SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

## CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

| S. NO | TITLE | DESCRIPTION | REFER TO POLICY CLAUSE NUMBER |
|---|---|---|---|
| 1 | **Product Name** | **Arogya Premier Policy** | |
| 2 | **What am I covered for** | **Following are covered as basic cover up to the limit specified in the policy** | IV. Scope of Cover |
| | | 1. Hospitalisation expenses | |
| | | 2. Pre-hospitalisation expenses | |
| | | 3. Post-hospitalisation expenses | |
| | | 4. Day care expenses | |
| | | 5. Ambulance including air ambulance expenses | |
| | | 6. Alternative treatment | |
| | | 7. Domiciliary hospitalisation | |
| | | 8. Maternity Expenses Traceable to Childbirth | |
| | | 9. Organ Donor Expenses | |
| | | 10. Health check up | |
| | | 11. Reinstatement of Sum Insured | |
| | | 12. Cumulative Bonus | |
| | | 13. HIV/AIDS Cover upto the limit Rs. 1,00,000 | |
| | | 14. Mental Illness Cover upto the limit Rs. 1,00,000 | |
| | | 15. Genetic Disorders or Diseases Cover upto the limit Rs. 1,00,000 | |
| | | 16. Internal Congenital Diseases Upto Rs. 10% of Sum Insured. | |
| | | 17. 12 Specific Procedures up to 50% of -of Sum Insured | |
| | | *Note: Insurer's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured for the Insured person as mentioned in the schedule.* | |
| 3 | **What are the major Exclusions in the policy** | Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions: | V. Exclusions |
| | | 1. Admission primarily for investigation & evaluation | |
| | | 2. Admission primarily for rest Cure, rehabilitation and respite care | |
| | | 3. Expenses related to the surgical treatment of obesity that do not fulfill certain conditions | |
| | | 4. Change-of-Gender treatments | |
| | | 5. Expenses for cosmetic or plastic surgery | |
| | | 6. Expenses related to any treatment necessitated due to participation in hazardous or adventure sports | |
| | | 7. Outpatient department treatment | |
| | | | |

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| | | (Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing). | |
| **4** | **Waiting period** | 1. Initial waiting period: 30 days for all illnesses (not applicable on renewal or for accidents) | V. Exclusions |
| | | 2. 90 days for specified disease and procedure | |
| | | 3. Specified surgeries/treatments/diseases are covered after specific waiting period of 12 months | |
| | | 4. Pre-existing diseases: Covered after 48 months unless otherwise provided | |
| | | 5. Maternity Benefit expenses are covered after waiting period of 9 months. | |
| **5** | **Payout basis** | Indemnity basis for covered expenses up to specified sum insured. | IV. Scope of Cover |
| **6** | **Cost sharing** | No cost sharing | |
| **7** | **Renewal Conditions** | The policy shall ordinarily be renewable except on misrepresentation by the insured person. grounds of fraud,<br>i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.<br>ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.<br>iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.<br>iv. 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.<br>v. No loading shall apply on renewals based on individual claims experience | VI. Conditions |
| **8** | **Renewal Benefits** | 1. For every four claim free policy years, free health check up for the insured subject to maximum INR 5000/-<br>2. Cumulative bonus will be allowed at the rate of 10% of expiring Policy's Sum Insured on every renewal of claim free policy. This cumulative bonus can be accumulated up to 50% and will get reduced by 10% in case of claim under the Policy. But accumulated cumulative bonus cannot be negative | IV. Scope of Cover |

