. No solo activity is covered.
9	Trekking	1. If mountainous terrain is included, maximum altitude that is covered under this Policy is 5500 meters above the mean sea level. Any climb above 3500 meters of altitude without proper acclimatization is not covered. 2. No skiing, rock climbing or pot holing is covered under trekking. Steep paths requiring ropes and chains or similar mountaineering equipment's are not covered. 3. Trekking to be undertaken as a part of group and under supervision of a guide qualified to do so under regulations as applicable.The guide must be certified in First Aid / Cardiopulmonary resuscitation (CPR) techniques from appropriate recognized organization.
10	Cycling	1. Off road, mountain biking above 3500 meters and professional / semiprofessional racing / rallies is not covered. 2. Cycling to be undertaken as a part of group and under supervision of a guide qualified to do so under regulations as applicable under the Destination jurisdiction. The guide must be certified in First Aid / Cardiopulmonary resuscitation (CPR) techniques from an appropriate recognized organization. The minimum group size is 7. 3. Maximum distance to be covered per day is 60 Kilometers from the previous starting point. No cycling after the local sunset is covered. 4. Helmets and the other prescribed safety equipment's of quality recognized by international agencies like the ISI to be used by the Cyclists.
11	Motor biking	1. Off road, mountain biking above 3500 meters and professional / semiprofessional racing / rallies is not covered. 2. Biking expeditions to be undertaken as a part of a group and under supervision

		of a guide qualified to do so under regulations as applicable under the Destination jurisdiction. The guide must be certified in First Aid / Cardiopulmonary resuscitation (CPR) techniques from an appropriate recognized organization. The minimum group size is 7. 3. Maximum distance to be covered per day is 240 Kilometers from the starting point. 4. Helmets and the other prescribed safety equipment's of quality recognized by international agencies like the ISI to be used by the Motorcyclists. 5. The expedition to be supported by an accompanying logistic truck with first aid, supplies and spares to be accompanying the group at all times. 6. Having a driving license applicable for Jurisdiction, Route, and Type of vehicle to be used is compulsory. Knowledge of operating bikes used for the expedition is compulsory. 7. Motor bikes used must be suitable and fit for the route planned. 8. A local motor insurance and permits to conduct the expedition in the selected route (if any) is compulsorily arranged prior to the trip.
12	Hot Air Ballooning	1. The Balloon to be operated by a person having Hot Air Balloon Licenses issued by respective Civil Aviation Authority or its equivalents. The minimum experience required is 5 years. 2. The hot air Balloon used for the expedition should have certified as "Airworthy" by respective Civil Aviation Authority. 3. Only tethered hot air ballooning is covered under the Policy.
13	All Terrain Vehicle tours	1. The guide overseeing the operations should have been certified on driving training course either from the European ATV safety institute or the All Terrain Safety Institute. 2. The participants must be wearing prescribed protective equipment's of recommended quality such as (not limited to) helmets, face shields, goggles, protective gloves and footwear and clothing as recommended for the operation of the ATV or quad bikes.
14	Personal Light Electric Vehicle (Segway/P LEV) tours	1. The equipment used is of a recognized make like the Segway and is properly maintained as per the requirement laid by the manufacturer. 2. Rides in slopes, loose stones, and mountainous terrain are not covered. 3. The participants must be wearing prescribed protective equipment's of recommended quality such as (not limited to) helmets, footwear and clothing as recommended for the operation of the PLEV.

3.2(d). Gym and Sports Injury Cover

We shall indemnify the Insured Person up to the limit specified in the Policy Schedule, if the Insured Person sustains any of the below listed injury due to participation or engagement in hobby sports or daily fitness activities during the Policy Year.

Injuries Covered:

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

Coverage:

Consultation from Orthopaedic Sports Specialist	Fees for medically necessary consultation and examination by Orthopaedic Specialist related to listed sports injury.
Diagnostic Tests	Medically necessary out-patient diagnostic procedures such as X-rays, MRIs, and CT scans to assess injuries.
Prescription Drugs	Drugs and medicines prescribed by Sports Specialist for pain relief and rehabilitation after injuries.
Physical Therapy	Fees for medically necessary sessions with licensed physical therapists to aid recovery from sports injuries.

Provided that:

i. This benefit is available to Insured Person up to 55 years of age.
ii. This benefit is available for amateurs on out-patient basis.
iii. The claim for Diagnostic Tests and Prescription Drugs shall become payable only in relation to a Consultation from Sports Specialist which is payable.
iv. The claim under this benefit shall be payable once in a Policy Year.
v. The benefit is available on an individual basis for individual policies and on floater basis for family floater policies.

vi. This benefit shall be available on Cashless basis, wherever the Cashless facility is unavailable, the bills and receipts can be reimbursed in a Policy Year (if applicable) towards each Policy.

vii. The amount claimed under this benefit is over and above the Base Sum Insured.

viii. Payments made under this benefit shall not be claimable under any other benefit.

Specific Exclusion related to benefit 3.2(d). Gym and Sports Injury Cover

i. Participation against Medical Advice or against the advice of the professional instructor (if any)

ii. If the Insured is already pregnant as on the date when the Insured undertook participation.

iii. Any Pre-existing Gym & Sports Injury.

iv. Expenses for any Cosmetic/ routine preventive health check-ups / dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances shall not be covered

3.2(e). Reconstructive Surgery

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, if during the Policy Year, the Insured Person sustains bodily Injury/ Accident which requires reconstructive surgery (for cosmetic purpose) within 6 months from the date of Accident/Injury, provided:

i. We have accepted Claim under the benefit 3(a). In-Patient Treatment.

ii. Claim arising out of pre-existing injuries will not be covered under this benefit.

iii. Standard Exclusion 13.1(e). Cosmetic or plastic Surgery: Code- Excl08 will not be applicable to the extent of limit covered under this benefit.

For the purposes of this benefit, Reconstructive Surgery shall mean surgery to reconstruct cutaneous or underlying tissue changed/ damaged by an Accident/Injury or Third Degree Burns, prescribed as necessary by a Medical Practitioner.

