SURAKSHA AUR BHAROSA DONO

Health Edge Insurance

PROSPECTUS

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

KEY FEATURES OF THE POLICY:

A. Single Comprehensive Plan variant with 9 Basic indemnity Covers and 18 Optional covers to stand in need of medical exigency.

B. Multiple Sum Insured range from 3 Lacs to 25 lacs available under the Policy.

C. Long term Policy options are available up to 3 years.

D. Various discount options like family discount (>=2 members), long term policy discount (will not apply if installment option is opted), Employee Discount (for SBI group)

E. Optional Covers like Wellness Benefit, Domestic Help/Staff Indemnity, Women care cover which includes Maternity benefit, New born baby cover, Assisted Reproduction Treatment and Global Treatment.

F. Flexi benefit option of Co-payment is available to avail discount on premiums.

AGE CRITERIA & ELIGIBILITY:

The Eligibility Criteria, Benefits & Optional Covers mentioned in this Prospectus, form part of the health cover provided under the Policy.

Minimum Entry Age	Proposer: 18 years
	Children: 91 Days to age 30 years
Maximum Entry Age	65 years
Maximum Entry Age for Domestic Help/Staff Indemnity (Optional Cover)	65 years
Sum Insured	3 Lacs, 5 Lacs, 7 Lacs, 10 Lacs, 15 Lacs, 20 Lacs and 25 Lacs
Renewability	Lifelong
Policy Term	1/2/3 Years
Premium Payment Options	Single Premium, Annual, Half-yearly, Quarterly and Monthly
How can You cover Yourself	Individual/Family Floater basis.
	In a family floater Policy, a maximum of 4 adults and any number of dependent children can be included in a single Policy.
Who are covered (Relationship with respect to the Proposer)	Individual: Self, legally married spouse, son, son-in-law, daughter, daughter-in-law, father, mother, brother, brother-in-law, sister, sisterin- law, mother-in-law, father-in law, grandmother, grandfather, grandson, granddaughter, uncle, aunt, nephew, niece, or any other relationship having an insurable interest. Family Floater: Self, legally married spouse, dependent children (natural/legally adopted), Parents and/or Parents-in-law.

SCOPE OF COVER

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

Benefits under the policy:

The benefits available under this Policy are described below:

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

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

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

iv. All claims paid under any benefit except for those admitted under Section D.11 (E-Opinion) shall reduce the Sum Insured for the Policy Year in which the Insured Event in relation to which the claim is made has been occurred, unless otherwise specified in the respective section. Thereafter only the balance Sum Insured after payment of claim amounts admitted shall be available for future claims arising in that Policy Year.

C. HOSPITALIZATION COVERS

C. 1 In-patient Hospitalization Treatment:

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

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

C. 2 Pre-hospitalization Medical Expenses

We will indemnify on Reimbursement basis only, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury for duration of 30 days.

C. 3 Post-hospitalization Medical Expenses

We will indemnify on Reimbursement basis only, the Insured Person's Post-Hospitalization Medical Expenses incurred following an Illness or Injury for duration of 60 days.

C. 4 Day Care Treatment

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

Conditions:

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 more than 2
iii. hours and would also cover treatment taken for Angiography, Dialysis, Radiotherapy or Chemotherapy for cancer.
iv. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Prehospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.2 and C.3.

What is not covered:

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

C. 5 Emergency Road Ambulance Cover (per hospitalization)

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

i. to be transferred to the nearest Hospital in an emergency
II. or from one Hospital to another Hospital
III. or from Hospital to Home

Provided that claim under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.7 (Modern Treatments) C.8 (AYUSH Treatments) is admissible under the Policy.

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

C. 6 Bariatric Surgery Cover

If You are hospitalized on the advice of a Medical Practitioner because of conditions mentioned below which required You to undergo Bariatric Surgery during the Policy Period, then We will pay You, Medical Expenses as listed in Section C.1 related to Bariatric Surgery up to the limit of 50000/-

Eligibility:

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

Body Mass Index (BMI);

A. Greater than or equal to 40 or

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

   I. Obesity-related cardiomyopathy

   II. Coronary heart disease

   III. Severe Sleep Apnea

   IV. Uncontrolled Type 2 Diabetes

Conditions

i. Our maximum liability will be restricted to up to Sublimit mentioned in the Policy Schedule.

ii. Bariatric surgery performed for Cosmetic reasons is excluded.

iii. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured shall obtain prior approval for cashless treatment from the Company.

iv. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

v. Standard Exclusion H. A. III. (Obesity / Weight Control) shall not be applicable to the extent of Sum Insured covered under this benefit.