<table>
<tr>
<td>9</td>
<td>Cancellation</td>
<td>
Cancellation:<br>
i. The policyholder may cancel this policy by giving 1Sdays'written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.
<table>
<tr><td>Period on risk</td><td>Rate of premium refunded</td></tr>
<tr><td>Up to one month</td><td>75% of annual rate</td></tr>
<tr><td>Up to three months</td><td>50%of annual rate</td></tr>
<tr><td>Up to six months</td><td>25% of annual rate</td></tr>
<tr><td>Exceeding six months</td><td>Nil</td></tr>
</table>
Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.<br>
ii. 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 or misrepresentation, non-disclosure of material facts or fraud.<br>
Cancellation of long term Policies:<br>
If a long term Policy issued with Policy period above 1 year is cancelled, than premium for the year which is fully utilised by insured will be retained in full by the Company. For current year, the premium will be refunded either on short period scale (If cancelled by the Insured) or on prorate basis (If cancelled by the Company). For the year which has not commenced, the premium will be refunded in full. Long term discount allowed on the Policy will be readjusted.
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<td>VI. Conditions</td>
</tr>
<tr>
<td>10</td>
<td>Claims</td>
<td>
a. For Cashless Service:<br>
Refer link for Hospital Network details –<br>
http://www.sbigeneral.in/portal/contact-us/hospital<br>
b. For Reimbursement of Claim: For reimbursement of claims the insured<br>
prescribed time limit as specified hereunder.
<table>
<tr><td>Sl No</td><td>Type of Claim</td><td>Prescribed Time limit</td></tr>
<tr><td>1</td><td>Reimbursement of hospitalization, day care and pre-hospitalization expenses</td><td>Within fifteen days of date of discharge from hospital</td></tr>
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<td>VI. Conditions</td>
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<table>
<tr><td>2</td><td>Reimbursement of post hospitalization expenses</td><td>Within fifteen days from completion of post hospitalization treatment</td></tr>
</table>
For details on claim procedure please refer the policy document.
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<tr>
<td>11</td>
<td>Policy Servicing</td>
<td>
If You/Insured Person may have a grievance that requires to be redressed, You/Insured Person may contact Us with the details of the grievance through:<br>
• Level 1<br>
Call us on our Toll Free for any queries that you may have @ 1800221111, 18001021111<br>
Email your queries to customer.care@sbigeneral.in<br>
Visit our website www.sbigeneral.in to register for your queries<br>
Please walk into any of our branch office or corporate office during business hours<br>
You may also fax us your queries at _1800227244, 18001027244<br>
• Level 2<br>
If you still are not happy about the resolution provided then you may please write to our head.customercare@sbigeneral.in<br>
• Level 3<br>
If you are dissatisfied with the resolution provided in the Steps as indicated above on your Complaint, you may send your ‘Appeal’ addressed to the Chairman of the Grievance Redressal Committee. The Committee will look into the appeal and decide the same expeditiously on merits.<br>
You can write to Head – Compliance, Legal & CS on the id - gro@sbigeneral.in<br>
• Level 4<br>
If your issue remains unresolved you may approach IRDA by calling on the Toll Free no. 155255 or you can register an online complaint on the
</td>
<td>VI. Conditions</td>
</tr>
</table>

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|---|---|---|---|
| | | website http://igms.irda.gov.in<br>• Senior Citizens: Senior Citizens can also write to seniorcitizengrievances@sbigeneral.in<br>If after having followed the above steps you are not happy with the resolution and your issue remains unresolved, you may approach the Insurance Ombudsman for Redressal. | |
| **12** | Grievances/ Complaints | a. Details of Grievance redressal officer - https://www.sbigeneral.in/portal/grievance-redressal<br>b. IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/<br>Insurance Ombudsman — The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document | VI. Conditions |
| **13** | Insured's Rights | 1. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception.<br>2. Right to migrate from one product to another product of the company<br>For Queries related to migration contact below:-<br>Toll free no. – 1800-22-1111<br>Email Id- Customer.care@sbigeneral.in<br>3. Right to port the from one company to another company.<br>For Queries related to portability contact below:-<br>Toll free no. – 1800-22-1111<br>Email Id- Customer.care@sbigeneral.in | VI. Conditions |
| **14** | Insured's Obligations | Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid. | |

Benefit Illustration :