For the purposes of this benefit, Third Degree Burns means burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

3.2(f). Prosthetics

We will indemnify Reasonable and Customary charges incurred by the Insured Person up to the limit specified in the Policy Schedule, towards installation of an external prosthesis equipment, as a result of injury/ Illness during the Policy Year, provided:-

i. The prosthetic device replaces a limb or a body part, limited to: -

a. Artificial arms, legs, feet, and hands.

b. Artificial part of the face which includes eyes, ears, nose and cheek

c. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.

ii. The prosthetic device is Medically Necessary and prescribed by the treating Medical Practitioner.

iii. We have accepted Claim under benefit 3(a) In-Patient Treatment

iv. Any repairs or replacement of the Prosthetic which is implanted during the Policy Period or which was an already existing prosthetic previous to purchase of will not be covered

3.2(g). Gender Reassignment

We will indemnify for Reasonable and Customary Medical Expenses incurred for Gender Reassignment Treatment taken by the Insured Person during the Policy Year, up to the limit specified in the Policy Schedule, provided the following Treatment/Procedures shall be covered:

i. Hormone Therapy: The treatment involves hormone therapy (administered either on an In-patient or outpatient basis) like Testosterone (masculinizing hormones) for Trans Man (Female to Male) and estrogen (feminizing hormones) for Trans Woman (Male to Female).

ii. Surgical Intervention including but not limited to below listed procedures

a. Genital surgery for Male-to-Female transsexuals

b. Genital surgery for Female-to-Male transsexuals

Specific condition applicable to benefit 3.2(g). Gender Reassignment

i. The coverage under this benefit will be as per the WPATH (World Professional Association for Transgender Health) protocol subject to applicable Indian Laws.

ii. This benefit includes (but not restricted to) primary care, gynecologic and urologic care, reproductive surgery options, voice related surgeries and communication therapy,and hormonal and surgical treatments.

iii. Active Line of Treatment would not be applicable for this treatment.

iv. Standard Exclusion 13.1(d). Change of Gender Treatments (Code- Excl07) shall not be applicable to the extent this benefit is applicable.

3.2(h). Vision Correction

We shall indemnify the Insured Person up to an amount specified in the Policy Schedule, for the Medical Expenses incurred during the Policy Year, for undergoing Medically Necessary Treatment Laser-Assisted In Situ Keratomileusis (LASIK) Surgery, including refractive keratotomy (RK) and photorefractive keratectomy (PRK) or any other advanced Surgical Procedures conducted to correct the refractive errors beyond +/- 4.5 dioptre to rectify the refraction of one or both eyes, on the written advice of the Medical Practitioner, provided:

i. This benefit shall become available only after the expiry of 12/24 months (as opted) from the date of inception of the Insured Person's first Policy with Us.

ii. We have accepted a Claim under any one of the following benefits, 3(a). In-Patient Treatment or 3(b). Day Care Treatment.

iii. The treatment carried out for the cosmetic reasons is excluded.

iv. Pre-Hospitalization and Post-Hospitalization expenses shall not be covered under this benefit.

v. This benefit waives the Standard Exclusion 13.1(l). Refractive Error (Code: Excl15) to the extent mentioned under this benefit.

3.2(i). Endless Sum Insured

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

i. This benefit can be opted at the time of Policy inception or at the time of first renewal.

ii. This benefit is available only with Sum Insured Rs. 10 Lakhs and above.

iii. This benefit shall not be available if Unlimited Sum Insured has been opted under the Policy.

iv. This benefit is applicable only for one Claim in the lifetime of the Policy, irrespective of Policy Tenure or Policy Type (Individual or Floater).

v. We have accepted Claim under Benefit 3(a). In-Patient Treatment, 3(b). Day Care Treatment or 3(c). AYUSH Treatment.

vi. If the Insured Person opts out of this benefit during any renewal, the same cannot be opted again.

vii. Once a Claim has been made under this benefit, it will cease to exist and cannot be opted again upon subsequent renewals. The benefit can be utilized upon exhaustion of sequence of utilization of the Sum Insured by the Insured Person at the time of making a Claim during the Policy Year will be as below:

a. Base Sum Insured

b. Cumulative Bonus (if applicable)

c. Endless Sum Insured (if opted)

viii. After utilization of all the above-mentioned Sum Insured, the Total Sum Insured shall be reduced to zero for that Policy Year following the payment of Claim under Endless Sum Insured.

ix. In a given Policy Year, either Endless Sum Insured (if opted) or Restore Benefit (if opted) can be utilised.

x. Benefit 10.1 Voluntary Deductible or benefit 10.2 Voluntary Co-Payment, if opted shall be applicable.

xi. This benefit shall not be applicable to optional covers 3.1(h), 3.2(a to h), 3.3, and to Sections 4, 5,6,7,8,9,10.

3.2(j). Plan Ahead

We shall provide continuity benefit for listed Waiting Periods served by the Policyholder (must be an Insured Person under the Policy) to the newly married spouse or newborn child added during the Policy Period.

i. First 30 days Waiting Period

ii. Specific Illness Waiting Period

iii. Pre-Existing Disease Waiting Period

Provided,

i. This benefit can be opted by the Insured at the time of new Policy inception or at any renewal.

ii. Only newly married spouse(age upto 35 years)/newborn child(maximum 2 living children) can be added to the Policy within 120 days of marriage/birth from the date specified in the marriage certificate/birth certificate, whichever is applicable.

iii. The newly married spouse/child can be added only if the marriage/birth of child has happened after taking this optional cover.

3.3. Maternity and Child Care Cover

3.3(a). Maternity Expenses

We will indemnify towards the Maternity Expenses of female Insured Person in case of normal delivery, routine or elective Caesarean or Maternity related Complications incurred on In-Patient Treatment, up to the limit specified in the Policy Schedule, provided:

i. This benefit is available only to female members between the age group of 18 years to 45 years.

ii. The benefit also covers expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner.

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

iv. The payment under this cover is limited to maximum two deliveries or termination for the female Insured Person covered under this Policy. Those female Insured Persons who are already having two or more children will not be eligible for this benefit.

v. This benefit also covers, covered delivery or termination, Pre-natal In-Patient Treatment Medical Expenses from the date of conception and up to the childbirth and Post-natal Inpatient Treatment Medical Expenses for a period of one month from the date of childbirth or termination shall be covered within the Maternity limit.

vi. For an admissible claim, this benefit also covers the Pre-natal and Post-natal Medical Expenses maximum up to Rs 10000 on OPD basis.

vii. The total of all expenses paid under this benefit shall not exceed the Maternity limit opted and specified in the Policy Schedule.

viii. This benefit waives off the Standard 13.1(o). Maternity (Code-Excl 18) to the extent mentioned under this benefit.

3.3(b). New Born Baby Care

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

Provided that,

i. The Claim under this benefit shall be payable, if We have accepted the Claim under Benefit 3.3(a) Maternity Expenses.

ii. The coverage will be available in respect of a newborn baby for 90 days from the date of delivery.

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

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

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

3.3(c). Child Vaccination

We will indemnify the Reasonable and Customary charges for expenses incurred during the Policy Year on vaccination of the child till he/she completes 12 years of age, provided that

i. The newborn/ child is covered as an Insured Person under the Policy.

ii. This benefit shall cover the charges for the vaccines of the Insured child during the Policy Period which are listed by the Ministry of Health and Family welfare under National Immunization Schedule.

iii. The Claim under this benefit will fall within the Base Sum Insured.