C. 7 Modern Treatments/Advanced Procedures

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Sections C.1 and C.4 respectively, in a Hospital and not limited to following:

1.	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2.	Balloon Sinuplasty
3.	Deep Brain stimulation
4.	Oral chemotherapy
5.	Immunotherapy- Monoclonal Antibody to be given as injection
6.	Intra vitreal injections
7.	Robotic surgeries
8.	Stereotactic radio surgeries
9.	Bronchial Thermoplasty
10.	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
11.	IONM - (Intra Operative Neuro Monitoring)
12.	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Prehospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections C.2 and C.3

C.8 AYUSH Treatment

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

C.9 Stay Fit Health Check-Up

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

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

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

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

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

v. 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.

vi. Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Booster Benefit (if opted).

What is not covered:

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

D. OPTIONAL COVERS

D. 1 Domestic help/staff Indemnity

On availing of this option, We will indemnify the Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person i.e. Domestic help in this case, during the Policy Period for an Illness, Injury or condition as described in the Section C.1 (Inpatient Hospitalization Treatment), Section C.4 (Day Care Treatment), Section C.8 (AYUSH), Section C.7 (Modern Treatments/Advanced Procedures), Section C.5 (Emergency Road Ambulance Cover) and Section C.6 (Bariatric Surgery Cover) of the base policy and contracted or sustained during the Policy Period

Conditions:

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

II. The Sum Insured under this cover is independent of the Sum Insured of the base policy.

III. This will be an individual coverage.

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

V. The terms and conditions will remain the same as that of covered sections under this optional cover as described in the Section C.1 (Inpatient Hospitalization Treatment), Section C.4 (Day Care Treatment), Section C.8 (AYUSH), Section C.7 (Modern Treatments/Advanced Procedures), Section C.5 (Emergency Road Ambulance Cover) and Section C.6 (Bariatric Surgery Cover)

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

D.2 Hospital Daily Cash benefit

On availing this option, We will pay per day Sum Insured up to maximum Number of days and in manner as specified in the Policy Schedule, if the Medically Necessary Hospitalization exceeds 24 hours, provided that, the claim is admissible under Section C.1(Inpatient Hospitalization Treatment) under this Policy.

Conditions:

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

ii. In case of ICU hospitalization, We will pay per day Sum Insured maximum of 2 times of Hospital Cash Limit as specified in Policy Schedule

iii. Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule irrespective of the type of Policy.

iv. Payment under this benefit will not reduce the Base Sum Insured mentioned in policy Schedule.

v. This cover is on benefit basis and no cashless facility will be extended for this cover.

vi. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

D.3 Accidental Death Cover for Primary Insured

On availing this option, We will pay a lump sum amount as specified in the Policy Schedule to the Primary Insured Person, if he/she suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and which solely and directly results in the Primary Insured Person's death within three hundred and sixty five (365) days from the date of Accident.

I. This cover can be only opted at the inception of the policy

II. The defined Sum Insured in the Policy Schedule will be over and above the Base Sum Insured under Section C.

III. Booster Benefit shall not be applicable on this cover.

Conditions:

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

D.4 Healing Benefit (>5 days of Hospitalization)

We will pay a lump sum amount as specified in the Policy Schedule upon Your Medically Necessary Hospitalization exceeding 5 consecutive and continuous days, provided that, claim is admissible under Section C.1 (Inpatient Hospitalization Treatment) or Section C.8 (AYUSH Treatments)

I. This Benefit is over and above Base Sum Insured

II. This is available per Hospitalization of each Insured Person

III. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

The payment under this benefit will be made if Length of stay per hospitalization is more than 5 days

D.5 Unlimited Refill (Related and Unrelated Illness both)

On availing this option, this benefit is triggered with the first paid claim itself and is available for all subsequent claims in a Policy Year.