| AROGYA PREMIERE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 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) | | | |
| Age of the members insured | Premium (Rs.) | Sum Insured (Rs.) | Premium (Rs.) | Discount, if any Family member discount) | Premium after Discount (Rs.) | Sum Insured (Rs.) | Premium or consolidated premium for all members of family (Rs.) | Floater discount if any | Premium after discount (Rs.) | Sum Insured (Rs.) |
| 35 yrs | 9385 | 10,00,000 | 9385 | 7.50% | 8681 | 10,00,000 | 9385 | 20% | 26909 | 10,00,000 |
| 30 yrs | 9385 | 10,00,000 | 9385 | 7.50% | 8681 | 10,00,000 | 9385 | | | |
| 15 yrs | 7433 | 10,00,000 | 7433 | 7.50% | 6875.5 | 10,00,000 | 7433 | | | |
| 10 yrs | 7433 | 10,00,000 | 7433 | 7.50% | 6875.5 | 10,00,000 | 7433 | | | |
| Total Premium for all members of the Family is Rs. 33636/- when each member is covered separately. Sum Insured available for each individual is Rs.10,00,000/- | | | Total Premium for all members of the Family is Rs. 31113/- when they are covered under a single policy. Sum Insured available for each family member is Rs. 10,00,000/- | | | | Total Premium when policy is opted on floater basis is Rs. 26909/- Sum Insured of Rs. 10,00,000/- is available for the entire family. | | | |
| Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.<br>The above illustration is for Arogya Premiere Plan.<br>Family size is considered 4 members = 2 A + 2 Dependent Child<br>Illustration is given for Sum Insured 10 Lac<br>please note above rates are exclusive GST. | | | | | | | | | | |

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the Customer Information Sheet and the policy document the terms and conditions mentioned in the policy document shall prevail.

## AROGYA PREMIER POLICY

### I. PREAMBLE

This Policy is issued to the Insured based on the proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, upon payment of the premium to Insurer and the realisation thereof by the Insurer. This Policy records the agreement between Insurer and Insured and sets out the terms of insurance and the obligations of each party.

### II. OPERATIVE CLAUSE

Subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, Insurer undertakes to indemnify the Insured the medical expenses which are medically necessary and mentioned in scope of cover up to the Sum Insured for the Insured as mentioned in the schedule of the Policy.

### III. DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the feminine and vice versa, wherever the context so permits:

1. **Accident**

   An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

   a) Central or State Government AYUSH Hospital or
   b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;

   **Or**

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

      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clocks;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out,
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. **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;

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

4. **Alternative treatments**

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

5. **Any one illness**

Any one illness means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

6. **Cashless facility**

"Cashless facility" means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization approved.

7. **Condition Precedent**

Condition Precedent shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

8. **Congenital Anomaly**

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

**a. Internal Congenital Anomaly**

Congenital anomaly which is not in the visible and accessible parts of the body

**b. External Congenital Anomaly**

Congenital anomaly which is in the visible and accessible parts of the body

This clause shall not apply to any Benefit offered on fixed benefit basis.

9. **Co-payment**

A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/Insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

10. **Cumulative Bonus**

Cumulative Bonus shall mean any increase in the Sum Insured granted by the Insurer without an associated increase in premium.

11. **Day Care Centre**

A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

a. has qualified nursing staff under its employment;

b. has qualified medical practitioner/s in charge;

c. has a fully equipped operation theatre of its own where surgical procedures are carried out;

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

12. **Day Care Treatment**

Day care treatment refers to medical treatment, and/or surgical procedure listed in annexure C which is:

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

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

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

13. **Deductible**

Deductible is 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 daily cash policy which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

Deductible will be applicable as specified under the Policy.

14. **Dental Treatment**

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

15. **Disclosure to information norm**

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of mis-representation, mis-description or non-disclosure of any material fact.

16. **Domiciliary Hospitalisation**

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:

a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

b. the patient takes treatment at home on account of non availability of room in a hospital.

17. **Emergency Care**

Emergency care means management for a severe 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.

18. **Grace Period**

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

19. **Hospital**

A 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 and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has qualified nursing staff under its employment round the clock;

b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

c. has qualified medical practitioner(s) in charge round the clock;

d. has a fully equipped operation theatre of its own where surgical procedures are carried out;

e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

20. **Hospitalisation**

Means admission in a Hospital for a minimum period of 24 In patient Care consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

21. **Illness**

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. **Acute Condition-** Acute condition is a disease, illness 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.

b. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—
2. it needs ongoing or long-term control or relief of symptoms—
3. it requires your rehabilitation or for you to be specially trained to cope with it—
4. it continues indefinitely—
5. it recurs or is likely to recur

22. **Injury**

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

23. **Inpatient Care**

Inpatient care means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.

24. **Intensive Care Unit**

Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

25. **Maternity Expenses**

Maternity expenses shall include—

a. medical treatment expenses traceable to childbirth ( including complicated deliveries and caesarean sections incurred during hospitalization).

b. expenses towards lawful medical termination of pregnancy during the Policy Period.