3.3(d). Assisted Reproduction Treatment

We will indemnify the Insured Person up to the limit specified in the Policy Schedule towards Reasonable and Customary charges incurred towards Medically Necessary Treatment related to Assisted Reproduction, during the Policy Year, provided

i. This benefit is applicable to both male and female Insured Person covered under the Policy.

ii. This benefit is available only to Insured members between the age group of 18 years to 45 years.

iii. This benefit shall become available only after the expiry of consecutive and continuous 24 months from the date of opting this benefit by the Insured Person under this Policy.

iv. The Assisted Reproduction Treatment is advised and necessitated by a registered Medical Practitioner.

v. This benefit can be availed once in a Policy Year.

vi. The Insured Person does not have a living child.

vii. The Insured Person cannot conceive by natural ways and is medically certified by the treating Medical Practitioner.

viii. The Medical Expenses also cover reversal of sterilization, Assisted Reproduction services including artificial insemination and advanced reproductive technologies but not limited to IVF, ZIFT, GIFT, ICSI, IUI.

ix. This benefit waives the Standard Exclusion 13.1(n). Sterility and Infertility (Code: Excl17) to the extent mentioned under this benefit.

Section 4 Personal Accident

If this section is opted, then it is mandatory to opt benefit 4.1 Accidental Death (AD) and/or benefit 4.2 Permanent Total Disablement (PTD) under this Policy.

4.1. Accidental Death (AD)

We shall pay lumpsum amount to the Nominee/Legal Heir/Assignee, specified in the Policy Schedule, on Death of the Insured Person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident.

4.2. Permanent Total Disablement (PTD)

We shall pay lumpsum amount to the Insured Person, specified in the Policy Schedule, if an Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident.

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

4.3. Permanent Partial Disablement (PPD)

We shall pay the following percentage of Sum Insured, specified in the Policy Schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

Permanent Partial Disablement (PPD)	Percentage of Sum Insured
The sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.	50%
Use of a hand or a foot without physical separation	50%
Loss of toes – all	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of Hearing - one ear	30%
Loss of four fingers and thumb of one hand	50%
Loss of four fingers of one hand	40%
Loss of thumb - both phalanges	25%
Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%
Loss of index finger – two phalanges	10%
Loss of index finger - one phalanx	5%
Loss of middle finger or ring finger or little finger – three phalanges	10%
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger – one phalanx	3%

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

4.4. Temporary Total Disablement (TTD)

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), We shall pay weekly benefit as specified in the Policy Schedule, till the time the Insured Person is able to return to work, provided that:

i. We shall be liable to make payment under this benefit in respect of the Insured Person, if the Temporary Total Disablement shall exceed the minimum number of 30 days as specified in the Policy Schedule, during the Policy Period.

ii. The compensation under this benefit shall not be payable for more than 104 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Personal Accident Sum Insured.

iii. The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

iv. Once a Claim is admissible and payable under this benefit, at any point of time if the Temporary Total Disablement becomes permanent in nature, and/or Insured Person cannot resume employment, We shall be liable to pay only for the duration till which the disablement was temporary in nature. Once the disablement is established to be permanent in nature, the Insured Person can no longer Claim under this benefit and further payouts will cease.

v. We will deduct any amounts already paid under benefit 4.2 Permanent Total Disablement (PTD) and 4.3 Permanent Partial Disablement (PPD) from the amount payable under this benefit.

vi. On exhaustion of opted limit under TTD, this benefit shall terminate and cease to operate in relation to such Insured Person.

vii. The compensation shall be paid by Us at quarterly intervals, after ascertaining the amount payable. If the period of Temporary Total Disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period.

viii. During the course of payment under this benefit, We shall

have right to call for a certification from an independent Medical Practitioner with regard to the continuity of Temporary Total Disablement specified under this benefit.

ix. The Insured shall notify Us immediately on resuming to his occupation/employment. Where it is found that the Insured resumed to his occupation/employment without notifying to Us and received the compensation under this benefit, We shall have right to claim the recovery of such benefit paid.

x. No Claim shall be payable under this benefit if the period of Temporary Total Disablement does not exceed the Time Excess as specified in the Policy Schedule.

xi. No compensation shall be payable under this Benefit in respect of any Injury to Dependent Children and Dependent Parents/Parents in law.

4.5. Home Modification Benefit

We shall pay lumpsum amount to the Insured Person, specified in the Policy Schedule, if an Insured Person sustains an Injury in an Accident during the Policy Period and incurs expenses towards necessary improvements carried out in the Insured Person's residence certified in writing by a Medical Practitioner following an Accident to adjust to the disablement for which a Claim has been accepted under the Policy, provided:

i. We have accepted a Claim under benefit 4.2 Permanent Total Disablement (PTD)

ii. This benefit will be payable only for expenses incurred within the territory of India and should exclusively benefit the Insured Person.

iii. The alterations to the Insured Person's Home, prompted by losses from an Accident, must be justified by the fact that they were not warranted prior to the Accident date and are a direct result or requirement of the loss occurring during the Policy Period.

iv. The modifications are carried out within three months from the Insured Person's discharge from Hospital.

v. Expenses shall not surpass the standard charges typically associated with similar alterations.

vi. Expenses related to the repair of normal wear and tear, or general renovation shall be excluded.

4.6. Child Education Benefit

We shall pay lumpsum amount to the Nominee/Legal Heir/Assignee , specified in the Policy Schedule for the education of the Insured's Dependent Children, If the Policyholder (must be an Insured Person under the Policy) suffers Accidental Death/ Permanent Total Disablement, solely and directly due to an Accident during the Policy Period, provided that:

i. We have accepted a Claim under benefit 4.1. Accident Death and/or 4.2. Permanent Total Disablement (PTD).

ii. The Dependent child(ren) is under the Age of 25 years and unmarried as on date of Accident.

iii. The Dependent children must be in full time education at an accredited educational institution.

iv. The limit is applicable per member, irrespective of number of Dependent child/ children.

v. In the event of Accidental Death, any Claim under this benefit that becomes admissible where the Dependent child(ren) is a minor, shall be payable to the Legal Heirs.