Conditions:

I. Single claim under this benefit will be payable up to 100% of Base Sum Insured as specified in the Policy Schedule
II. The sequence of utilization of Sum Insured will be as below: Base Sum Insured followed by; Booster Benefit (if any) followed by; Unlimited Refill
III. Claims under this benefit will be payable only under Section C.1 (Inpatient Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.8 (AYUSH Treatments) arising in that Policy Year for any or all Insured Person(s).
IV. For Family Floater Policies, the amount under this benefit will be available on a floater basis to all Insured Persons in that Policy Year.
V. Anyone Illness clause will not be applicable under this benefit.

D.6 Vector Borne Fixed Benefit

On availing this option, We will pay lump Sum amount as specified in the Policy Schedule under below listed covers on Medically Necessary Hospitalization of Insured Person due to:

1.	Dengue
2.	Malaria
3.	Filaria (Lymphatic Filariasis)
4.	Kala-azar
5.	Chikungunya
6.	Japanese Encephalitis
7.	Zika Virus

i. Claim will be payable subject to fulfilment of the definition of the Vector Borne disease covered, continuous 48 hours of hospitalization due to the covered Vector Borne Diseases as listed above and defined below and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem).
II. This benefit will be provided once in the lifetime of the per Insured Person, irrespective of Individual or Family Floater. The coverage under this benefit shall cease to exist upon occurrence of any one Claim is admitted by the Company.
III. Insured Person shall not bear specified percentage of admissible Claim amount if Co-payment under Section D.15 is opted and specified in the Policy Schedule.
IV. Any Pre-existing illness will not be covered.

D.7 Critical Illness Cover

On availing this option, We will pay a lumpsum amount as specified in the Policy Schedule against this benefit, If the Insured Person who is aged between 18 to 45 years are covered under this Policy suffers from Critical Illness as listed below (defined below this section - Definitions related to Section D.7 – Critical Illness Fixed Benefit), whose diagnosis first occurs after the 90 days Waiting Period from commencement of the first Policy with Us.

List of Serious Illness

Sr. No.	Name of Illness	Sr. No.	Name of Illness
1	Cancer of Specified Severity	31	Progressive Scleroderma
2	Myocardial Infarction (First Heart Attack of Specific Severity)	32	Chronic Adrenal Insufficiency (Addison's Disease)
3	Open Chest CABG	33	Other Serious Coronary Artery Disease
4	Open Heart Replacement or Repair of Heart Valves	34	Severe Rheumatoid Arthritis
5	Coma of Specified Severity	35	Cardiomyopathy
6	Kidney Failure Requiring Regular Dialysis	36	Infective Endocarditis
7	Stroke Resulting in Permanent Symptoms	37	Medullary Cystic Disease
8	Major Organ /Bone Marrow Transplant*	38	Apallic Syndrome
9	Permanent Paralysis of Limbs	39	Creutzfeldt-Jacob Disease (CJD)
10	Motor Neuron Disease with Permanent Symptoms	40	Ebola
11	Multiple Sclerosis with Persisting Symptoms	41	Pneumonectomy
12	Benign Brain Tumor	42	Brain Surgery
13	Blindness	43	Severe Ulcerative Colitis
14	Deafness	44	Chronic Relapsing Pancreatitis
15	End Stage Lung Failure	45	Progressive Supranuclear Palsy
16	End Stage Liver Failure	46	Terminal Illness
17	Loss of Speech	47	Fulminant Hepatitis
18	Loss of Limbs	48	Crohn's Disease
19	Major Head Trauma	49	Bacterial Meningitis
20	Primary (Idiopathic) Pulmonary Hypertension	50	Loss of One Limb and One Eye
21	Third Degree Burns	51	Necrotising Fasciitis
22	Alzheimer's Disease	52	Muscular Dystrophy

23	Parkinson's Disease	53	Hemiplegia
24	Aorta Graft Surgery	54	Poliomyelitis
25	Amputation of Feet Due to Complications from Diabetes	55	Tuberculosis Meningitis
26	Myasthenia Gravis	56	Encephalitis
27	Elephantiasis	57	Myelofibrosis
28	Aplastic Anaemia	58	Pheochromocytoma
29	Loss of Independent Existence (Cover up to Age 74)	59	Systemic Lupus Erythematosus with Lupus Nephritis
30	Dissecting Aortic Aneurysm	60	Eisenmenger's Syndrome

Survival Period

Claim under this Cover is payable only if Insured Person survives 28 days from the diagnosis, fulfilment of the definition of the Critical illness covered and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem)

Condition:

I. The coverage under this benefit shall cease to exist upon occurrence of any one Critical Illness cover for which, Claim is paid by the Company. This benefit will be provided once in the lifetime of the per Insured Person.