26. **Medical Advise**

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

27. **Medical expenses**

Medical Expenses means those expenses that an Insured person has necessarily and actually incurred for medical treatment on account of Illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

28. **Medical Practitioner**

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.'

29. **Medically Necessary**

Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

a. is required for the medical management of the illness or injury suffered by the Insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a medical practitioner,

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

30. **Migration"** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

31. **Network Provider**

"Network Provider" means hospitals or health care providers enlisted by an Insurer or by a TPA and Insurer together to provide medical services to an Insured on payment by a cashless facility.

32. **New-born baby**

New-born baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

33. **Non- Network**

Any hospital, day care centre or other provider that is not part of the network.

34. **Notification of Claim**

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

35. **OPD treatment**

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

36. **Portability**

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

37. **Post-hospitalization Medical Expenses**

Post-hospitalization Medical Expenses means medical expenses incurred during predefined

number of days immediately after the insured person is discharged from the hospital provided that:

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

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

insurance company.

38. **Pre-existing Disease means any condition, ailment, injury or disease:**

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

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

39. **Pre-hospitalization Medical Expenses**

Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

40. **Qualified Nurse**

Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

41. **Reasonable and Customary Charges**

Reasonable and Customary charges mean 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 .

42. **Renewal**

Renewal defines 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 **Room Rent**

43. **Room Rent**

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

44. **Surgery or Surgical Procedure**

Surgery or Surgical Procedure 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

45. **Unproven/Experimental treatment**

Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

46. **Administrator**

Administrator means any third party administrator (TPA) engaged by the Insurer for providing policy and claims facilitation services to the Insured as well as to the Insurer and who is duly licensed by IRDA for the said purpose.

47. **Age**

Age means completed years as at the commencement date of the Policy Period.

48. **Diagnostic centre**

Diagnostic centre means the diagnostic centrers which have been empanelled by Insurer (or administrator) as per the latest version of the schedule of diagnostic centrer maintained by Insurer, which is available to Insured on request.

49. **Epidemic disease**

Epidemic disease means a disease which occurs when new cases of a certain disease, in a given human population, and during a given period, substantially exceed what is the normal "expected" incidence rate based on recent experience (the number of new cases in the population during a specified period of time is called the "incidence rate").

50. **Family**

Family means the spouse, dependent children, parents and parents in law.

51. **Family Cover**

a. **"Family floater cover"** means the cover under the Policy which is available in aggregate not separately for all members of family who are specified as Insureds in Policy Schedule and which can be used by all or any of them.

b. **"Family non floater cover"** means the cover under the Policy which is available separately for all members of family who are specified as Insureds in Policy Schedule.

52. **Group**

Group means any association of persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. Non-employer-employee groups, like employee associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add on benefit, borrowers of a bank, professional associations or societies may also be treated as a group. However, an association of persons coming together with a purpose of availing an insurance cover, will not be treated as a group for the purpose of this Policy.

53. **Insured**

Insured means a person named as Insured in the Policy Schedule.

54. **Insurer**

Insurer means SBI General Insurance Company Limited.

55. **Mental illness/ disease**

Mental illness/ disease means any mental disease or bodily condition marked by disorganization of personality, mind, and emotions to impair the normal psychological, social or work performance of the individual regardless of its cause or origin.

56. **Other insurer**

Other insurer means any of the registered insurers in India other than SBI General Insurance Company Limited.

57. **Package service expenses**

Package service expenses means expenses levied by the hospital/nursing home for treatment of specific surgical procedures/medical ailments as a lump sum amount under agreed package charges based on the room criteria as defined in the tariff schedule of the hospital.

58. **Policy**

Policy means the complete documents consisting of the Policy wording, Schedule and endorsements and attachments if any.

59. **Policy Period**

Policy Period means the period commencing with the commencement date of the Policy and terminating with the expiry date of the Policy as stated in the Policy Schedule.

60. **Proposal**

Proposal means application form which the Insured duly fills in and signs for this insurance and any other information Insured provides in the said form or otherwise to Insurer.

61. **Proposer**

Proposer means the person furnishing complete details and information in the proposal form for availing the benefits either for himself and/or towards the person to be covered under the Policy and consents to the terms of the contract of insurance by way of signing the same.

62. **Schedule**

Schedule means that portion of the Policy which sets out Insured's details, the type of insurance cover in force, the Policy Period and the Sum Insured. Any annexure and/or endorsement to the Schedule shall also be a part of the Schedule.