4.7. Loan Protector Benefit

We shall pay the fixed limit or outstanding loan amount, whichever is lower as specified in the Policy Schedule, if the Policyholder (must be covered as an Insured Person under this Policy) suffers Accidental Death/ Permanent Total Disablement, solely and directly due to an Accident during the Policy Period, provided that:

i. We have accepted a Claim under benefit 4.1 Accident Death (AD) or 4.2. Permanent Total Disablement (PTD).

ii. The loan must be in the name of the Policyholder and from a financial institution.

iii. This benefit will be payable only if the Insured Person has taken loan within the territory of India.

iv. Any overdue and unpaid payments by the primary Insured Person prior to the date of Accident will not be considered for the purpose of this benefit, due to any reasons whatsoever and shall be deemed as paid by the primary Insured Person.

v. Submission of credible evidence is required to confirm that Permanent Total Disablement has completely prevented Insured Person from engaging in their employment or occupation as specified in the Policy Schedule.

vi. This benefit is payable once in lifetime of this Policy.

Specific Conditions applicable to Section 4 Personal Accident:

i. This benefit is available on Individual Sum Insured basis

ii. This benefit is available for 18 years to 65 years of age. Dependent child can be covered from 91 days to 25 years provided either of the parent is covered as an Insured Person under the Policy.

iii. The maximum liability to pay the Claim under this section is limited to Personal Accident Sum Insured specified in the Policy Schedule except for benefit 4.4,4.5,4.6 and 4.7 which are over and above the Personal Accident Sum Insured.

iv. Personal Accident, if opted, shall terminate in the event of a Claim in respect of that Insured Person, becomes admissible and accepted by Us under benefit 4.1. Accidental Death (AD) and/or 4.2 Permanent Total Disablement (PTD). Except if Claim is paid under benefit 4.3. Permanent Partial Disablement, the amount payable for the subsequent Claim/s under any benefit of Personal Accident shall be reduced by the amount/s already paid.

v. In the event of Permanent Total Disablement, the Insured will be under obligation to:

   a. Have himself/herself examined by the Panel Doctors appointed (at the sole discretion of Company) and We will pay the costs involved thereof; Any non-compliance to the same may result in rejection of the Claims.

   b. Registered and Qualified Medical Practitioner providing treatment or giving expert opinion and any other authority to supply Us any information that may be required on the condition of the Insured.

   c. The disablement / death must occur within 12 months of the date of Accident.

vi. In the event of Accidental Death (AD), where Claim payment has been made owing to disappearance of Insured Person following an Accident, if after the payment of Accidental Death claim, it is found that the Insured Person has survived the Accident, then the Policy Holder has to refund the payment back to Us in consideration of the obligatory guarantee as provided during the Claim.

Specific Exclusions applicable to Section 4 Personal Accident:

We shall not be liable to make any payment for any Claim under Personal Accident in respect of any Insured Person, caused by or arising from or in any way attributable to any of the following unless otherwise stated in the Policy:

i. Any Pre-existing condition or Disability or any complication arising therefrom.

ii. Certification by a Medical Practitioner who is a member of the Insured Person's Family.

iii. Benefit under Accidental Death, Permanent Total Disablement and Permanent Partial Disablement arising from Medical or surgical treatment except as necessary solely and directly as a result of an Accident.

iv. An Insured Person flying in an aircraft other than as a fare paying passenger in any scheduled airlines in the world.

v. Insured Persons whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or Professional Sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule

vi. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.

Section 5 OPD Cover

We will indemnify the Insured Person up to the limit specified in the Policy Schedule, for the Medical Expenses incurred during the Policy Year, for OPD treatment of the Insured Person.

For the purposes of this benefit, the Medical Expenses will include:

Consultation	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 centre.
Pharmacy	Drugs and medicines prescribed by a Medical Practitioner
Surgical Treatment	Minor Surgical procedure such as POP, suturing, dressings for Accidents and animal bite related Outpatient procedures etc. carried out by a Medical Practitioner, which are supported with requisite diagnostic results (wherever applicable).
Dental Treatment	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.
Physiotherapy	Fees for medically necessary physiotherapy sessions recommended by the Medical Practitioner.

The benefit is subject to following:

i. This benefit can only be availed by Insured Person(s) up to the age of 65 years.

ii. The Claim for Diagnostic Tests and Pharmacy shall become payable only in relation to an OPD consultation which is payable.

iii. Dental Implants, CAD/CAM restorations and bone graft are not covered.

iv. The benefit is available on an individual basis for individual policies and on floater basis for Family floater policies.

v. Our maximum liability to pay the Claim under this benefit is limited to OPD limit and for the option selected and as specified in the Policy Schedule.

vi. Any unutilized OPD limit shall not be carried forward to next Policy Year.

vii. This benefit shall be available on Cashless basis, wherever the Cashless Facility is unavailable, the bills and receipts can be reimbursed and submitted for reimbursement twice in a Policy Year (if applicable) towards each Policy.

viii. The amount claimed under this benefit is over and above the Base Sum Insured.

ix. OPD Expenses for any Cosmetic/ routine preventive health check-ups / dietary supplements, frames for prescribed lenses or any lenses including contact lenses and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances shall not be covered.

x. If Voluntary Co-Payment is opted, then it shall be applicable on each and every Claim made under this benefit.

Section 6 Global Cover

We will indemnify the Insured Person, up to the limit specified in the Policy Schedule, towards Medically Necessary Expenses incurred for In-Patient Treatment or Day Care Treatment or OPD Treatment including Planned Hospitalization incurred outside India and anywhere across the world, during the Policy Year, provided:

i. This benefit can only be availed by Insured Person(s) up to the age of 65 years.

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

iii. In-Patient Hospitalization, Day Care Procedure or Out-Patient treatment, taken as Emergency Care shall be covered up to the Sum Insured specified in the Policy Schedule, provided the same is critical and cannot be deferred till the Insured Person's return to the Republic of India.

iv. The benefit is available on Reimbursement basis.

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

vi. For Emergency Care, the coverage is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative basis as a whole in a Policy Year.

vii. The coverage under Planned Hospitalization is for the below listed Critical Illness under this benefit.

viii. In case of an addition of any new members to the Policy, a Waiting Period of 24 months shall be applicable under this benefit.

ix. Unlimited Sum Insured shall not be available under this benefit, the maximum liability under this benefit shall be limited to Sum Insured as specified in the Policy Schedule.

x. Section 11 No Claim Bonus, and benefits 3.1(h). Restore Benefit, 3.2(j) Endless Sum Insured and 3.3. Maternity and Child Care Cover will not be available for Global Cover.

xi. Pre and Post Hospitalization expenses shall be excluded under this benefit.

xii. In case of Planned Hospitalization, prior intimation at least 7 days in advance of the travel and due approval from Us will be necessary.

xiii. The onus of procuring all the medical documents /requirements to adjudicate any Claim will be on the Insured Person.

xiv. The Sum Insured under this benefit is over and above the Base Sum Insured.

xv. The Claim payment under this benefit shall be payable in Indian Rupees.