II. This optional cover cannot be opted again (by the insured who has claimed under this benefit) in any of the subsequent renewals. The base policy can be renewed continuously even after claim is paid under this benefit for the Insured who has claimed under this benefit.

III. Irrespective of the type of Policy the benefits under this Section shall be available on an individual basis to each Insured Person whose age is between 18 to 45 years, up to the limits specified in the Policy Schedule

IV. Any Pre-existing Critical illness will not be covered.

V. The Sum Insured is independent and over and above of Base Cover

VI. This cover can be only opted at the inception of the policy.

VII. Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

D.8 Claims Safeguard

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

D.9 OPD Cover

On availing this option, We will indemnify the Medical Expenses per member incurred up to the amount specified against this Benefit in the Policy Schedule for the OPD expenses including Diagnostics and Pharmacy, irrespective of type of Policy (floater or individual basis cover

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

Condition:

i. 50% co-payment will be applicable on Professional Fees

ii. 30% co-payment will be applicable on Diagnostics and Pharmacy Expenses to be borne by the Insured

iii. The cover excludes expenses incurred towards Spectacles, Contact Lenses, Physiotherapy, Preventive Tests, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, any type of Dental treatment, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

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

D.10 Booster Benefit

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

Condition:

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

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

iii. Booster Benefit shall be available only if the Policy is renewed/ premium paid within the Grace Period.

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

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

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

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

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

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

x. In case of Mid-term addition in floater policies, the accumulated Booster Benefit will be available among all the Insured Persons including the newly added member on floater basis.

xi. In case of Mid-term addition in Individual policies, the Booster Benefit will be accrued for the newly added member from subsequent renewal

xii. Mid-term addition of member will be allowed up to first 6 months of the policy year only.

D.11 E-Opinion

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

Condition:

i. 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:

ii. You may have option to choose E-Opinion from the list of Specialist as provided by Us on Our Website.

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

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

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

vi. The E-Opinion provided under this benefit shall be limited to the covered Illness and not be valid for any medico legal purposes.

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

Insured Person shall not bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section D.15 is opted and specified in the Policy Schedule.

D.12 Women Care Benefit

D.12.1 Maternity Expenses

On availing this option, We will indemnify the Medical Expenses incurred up to the amount specified against this Benefit in the Policy Schedule for the Maternity Expenses incurred in respect of the Hospitalization of the female Insured Person for the delivery of the child during the Policy Period, subject to a waiting period of 48 months.

Condition:

i. The cover under this benefit shall include Pre-natal and Post-natal medical expenses.

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

iii. The insured person for whom the claim has been made under this benefit has to be the female insured covered under the policy and respective waiting periods as mentioned above shall apply.

iv. Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit except in case of lifethreatening situation under the advice of Medical Practitioner

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

v. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person.

vi. Medical Expenses for ectopic pregnancy are not covered under this Benefit but shall be covered under Section C.1

vii. Pre-natal medical expenses will be covered from the date of confirmation of pregnancy till the delivery and Post-natal medical expenses for a period up to eight (8) weeks after delivery.

D.12.2 New Born Baby Cover

On availing this option, the Company will indemnify up to the Sum Insured amount specified against this Benefit in the Policy Schedule for the Medical Expenses incurred in respect of a New Born Baby subject to mother being covered under the Policy.