63. **Sum Insured**

Sum Insured means the specified amount mentioned in the Schedule to this Policy which represents the Insurer's maximum liability for any or all claims under this Policy during the currency of the Policy subject to terms and conditions.

64. **Tele-consultation**

means engagement between licensed tele-consultation service provider/ professional and the insured/ covered member that is provided via a range of technology enabled communication media other than face-to-face interactions, such as telephone, internet, and others.

## IV. SCOPE OF COVER

If the Insured suffers an illness/disease and/or injury during the Policy Period, this Policy covers below medical expenses incurred for medical treatment arising out of that illness/disease and/or injury:

1. **Eligible hospitalisation expenses: -** while the Insured was under inpatient care medical expenses incurred for:
    a. Room rent, boarding expenses
    b. Medical practitioners fees(including Teleconsultation )
    c. Intensive care unit
    d. Nursing expenses
    e. Anesthesia, blood, oxygen, operation theatre expenses, surgical appliances, medicines & consumables, diagnostic expenses and x-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, prosthesis/internal implants and any medical expenses incurred which is integral part of the operation
    f. Physiotherapy as inpatient care and being part of the treatment
    g. Drugs, medicines and consumables consumed during hospitalization period.
    h. Diagnostic procedures
    i. Dressing, ordinary splints and plaster casts.
2. **Pre-hospitalisation expenses: -** the maximum amount that can be claimed under this head is limited to 60 days for each of the admitted hospitalisation and domiciliary hospitalization claims under the Policy.
3. **Post-hospitalisation expenses: -** the maximum amount that can be claimed under this head is limited to 90 days for each of the admitted hospitalization and domiciliary hospitalization claims under the Policy.
4. **Day care expenses:** Insurer shall pay for day care expenses incurred on technological surgeries and procedures requiring less than 24 hours of hospitalisation up to the Sum Insured.
5. **Ambulance expenses: - -** Actual ambulance expenses including air ambulance or INR 1,00,000 whichever is lower will be reimbursed for per valid hospitalization claim for transferring insured to or between Hospitals in the Hospital's ambulance or in an ambulance provided by any ambulance service provider
6. **Alternative treatment: -** taken in a government hospital or in any institute recognized by government and/or accredited by quality council of India/national accreditation board on health.
7. **Domiciliary hospitalisation: -** Insurer will cover reasonable and customary charges towards domiciliary hospitalisation including pre and post hospitalization expenses.

    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:

    a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b. the patient takes treatment at home on account of non availability of room in a hospital.
8. **Maternity Expenses: -** Insurer will cover reasonable and customary charges towards maternity expenses during hospitalisation.
9. **Organ donor: -** the medical expenses for an organ donor's treatment for the harvesting of the organ donated including pre and post hospitalization as stated in scope of cover above, provided that:

a. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for the use of the Insured, and

b. Insurer have accepted an inpatient hospitalisation claim under "Inpatient care" as mentioned under "Eligible hospitalisation expenses".

10. **Health check up:** the Insurer will reimburse health check up expenses up to INR.5000/- per Insured, after each 4 consecutive claim free years of policy renewed continuously.

    Entitlement of free health check up will be considered separately for each and every Insured. If claim is made by any of Insured in case of family floater cover, then the Policy Period will not be considered claim free for all of family members.

11. **Reinstatement of Sum Insured: -** the Insurer will reinstate the Sum Insured up to 100% of the basic Sum Insured when the Sum Insured gets reduced due to claim.

12. **Cumulative Bonus: -** cumulative bonus will be allowed at the rate of 10% of expiring Policy's Sum Insured on every renewal of claim free policy. This cumulative bonus can be accumulated up to 50% and will get reduced by 10% in case of claim under the Policy. But accumulated cumulative bonus cannot be negative.

    Entitlement of cumulative bonus will be considered separately for each and every Insured but in case of family floater cover If claim is made by any of Insured, then in the subsequent Policy Period the cumulative bonus will be decreased by 10% of the Sum Insured.

    In case of long term policy cumulative bonus will be allowed or reduced, as the case may be, at the end of every 'policy year'

    Admissibility of certain incidental expenses will be as per Standard List of Excluded expenses in Hospitalisation indemnity policies as per IRDA health Insurance guidelines - Annexure B.