Below is the list of Critical Illness covered under this benefit towards Planned Hospitalization:

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

8	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases: a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and iv. Dyspnea at rest.
9	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases: I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
10	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to: a. Intra cranial Surgery by the route of Burr Hole Procedure or Craniotomy II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a. no response to external stimuli continuously for at least 96 hours; b. life support measures are necessary to sustain life; and c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. d. The condition has to be confirmed by a specialist Medical Practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.
11	Surgery for Pheochromocy -toma	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	Pneumonecto my - 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.

Section 7 Benefit Based Covers

7.1. Critical Illness

We shall pay lump sum amount to the Insured Person/Nominee/Legal Heir/Assignee as specified in the Policy Schedule, if the Insured Person is diagnosed with any of the below listed Critical Illness, during the Policy Period, provided,

i. The Critical Illness for which Insured Person is suffering from occurs or manifest itself during the Policy Period as first incidence.

ii. A Waiting Period of 90 days is applicable at the commencement of the Policy.

iii. This benefit shall terminate in the event of Claim of a covered Critical Illness becoming accepted and paid. In consequence thereof, no other benefit shall be payable under this benefit.

iv. Claims will be payable only if Critical Illness Claim occurs while the cover is in force. A written intimation of Critical Illness Claim should be given within 30 days of incidence of Critical Illness condition, unless otherwise agreed by Us.

v. The Sum Insured under this benefit is over and above the Base Sum Insured.

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

vii. Unlimited Sum Insured shall not be available under this benefit, the maximum liability under this benefit shall be limited to Sum Insured as specified in the Policy Schedule.

Below is the List of Critical Illness

1. Cancer of Specified Severity

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:

1. All tumors which are histologically described as carcinoma in situ, benign, pre- malignant, 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.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. 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;
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3.
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. 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. Myocardial Infarction (First Heart Attack of Specific Severity)

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.

The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

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 breastbone) or minimally invasive keyhole coronary artery bypass procedures. 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.

4. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma of Specified Severity

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.

The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. Kidney Failure Requiring Regular Dialysis

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.

7. Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident produces permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization 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.

The following are excluded:

1. Transient ischemic attacks (TIA).
2. Traumatic Injury of the brain.
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ /Bone Marrow Transplant

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 uses hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

1. Other stem-cell transplants.
2. Where only islets of Langerhans are transplanted.

9. Motor Neuron Disease with Permanent Symptoms

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 and must be present for more than 3 months.

10. Permanent Paralysis of Limbs

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 corticospinal 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 that has persisted for a continuous period of at least 3 months.

7.2. Hospital Daily Cash

We shall pay the Insured an amount equal to the Hospital Daily Cash amount as specified in the Policy Schedule per day of Hospitalization, during the Policy Year, provided:

i. A Deductible of no. of hours (as specified in the Policy Schedule) shall apply under this Benefit; thus, the benefit shall become payable only after the completion of the opted no. of hours of Hospitalization of the Insured Person.

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

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

iv. We have accepted a Claim under benefit 3(a). In-Patient Treatment and/or Section 4 Personal Accident.

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

vi. The payment under this benefit is over and above the Base Sum Insured.

Section 8 Preventive Care

8.1. Health Check Up

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

i. This benefit is available only once in a Policy Year

ii. This benefit shall be available only through pre-designed health packages as per Sum Insured opted. Insured Person will not be able to modify the pre-designed packages.

iii. The pre-defined health check-up packages maybe modified by Us from time to time without prior notice, but the opted Sum Insured will not be changed.

iv. If this benefit is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year and it will be the Insured Person's choice and responsibility to utilize the same with in the designated Policy Year. We shall not be liable to provide any reminders or notifications for the same.

v. In case of an Individual Policy, this benefit shall apply on individual basis and in case of a Floater Policy, this benefit shall apply on floater basis.

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

vii. Availing of Claim under this benefit will not impact the Cumulative Bonus.

viii. This benefit is over and above the Base Sum Insured, if Unlimited Sum Insured is not opted under the Policy.

8.2. E-Opinion

Under this benefit, the Insured Person may avail E-Opinion on his/her medical condition occurring during the Policy Year from a Medical Practitioner from our empanelled network, provided, it is agreed and understood that the E-Opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

i. The Insured Person may have an option to choose E-Opinion from the list of specialists as provided by Us on Our website/app from our empanelled network.

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

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

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

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

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

Section 9 Modifiers

9.1. Reduction in Room Rent Limits

Under this benefit, the Policyholder shall be allowed to opt the Room Rent category Actuals to Single Private A.C Room or Twin Sharing Room for Hospitalization allowable under section 3 of this Policy, if so, requested by the Insured and accepted by Us. The agreed Room Rent category shall be expressly specified in the Policy Schedule.

If the Hospital Room rate is more than the opted Policy's per day limit, then associated medical expenses will be paid in the same proportion of the difference between the approved room rate/ room category and the actual room rate.

9.2. Reduction in Specific Disease Waiting Period

Under this benefit, We will reduce the 24 months Waiting Period for Specific Diseases specified in Section 12, point no.12.2 of this document, to 12 months. Such reduction, if allowed, shall be expressly specified in the Policy Schedule. All other terms and condition of respective Policy section shall remain unaltered.

9.3. Change in PED Waiting Period

Under this benefit, We will change the 24 months Waiting Period for Pre-Existing Diseases (PED) specified in Section 12, point no. 12.1 of this document, to the number of months as opted by You. Such change, if allowed, shall be expressly specified in the Policy Schedule. All other terms and condition of respective Policy section shall remain unaltered.

9.4. Change in Maternity Expenses Waiting Period

Under this benefit, We will reduce the 24 months Waiting Period for Maternity Expenses specified in Section 12, point no.12.4 of this document, to the number of months as opted by You. Such reduction, if allowed, shall be expressly specified in the Policy Schedule. All other terms and condition of

respective Policy section shall remain unaltered.

9.5. Reduction in Global Cover Waiting Period

Under this benefit, We will reduce the 24 months Waiting Period for Global Cover specified in Section 12, point no.12.6. of this document, to the number of months as opted by You. Such reduction, if allowed, shall be expressly specified in the Policy Schedule. All other terms and condition of respective Policy section shall remain unaltered.

Section 10 Voluntary Covers for Discounts

If this Section is opted, then Policyholder can opt either benefit 10.1 or 10.2 under this Policy.

10.1. Voluntary Deductible

Under this benefit, We will provide a discount in the premium, if You Voluntary opts Annual Aggregate Deductible/Per Claim Deductible, as specified in the Policy Schedule. The agreed limits of Deductible shall be expressly specified in the Policy Schedule.