Condition:

i. The claim under this benefit shall be payable, if the Company has accepted the claim under Benefit-D.12.1

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

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

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

v. For Family Floater Policies, the amount under this benefit will be available on a floater basis.

vi. For Individual Policies, the amount under this benefit will be available with in Mother's In-patient Hospitalization Treatment cover under section C.1 in that Policy Year.

vii. The waiting period for genetic disorders and internal congenital anomalies shall not apply to new born baby covered under policy

D.12.3 Assisted Reproduction Treatment:

On availing this option, the Company will reimburse medical expenses up to INR 1 Lakh incurred on Assisted Reproduction Treatment, where indicated, for sub-fertility subject to:

Condition:

i. A waiting period of 48 months from the date of first inception of this policy with the Company for the insured person.

ii. Company will pay one Assisted Reproduction Treatment cycle for each eligible Insured Person in a Policy Year.

iii. For the purpose of claiming under this benefit, in- patient treatment is not mandatory.

iv. Exclusion F.A.XIV (ii) will not be applicable under this section.

v. Benefits under this Section shall be available on an individual basis to each eligible Insured Person whose age is between 18 and above up to the limits specified in the Policy Schedule, irrespective of the type of Policy

Special Exclusions:

The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of:

i. Pre and Post treatment expenses

ii. Sub-fertility services that are deemed to be unproven, experimental or investigational

iii. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided.

iv. Reversal of voluntary sterilization

v. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery/ previous deliveries is/are not alive at the time of treatment

vi. Payment for services rendered to a surrogate

vii. Costs associated with cryopreservation and storage of sperm, eggs and embryos

viii. Selective termination of an embryo.

ix. Services done at unrecognized centre

x. Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures

xi. Exclusion F.A.XV of the Policy Terms & Conditions shall be not applicable to Section D.12

xii. This Benefit is over and above Base Sum Insured

D. 13 Global Treatment

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

SR. No.	Name of Illness
1.	Cancer Treatment Surgery
2.	Heart Valve Replacement
3.	Bone Marrow Transplant
4.	Pulmonary Artery Graft Surgery
5.	Aorta Graft Surgery

6.	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction
7.	Surgical Treatment for Stroke
8.	Lung Transplant Surgery in case of End Stage Lung Disease
9.	Kidney Transplant Surgery in case of End Stage Renal Failure
10.	Surgical Treatment of Coma
11.	Surgery for Pheochromocytoma
12.	Liver Transplant Surgery in case of End Stage Liver Disease
13.	Pneumonectomy - Removal of an entire lung
14.	Surgical removal of an eyeball
15.	Heart transplant surgery
16.	Craniotomy for Cerebral Aneurysm

Condition:

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

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

iii. The planned treatment under this cover shall be claimed only on Reimbursement basis only.

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

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

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

vii. Claim amount will be paid in INR in Indian account of the Insured.

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

Section D.5 {Unlimited Refill (Related and Unrelated Illness both)} will not be applicable if claim is admissible under this section.

D.14 Wellness Benefit

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

On availing this option, The Insured Person may avail wellness services as mentioned in the Policy Schedule. The services may include any or all as specified in the policy schedule: Services	**Utilization Parameter (if applicable as per Policy Schedule)**
D.14.1 Health Assistance (A.I. Personal Fitness coaching)	Unlimited
D.14.2 Dietician and Nutrition E-consultation	Unlimited
D.14.3 Unlimited Gym Membership	**Option 1** - Eligible Customer must utilise Gym Services at least once every quarter (3 months periods from policy start date) to activate the next quarter. Once suspended, cannot be activated thereafter. **Option 2** - Eligible Customer must utilise Gym Services at least once in the first 6 months (from policy start date) to activate the next 6 months. Once suspended, cannot be activated thereafter.
D.14.4 Walk Healthy Benefit	Collect health benefits by taking steps counted on our App or Activity tracker of the vendor and get discount up to 30% on renewal premium.

Condition:

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

ii. The above-mentioned optional covers (D.14.1 to D.14.4) can only be opted at inception of the policy and cannot be opted at subsequent renewals.

iii. This cover will be available on optional basis. D 14.1 [Health Assistance (A.I. Personal Fitness coaching)], D14.2[Dietician and Nutrition E-consultation], D14.3 [Unlimited Gym Membership]. Wellness benefit can be availed only as a combination i.e with or without D 14.4[Walk Healthy Benefit]

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

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

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

D.14.4 Conditions Applicable to Walk Healthy Benefit

What is covered: We will offer a discount on Renewal premium if the eligible Insured Person(s) achieves the health points target on the mobile application provided by Us as per the grid mentioned below. Conditions - The above coverage is subject to fulfilment of following conditions:

a. Steps taken by the Insured Person, who is covered as an Adult under the policy, are recorded every day. Steps will be counted by the mobile App which is provided to use ONLY would be considered.