For the purposes of this benefit,

Annual Aggregate Deductible: under this option an annual Aggregate Deductible is applicable. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Year has to exceed the annual Aggregate Deductible as mentioned in the Policy Schedule.

Per Claim Deductible: Under this option Deductible is applicable on per claim basis. For any admissible Claim amount, the Insured Person shall bear an amount equal to the Per Claim Deductible amount as opted and specified in the Policy Schedule.

i. In case of an Individual Policy, the Deductible shall apply on individual basis and in case of a Floater Policy, shall apply on floater basis.

ii. The Voluntary Deductible(if opted) shall not be applicable on Section 3.1(a),3.1(b),3.1(c),3.1(h),3.2(a),3.2(b),3.2(d), 3.2(j),4,5,6, 7,8.

10.2. Voluntary Co-Payment

Under this benefit, the Insured Person will pay the pre-determined percentage, specified in the Policy Schedule,

as Voluntary Co-Payment on each and every Claim made during the Policy Year, provided:

i. Voluntary Co-payment will be applicable on all covers specified in the Policy Schedule unless otherwise agreed by Us.

ii. Voluntary Co-payment will be applied in addition to the existing co-payment if any.

iii. Irrespective of type of Policy, the Co-Payment shall be applicable on each and every Claim incurred under the Policy during the Policy Year.

iii. The Co-Payment shall not be applicable on Section 3.1(a),3.1(b),3.1(c),3.1(h),3.2(a),3.2(b),3.2(d),3.2(j),4,5,6,7,8.

Section 11 No Claim Bonus (Available only with Section 3 Hospitalization Cover)

Under this Section, Policyholder/Insured Person can opt either Benefit 11.1. Cumulative Bonus or Benefit 11.2. Discount in Premium, if no claim has been made under the expiring Policy by any of the covered Insured Person(s).

11.1. Cumulative Bonus

We will provide a percentage of the Base Sum Insured as Cumulative Bonus, at the end of each completed and continuous Policy Year, as specified in the Policy Schedule, provided no claim has been made in the expiring Policy Year.

Specific condition applicable to benefit 11.1. Cumulative Bonus

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

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

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

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

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

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

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

viii. In case of a Claim in any given Policy Year the Cumulative Bonus shall not decrease.

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

x. For a Claim to be admissible under Cumulative Bonus it should be admissible under the Section 3,3.1(d),3.1(e),3.1(f).

xi. The Cumulative Bonus shall not be available if Unlimited Sum Insured option has been opted under this Policy

11.2. Discount in Premium

If opted, We shall provide a percentage of discount in premium, at the time of each renewal of the Policy , provided no claim has been made in the expiring Policy Year.

Section 12 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:

12.1. Pre-Existing Diseases (Code-Excl01):

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

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

iii. If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant

IRDAI (Health Insurance) Regulations, then Waiting Period

for the same would be reduced to the extent of prior coverage.

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

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

i. Expenses related to the treatment of listed Conditions; Surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for Claims arising due to an accident.

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

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

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

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

1. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. Kidney stone, Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/Fistula in anus, Hemorrhoids including
Pilonidal sinus	Gout and Rheumatism
Benign tumors, Cysts, Nodules, Polyps including breast lumps	Osteoarthritis and Osteoporosis
Polycystic ovarian diseases	Fibroids (Fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate
Genetic Disorder	

2. Surgical Procedures

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

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

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

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

iii. The within referred Waiting Period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Note: The above Waiting Period shall not be applicable for Claims arising due to Critical Illness Cover.

12.4. Maternity and Child Care Cover

A Waiting Period of 24 months shall apply for all Claims under the benefit 3.3. Maternity and Child Care Cover.

12.5. Vision Correction

A Waiting Period of 12/24 months (as opted) shall apply for all Claims under the benefit 3.2(h). Vision Correction.

12.6. Global Cover

A Waiting Period of 24 months shall apply to all Claims under the benefit Section 6 Global Cover except for Emergency Care.

12.7. Critical Illness

A Waiting Period of 90 days shall apply to all Claims under the benefit 7.1 Critical Illness

12.8. Bariatric Surgery

A Waiting Period of 24 months shall apply to all Claims under the benefit 3(g). Bariatric Surgery.

Section 13 Exclusions (applicable to all benefits under the Policy)

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

13.1. Standard Exclusions

13.1(a). Investigation & Evaluation (Code: Excl04)

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

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

13.1(b). Rest Cure, rehabilitation and respite care (Code: Excl05)

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

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

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

13.1(c). Obesity/ Weight Control (Code: Excl06): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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

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

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

iv. Body Mass Index (BMI);

a. greater than or equal to 40 or

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

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

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

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

13.1(e). Cosmetic or Plastic Surgery (Code: Excl08):

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

13.1(f). Hazardous or Adventure Sports (Code: Excl09):

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

13.1(g). Breach of law (Code: Excl10):

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

13.1(h). Excluded Providers (Code: Excl11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of

life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete Claim (For updated and detailed list of Excluded Providers refer website- https://www.sbigeneral.in/).

13.1(i). Substance Abuse and Alcohol (Code: Excl12):

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

13.1(j). Wellness and Rejuvenation (Code: Excl13):

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

13.1(k). Dietary Supplements & Substances (Code: Excl14):

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

13.1(l). Refractive Error (Code: Excl15):

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

13.1(m). Unproven Treatments-Code (Code: Excl16):

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

effectiveness.

13.1(n). Sterility and Infertility (Code: Excl17):

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization.

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

iii. Gestational Surrogacy.

iv. Reversal of sterilization.

13.1(o). Maternity (Code-Excl 18):

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.

13.2. Specific Exclusions

13.2(a). An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self-Injury, or attempted suicide while sane or insane.

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

13.2(c). Any Medical Expenses which are not Reasonable and Customary Charges.

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

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

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

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

13.2(h). If as per any or all of the medical references herein below containing guidelines and protocols for evidence-based medicines, the Hospitalization for treatment under Claim is not necessary or the stay at the Hospital is found unduly long:

i. Medical text books,

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

iii. World Health Organization (WHO) protocols,

iv. Published guidelines by healthcare providers,

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

13.2(i). In respect of the existing diseases, disclosed by the Insured and mentioned in the Policy Schedule (based on Insured's consent), Policyholder is not entitled to get the coverage for such specified ICD codes.

13.2(j). Non-payable items: Expenses against Items mentioned in "Annexure II" shall not be payable. This exclusion shall be waived off, if optional benefit 3.1(g). Consumables Cover has been opted under the Policy.

13.2(k). Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other

sequence to the loss, Claim or expense. For the purpose of this exclusion:

i. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

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

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

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

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

13.2(n). Stem cell storage/preservation

13.2(o). Treatment taken outside India, except for Section 6 Global Cover.

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

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

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

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

Section 14 Terms and Clauses (Applicable to all benefits under the Policy)

14.1. Condition Precedent to the contract

14.1(a). Disclosure of Information

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

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

14.1(b). Condition Precedent to Admission of Liability

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

14.1(c). Withdrawal of the Product

i. In the likelihood of this product being withdrawn in future,

the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of Waiting Period as per

IRDAI guidelines, provided the Policy has been maintained without a break.

14.1(d). Premium Payment in Instalment

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

i. Grace Period would be given to pay the instalment premium due for the Policy.

In case of monthly instalment option, a Grace Period of 15 days is applicable. Whereas, in case of Single, Half Yearly, Quarterly instalment options, a Grace Period of 30 days is applicable.

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

iii. The Insured Person will get the accrued continuity benefit in respect of the Sum Insured,

No Claim Bonus, Specific Waiting Periods, Waiting Periods for Pre-existing Diseases, Moratorium period etc in the event of payment of premium within the stipulated Grace Period

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

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

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

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

14.1(e). Possibility of Revision of terms of the Policy including the Premium Rates

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

14.1(f). Nomination

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

14.1(g). Currency

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

14.1(h). Premium

The premium payable under this

Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official

form signed by Our duly authorized official. The due payment of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a Condition Precedent to Our liability to make any payment under this Policy.

14.1(i). Territorial Jurisdiction

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

14.1(j). Terms and conditions of the Policy

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

14.2. Condition Applicable During the Contract

14.2(a). Fraud

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

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

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

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

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

iii. Any other act fitted to deceive; and

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

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

14.2(b). Moratorium Period

After completion of sixty continuous months of coverage (including Portability and Migration) in health insurance Policy, no Policy and Claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy. Wherever, the Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Sums Insured only on the enhanced limits.

14.2(c). Free Look Period

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

ii. In the event a Policyholder disagrees to any of the Policy

terms or conditions, or otherwise and has not made any Claim, he shall have the option to return the Policy to the Insurer for cancellation, stating the reasons for the same.

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

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

14.2(d). Addition of Insured during the Policy Period

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

Option of Mid-term inclusion of a person in the Policy as an Insured will be only upon marriage or childbirth (inclusion of child only if less than 1 year of age), additional differential Premium will be calculated on a pro rata basis. Otherwise, child addition can happen only in next enewal or at the start of next Policy Year in multi-year policies.

14.2(e). Change of Sum Insured

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

14.2(f). Notice and Communication

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

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

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

14.2(g). Automatic change in Coverage under the Policy

i. The coverage for the Insured Person(s) shall automatically terminate: In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the other Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.

ii. Upon exhaustion of Sum Insured and Cumulative Bonus, for the Policy year. However, the Policy is subject to

Renewal on the due date as per the applicable terms and conditions.

14.2(h). Alterations in the Policy

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

14.3. Condition When a Claim Arises

14.3(a). Claim Settlement (provision for Penal Interest)

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

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

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

14.3(b). Complete Discharge

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

14.3(c). Multiple Policies (applicable for Indemnity Section only)

i. Indemnity Policies:

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

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

ii. Benefit based Policies:

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

14.3(d). Records to be Maintained

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

14.3(e). Conditions when a Claim arises

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

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

14.3(f). List of Documents for Claims:-

Section Name	Cover Name	Claim Documents
Hospitalization Cover	In-Patient Treatment Day Care Treatment AYUSH Treatment Domiciliary Hospitalization Pre-Hospitalization Post Hospitalization Bariatric Surgery Cumulative Bonus	1. Duly filled and signed Claim form 2. Medical Practitioner's referral letter advising Hospitalization 3. Certified copy of Hospital Discharge Summary 4. Certified copy of final Hospital bill, pharmacy bills, Investigation labs bills 5. All original reports of Investigations done 6. Ambulance/Cab receipt/ bill 7. Pre and Post consultation bills 8. First Information Report/ Final Police Report, if applicable 9. Postmortem report, if available 10. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in Claim form with KYC Form 11. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc. 12. Certified copy of Death certificate issued by municipal authority (in case of death of insured) 13. KYC details and Documents
Essential Covers	Road Ambulance Air Ambulance Radio Cab Organ Donor Modern Treatments Home Health Care Consumables Cover Restore Benefit	1. Same Documents as mentioned in Section-Hospitalization Cover
Special Covers	Convalescence Companion Cover Adventure Sports Gym and Sports Injury Reconstructive Surgery Prosthetics Gender Reassignment Surgery Vision Correction Endless Sum Insured Plan Ahead	1. Same Documents as mentioned in Section-Hospitalization Cover 2. All consultation bills and prescriptions of Sports Specialist/Medical Practitioner 3. Diagnostic test bills along with copy of reports 4. Physiotherapy bills 5. Travel, food and accommodation proof(bills), if applicable
Maternity and Child Care Cover	Maternity Expenses (including Pre and Post Natal Care) Newborn Baby Care Child Vaccination Assisted Reproduction Treatment	1. Same Documents as mentioned in Section-Hospitalization Cover 2. Medical Practitioner's written recommendation in case of medical termination of pregnancy 3. Newborn baby Vaccination bills and receipts
Personal Accident	Accidental Death (AD) Permanent Total Disablement (PTD) Permanent Partial Disablement (PPD) Temporary Total Disablement (TTD) Home Modification Benefit Child Education Benefit Loan Protector	1. Duly completed and signed Claim Form, in original 2. Death certificate 3. Postmortem report if available and applicable 4. First Information Report/ Final Police Report, MLC (if registered)/ Panchama, wherever applicable 5. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased. 6. Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel of the related speciality 7. Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any 8. Photographs of the Insured Person highlighting the injury / disability 9. Bills for home modification 10. Proof of Full-time education at an accredited Education Institution 11. Loan Disbursement letter and proof of outstanding loan amount.
OPD Cover	OPD Cover	1. Duly completed and signed Claim form 2. All consultation bills 3. Diagnostic test bills along with copy of reports 4. Bills of Surgical Treatment
Global Cover	Global Cover	1. Duly completed and signed Claim Form 2. Passport Copy with Visa Stamp 3. Medical Practitioner's referral letter advising Hospitalization 4. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation 5. Original bills, receipts and discharge card from the Hospital / Medical Practitioner 6. Original bills from pharmacy / chemists 7. Original pathological / diagnostic test reports and payment receipts 8. Indoor case papers 9. First Information Report/ Final Police Report, if applicable 10. Postmortem report, if available
Benefit Based Covers	Critical Illness	1. Same Documents as mentioned in Section-Hospitalization Cover 2. Certified copy of first Hospital consultation & first diagnostic report
	Hospital Daily Cash	1. Same Documents as mentioned in Section-Hospitalization Cover

Preventive Care	Health Check Up Second opinion/ E-Opinion	1. Duly completed and signed Claim Form 2. Health Check up bills and Receipts 3. Consultation Bills
Modifiers	Reduction in Room Rent Limits Reduction in Specific Waiting Period Change in PED Waiting Period Change in Maternity Period Change in Global Waiting Period	1. Same Documents as mentioned in Section- Hospitalization Cover
Voluntary Covers for Discounts	Voluntary Deductible Voluntary Co-Payment	1. Same Documents as mentioned in Section- Hospitalization Cover

Note:

1. Case specific additional documents may be requested if required for justified Claim decision & processing.
2. The Company at its discretion may revise the list of documents mentioned above.
3. Certified copies of document meaning documents attested by any vested authority (e.g. Notarized Documents, attested from Gazetted officer, SBI Branch Manager, Special Executive officer, any officer who is having authority of attestation of documents).