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

c. Note: For long term policies the discount grid as per table no.2 and 3 will be applied.

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

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

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

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

Policy duration	End of 9 months	Steps at the end of 9 months (A) This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on second year of Policy Period (1st Renewal) NOTE: Discount applicable on Individual Policies and on Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
1 Year	End of 9 months	1500000			0%	0%	0%	0%
		1500001- 2250000			5%	2.50%	1.65%	1.25%
		2251000 -3000000			15%	7.50%	5.0%	3.75%
		3000001 - 3750000			20%	10%	6.65%	5.00%
		>=3751000			30%	15%	10.0%	7.50%

Policy duration	End of 21 months	Steps at the end of 21 months (A). This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considered for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium NOTE: Discount applicable on Individual Policies and or Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
Year 1 and 2 (2 years)	End of 21 months	3000000			0%	0%	0%	0%
		3000001 - 4500000			5%	2.50%	1.65%	1.25%
		4500001 - 6000000			15%	7.50%	5.0%	3.75%
		6000001 - 7500000			20%	10%	6.65%	5.00%
		>=7501000			30%	15%	10.0%	7.50%

Policy duration	End of 33 months	Steps at the end of 33 months (A).This will be considered for discount on the first renewal.	Steps in next 3 months (B)	Total Steps considere d for discount (A + B) from 2nd Policy Period onwards	Discount on renewal premium NOTE: Discount applicable on Individual Policies and or Floater Policies			
					1 Adult	2 Adults	3 Adults	4 Adults
Year 1, 2 and 3	End of 33 months	Upto 4500000			0%	0%	0%	0%
		4500001 - 6750000			5%	2.50%	1.65%	1.25%
		6751000 - 9000000			15%	7.50%	5.0%	3.75%
		9000001 - 11250000			20%	10%	6.65%	5.00%
		>=11251000			30%	15%	10.0%	7.50%

D.14 Wellness Benefit

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

Note 1: This co-payment will be additive to any other co-payment in the Policy, if applicable.

Note 2: Co-payment will be applicable under any admissible claim under Section C.1 (In-patient

Hospitalization Treatment) or Section C.4 (Day Care Treatment) or Section C.6 (Bariatric Surgery Cover) or Section C.7 (Modern Treatment/Advanced Procedures) or Section C.8 (AYUSH Treatment).

E. WAITING PERIOD

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

I) First Thirty Days Waiting Period:

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

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than 24 months.

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

Note: The above waiting period shall not be applicable for claims arising due to Critical Illness Cover, Hypertension, Diabetes and Cardiac Condition. Waiting period specific to these ailments are mentioned in E. IV, V.

II) Specified diseases and Procedures Waiting Period:

a) 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.

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

c) If any of the specified disease / procedures falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

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

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

i. Illnesses

Internal Congenital diseases	Non-infective Arthritis
Diseases of gall bladder including cholecystitis	Urogenital system e.g. 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	

ii. Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy
Dilatation and curettage (D&C)	Nasal concha resection
Myomectomy for fibroids	Surgery of Genito urinary system
Surgery on prostate	Cholecystectomy
Hernia	Hydrocele/Rectocele

Surgery for prolapsed inter vertebral disc	Joint replacement surgeries
Surgery for varicose veins and varicose ulcers	Surgery for Nasal septum deviation
Surgery for Perianal Abscesses	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries

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

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

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

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

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

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

V) Critical Illness Cover: : A waiting period of 90 days shall apply for all claims under Crical Illness Benefit.

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

VII) Women Care Benefit: A waiting Period of shall apply for all claims under the Women Care Benefit as Maternity Expenses: 48 months, Assisted Reproduction Treatment: 48 months

F. GENERAL EXCLUSIONS

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

A. Standard Exclusions

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

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

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

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

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

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

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

III. Change of Gender Treatments (Code- Excl 07)

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

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

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

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

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

VI. Breach of Law (Code- Excl 10)

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

VII. Excluded Providers (Code-Excl 11)

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

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

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

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

XI. Refractive Error (Code-Excl 15)

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

XII. Unproven Treatments (Code- Excl 16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment.

Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

XIII. Sterility and Infertility (Code-Excl 17)

Expenses related to sterility and infertility. This includes:

a) Any type of contraception, sterilization

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

c) Gestational Surrogacy

d) Reversal of sterilization

XIV. Maternity (Code-Excl 18) (Not Applicable for Section D.12 – Women Care Benefit)

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

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

B. Specific Exclusions

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

II. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

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

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

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

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

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

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

VI. Vaccination or inoculation except as part of post-bite treatment for animal bite.

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

VIII. Expenses related to Domiciliary hospitalization shall not be covered.

IX. Non-payable items: Expenses against items mentioned in "List I" shall not be payable. This exclusion shall be waived off, if Optional Benefit-D.8 has been opted under the Policy.

X. 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.

XI. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

XII. If as per any or all of the medical references herein below containing guidelines and protocols for evidencebased medicines, the Hospitalization for treatment under claim is not necessary or the stay at the Hospital is found unduly long:

a. Medical text books,

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

c. World Health Organization (WHO) protocols,

d. Published guidelines by healthcare providers,

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

XIII. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person.

Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

G. CONDITIONS

Claim Procedures

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 / Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner Hospital 5. Date and time of event if applicable 6. Date of admission	
Particulars to be provided for preauthorization	1. Policy Number 2. Name of the Insured person(s) named in the Policy schedule availing treatment 3. Nature of disease/Illness/Injury 4. Name and address of the attending 5. Medical Practitioner/ Hospital 6. Date of admission & probable date of discharge 7. Approximate Claim Expenses 8. Treatment Details 9. Claim Form / Pre-Authorization Request form 10. Any other relevant information as required 11. cKYC Form and KYC Documents	Not Applicable
Process for obtaining Pre-Authorization	I. If the particulars are not provided in full or are insufficient for us to consider the request in Predefined Claim Form, We will request additional information or documentation II. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may: • Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or • Reject the request for preauthorization specifying reasons for the rejection.	Not Applicable
List of Documents Procedure for Cashless Claims in case of Home Health Care	Not Applicable On receipt of duly filled pre-authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may: a. Issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or b. Reject the request for pre-authorization specifying reasons for the rejection.	As listed below Not Applicable

- **List of Documents for Reimbursement Claims:**
  1. Duly filled and signed claim form
  2. Certified copy of Hospital discharge Summary
  3. Certified copy of final hospital bill, pharmacy bills, Investigation labs bills
  4. All original reports of Investigations done
  5. Self-attested Copy of PAN card & Aadhar card, photo Id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form with cKYC Form
  6. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc.
  7. Certified copy of Death certificate issued by municipal authority (in case of death of insured)
  8. KYC details and Documents

- **Claim Document Submission Address**

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

  Please do mention appropriate claim number on claim documents dispatched.

  Accident & Health claims team SBI General Insurance Company Limited

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

- **Conditions for obtaining Cashless Facility:**
  - ◊ Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers and empaneled Service providers are available on Our Website and can be obtained by Contacting Our TPA.
  - ◊ 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.
  - ◊ 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.
  - ◊ We will make payment for the Cashless authorized amount directly to the Network Provider.
  - ◊ 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.
- **Claim Assessment**

  We will pay fixed amounts as specified in the applicable Sections in accordance with the terms of this Policy. We are not liable to make any payments that are not specified in the Policy.
- **Condonation of delay:**

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

Standard Condition for Claim Process

Claim Settlement

i. The Company shall settle or reject a claim within 15 days from the date of receipt of claim submission.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of claim submission to the date of payment of claim at a rate 2% above the bank rate.

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

Fraud

If any claim made by the Insured Person, is any respect of fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or

anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

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

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

c) any other act fitted to deceive; and

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

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

Complete Discharge

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

Payment of Claim

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

J. RENEWAL POLICY

1. 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.

2. 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.