- **Claim Document Submission Address**

  All Claim related documents need to be sent to below address.

  Please do mention appropriate Claim number on Claim documents dispatched.

  Accident & Health Claims team

  SBI General Insurance Company Limited

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

- **Conditions for obtaining Cashless Facility:**

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

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

  iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital

  and locations match with the details as per Cashless authorized.

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

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

- **Claim documents submission:**

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

- **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.

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

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

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

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

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

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

14.3(h). Payment of Claim

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

14.3(i). Sequence of Sum Insured Applicability under Section-3

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

i. Base Sum Insured

ii. Cumulative Bonus (if applicable)

iii. Endless Sum Insured (if opted)/Restore Benefit(if opted)

14.3(j). Overriding effect of the Policy Schedule

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

14.4. Conditions For Renewal of The Contract

14.4(a). Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period etc. in the previous Policy to the Migrated Policy.

For Detailed Guidelines on Migration, kindly refer the link- https://content.sbigeneral.in//uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

14.4(b). Portability

The Insured Person will have the option to port the Policy to other Insurers by applying to such Insurer to port the entire Policy along with all the members of the Family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.

For Detailed Guidelines on Portability, kindly refer the link- https://content.sbigeneral.in//uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

14.4(c). Renewal Conditions:

i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.

ii. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

iii. Renewal shall not be denied on the ground that the Insured Person had made a Claim or Claims in the preceding Policy years.

iv. Request for Renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

v. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

vi. No loading shall apply on Renewals based on individual Claims experience.

14.4(d). Material Change

The Insured Person shall notify the Company in writing of

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

14.5. Conditions for Cancellation of the Contract

14.5(a). Cancellation

Cancellation by you:

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

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

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

Cancellation by Us:

We may cancel the Policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

14.6. Conditions For Grievance Redressal

14.6(a). Redressal of Grievances

Stage 1: Bima Bharosa

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

Stage 2: Head – Customer Care

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

Email: head.customercare@sbigeneral.in

Phone: 1800 102 1111

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

Email: Seniorcitizengrivences@sbigeneral.in

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

Stage 3: Grievance Redressal Officer (GRO)

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

Email: gro@sbigeneral.in

Designation: Grievance Redressal Officer

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

Phone: 022-45138021

Stage 4: Escalation to Insurance Ombudsman

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

Submit your Grievance online:

https://www.cioins.co.in/Ombudsman

Section 15 Illustrations

Illustration 1 - Application of Endless Sum Insured

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

Claim Details			Sum Insured Available			Sum Insured Utilization			Total Claim Amount Paid (in Rs.)	Remarks
Claim No.	Treatment taken for disease/ illness/injury	Claim Amount (in Rs.)	Base Sum Insured (in Rs.)	CB (in Rs.)	Endless Sum Insured (in Rs.)	Base Sum Insured (in Rs.)	Cumulative Bonus (in Rs.)	Endless Sum Insured (in Rs.)		
Claim No.1	Stroke	1,200,000	1,000,000	500,000	Available	1,000,000	200,000	0	1,200,000	10 Lacs will be paid from Base Sum Insured 2 Lacs will be paid from CB
Claim No.2	Accident	500,000	0	300,000	Available	0	300,000	0	300,000	3 lacs paid from balance CB amount and remaining claim amount of Rs. 2 Lacs will be paid by the Insured Person from his pocket.
Claim No.3	Cancer	2,500,000	0	0	Available	0	0	2,500,000	2,500,000	Base Sum Insured and CB has been exhausted therefore, Insured Person is eligible to Claim under Endless Sum Insured and since this benefit can be used in once in lifetime of the Policy. The Insured Person chose to avail the Claim under this benefit being a high-ticket size claim.
Claim No.4	Dengue	100,000	0	0	0	0	0	0	0	All the Sum Insured under the Policy has been exhausted, therefore Insured Person will not get any Claim for the remaining Policy Year.

In the above scenario, total Claim amount is 43 lacs, and Insured Person received 40 lacs from the Policy which also includes high value Claim amount which was above his Base Sum Insured as the Insured Person opted Endless Sum Insured under the Policy.

Illustration 2 - Application of Restore Benefit

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

Claim Details			Sum Insured Available			Sum Insured Utilization			Total Claim Amount Paid (in Rs.)	Remarks
Claim No.	Treatment taken for disease/ illness/injury	Claim Amount (in Rs.)	Base Sum Insured (in Rs.)	CB (in Rs.)	Restore Benefit(in Rs.)	Base SI (in Rs.)	CB (in Rs.)	Restore Benefit(in Rs.)		
Claim No.1	Stroke	900,000	1,000,000	500,000	0	900,000	0	0	900,000	9 Lacs will be paid from Base Sum Insured
Claim No.2	Accident	500,000	100,000	500,000	900,000	100,000	400,000	0	500,000	1 lac paid from Base Sum Insured and 4 lacs from CB.
Claim No.3	Stroke	1,000,000	0	100,000	1,000,000	0	100,000	900,000	1,000,000	Base Sum Insured and CB has been exhausted therefore, Insured Person is eligible to Claim from Restore Benefit which can Claim both for related/unrelated illness or Injury
Claim No.4	Dengue	100,000	0	0	1,000,000	0	0	100,000	100,000	Since Restore can be claimed for related/unrelated illness or Injury, therefore 1 lac is paid from Restore benefit
Claim No.5	Malaria	100,000	0	0	1,000,000	0	0	100,000	100,000	Insured Person has Restore benefit to pay future Claims upto 10 lacs per Claim amount

In the above scenario, the Claim amount was 26 lacs, and Insured Person received 26 lacs from this Policy and for the remaining Policy Year Insured Person has 10 lacs Sum Insured which can be utilized for future Claims.