K. 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

L. WITHDRAWAL OF THE POLICY

A. 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.

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

M. MORATORIUM PERIOD

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

N. NOMINATION

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

O. TELE UNDERWRITING/ PRE-POLICY MEDICAL CHECKUP

There is no underwriting till 55 years of age. The Company may ask for-Policy Medical Check-up or Tele underwriting on case-to-case basis depending on the declaration provided in the Proposal form.

In case the Insured Person undergoes a medical check-up then 100% cost for such test shall be borne by the Company, where the Proposal is accepted, and Policy is issued.

The cases where the Proposal is rejected, or the Proposer denies the accepted proposal then 100% cost for such tests shall be borne by the Customer.

P. PREMIUM PAYMENT IN INSTALLMENTS

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.

Option	Instalment Premium Option
Option 1	Half yearly
Option 2	Quarterly
Option 3	Monthly
Option 4	Annual
Option 5	Single

Q. REVISION OF TERMS OF PREMIUM RATES AND CHANGE OF SUM INSURED

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

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

Change of Sum Insured

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

R. LOADINGS

i. We may apply a risk loading (additional premium) on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Person, including the health status, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.

ii. The maximum risk loading applicable for an individual shall not exceed above 150% per Insured Person. Loadings will be applied from the Inception Date of the first Policy including subsequent Renewals. There will be no loadings based on individual claims experience on Renewals for the Policies Renewed with Us continuously without any break.

iii. We will inform You about the applicable risk loading through a counteroffer letter and We will only issue the Policy once We receive your consent and applicable additional premium. In case, You neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.

iv. Your Policy shall not be issued unless We receive Your consent.

S. DISCOUNTS

Insured is eligible for discount on premium as below:

Discount Type	Description
Floater discount	2 members = 20% 3 members = 25% > 3 members = 30%
Non-Floater Discount	A discount of 5% for >=2 members
Term Discount	Discount to the Annual Premium: 4% for 2 years & 6% for 3 years
No. of Days of Hospitalization Option	Discount to the Annual Premium: 10% for 5 days & 5% for 10 days

T. CANCELLATION

a) Cancellation by you:

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

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

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

b) Cancellation by Us:

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

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 (3) above.

d) 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

U. 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 5 days, you may escalate the matter to the Grievance Redressal Officer (GRO) which will undergo a detailed case investigation, and we aim to resolve the issue within 7 days from the date of receipt of your Grievance at GRO Desk

Email: gro@sbigeneral.in

Phone: 022-45138021

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

Stage 4: Escalation to Insurance Ombudsman

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

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

V. CONTACT US

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

Contact details for Policy Servicing	Contact details for Claim Servicing
SBI General Insurance Company Limited, **Address:** 9th Floor, Wing A & B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099. **Email:** customer.care@sbigeneral.in ; seniorcitizengrievances@sbigeneral.in (for Senior Citizens) **Toll free number** 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7) **Website:** www.sbigeneral.in **Fax No:** 1800227244, 18001027244	**Accident & Health claims team,** **SBI General Insurance Company Limited,** **Address:** 9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045. **Email:** sbig.health@sbigeneral.in **Toll Free number:** 1800 210 3366, 1800 210 6366 **Website:** www.sbigeneral.in **Fax No:** +91 20 49334525

W. SECTION 41 OF INSURANCE ACT 1938 (PROHIBITIOB OF REBATES)

I. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

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

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

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

DISCLAIMER

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

IRDAI Reg No. 144

Annexure attached to this Prospectus:

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

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any Family member discount)	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	6305	500000	6305	5%	5990	500000	21,502	30%	15,051	5,00,000
30 yrs	6305	500000	6305	5%	5990	500000				
15 yrs	4446	500000	4446	5%	4224	500000				
10 yrs	4446	500000	4446	5%	4224	500000				
Total Premium for all members of the Family is ₹21,502/- when each member is covered separately. Sum Insured available for each individual is ₹5,00,000/-			Total Premium for all members of the Family is ₹20,428/- when they are covered under a single policy. Sum Insured available for each family member is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹15,051/- Sum Insured of ₹5,00,000/- is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading.

Also, the premium rates are exclusive of taxes applicable.

- Family size is considered 4 = 2 Adult + 2 Dependent Child
- Illustration is given for Sum Insured 5 Lac

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.