13. HIV/AIDS Cover: We will cover expenses incurred for Inpatient treatment due to any condition caused by or associated with human immunodeficiency virus or variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS upto the Limit Rs.1,00,000 except for the conditions which are permanently excluded

14. Mental Illness Cover: We will cover for the expenses incurred for the inpatient Treatment for any mental illness or psychiatric or psychological ailment / condition upto the limit Rs.1,00,000

15. Genetic Disorders or Diseases are covered up to the Limit Rs. 1,00,000

16. Internal Congenital Diseases are Covered upto the Limit Rs. 10% of Sum Insured.

17. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of -of Sum Insured, specified in the policy schedule, during the policy period:

    A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)

    B. Balloon Sinuplasty

    C. Deep Brain Stimulation

    D. Oral Chemotherapy

    E. Immunotherapy - Monoclonal Antibody to be given as injection

    F. Intra Vitreal Injections

    G. Robotic Surgeries

H. Stereotactic Radio Surgeries

I. Bronchial Thermoplasty

J. Vaporisation of the Prostrate ( Green Laser Treatment or Holmium Laser Treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

## V. EXCLUSIONS: -

Insurer will not pay expenses incurred by the Insured in respect of claims arising out of or howsoever related to any of the following:

### 1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 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 the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

### 2. Specified disease/procedure waiting period- (Code- Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 Days/12 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/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

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

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

f) List of specific diseases/procedures

i. 12 Months waiting Period

- Any types of gastric or duodenal ulcers;
- Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;
- Surgery on all internal or external tumour /cysts/nodules/polyps of any kind including breast lumps;
- All types of Hernia and Hydrocele;

- Anal Fissures, Fistula and Piles;
- Cataract;
- Benign Prostatic Hypertrophy;
- Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;
- Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;
- Surgery of Genitourinary tract;
- Calculus Diseases;
- Sinusitis, nasal disorders and related disorders;
- Gall bladder stones
- Surgery for prolapsed intervertebral disc unless arising from accident;
- Vertebro-spinal disorders (including disc) and knee conditions;
- Surgery of varicose veins and varicose ulcers;
- Chronic Renal failure;
- Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by accidental bodily injury.

ii. 90 Days Waiting Period

- Hypertension, Heart Disease and related complications;
- Diabetes and related complications;

**3. 30-day waiting period- (Code- Excl03 )**

- 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.
- This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Maternity Expenses - Insurer shall not be liable to make any payment under this Policy in connection with or in respect of maternity expenses within first 9 months from the date of inception of the Policy. However this 9 months exclusion would not be applicable in case of continuous renewal within grace period, up to Sum Insured and/or limit under previous policy.
5. Treatment taken outside India.
6. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

7. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

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

9. **Refractive Error: (Code- Excl15)**
   Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

10. **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.

11. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, artificial limbs, dentures, artificial teeth and all other external appliances , prosthesis and/or devices.

12. Expenses incurred on items for personal comfort like television, telephone, etc. Incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital/nursing home.

13. External medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of sleep apnoea syndrome (C.P.A.P), continuous ambulatory peritoneal dialysis (C.A.P.D) and oxygen concentrator for bronchial asthmatic condition.

14. Dental treatment or surgery of any kind unless required as a result of accidental bodily injury to teeth requiring hospitalization treatment.

15. Convalescence, general debility, “run-down” condition, rest cure, i/external congenital anomaly.

16. Intentional self-injury and suicide (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

17. **B*reach 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.

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

19. Venereal disease or any sexually transmitted disease or sickness. (excluding HIV / AIDS as mentioned under scope of cover)

20. Outpatient department treatment

21. **Sterility and Infertility: (Code- Excl17)**
    Expenses related to sterility and infertility this includes:
    i. Any type of 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

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

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

24. Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury.

25. Medical practitioner's home visit expenses during pre and post hospitalization period, attendant nursing expenses.

26. **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 Outpatient department treatment

27. **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.

28. Stay in a hospital without undertaking any active regular treatment by the medical practitioner, which ordinarily cannot be given without hospitalization.

29. Expenses incurred at hospital or nursing home primarily for diagnosis irrespective of 24 hours hospitalization without diagnosis of any disease which does require any follow up treatment covered under this policy.

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

31. **Rest Cure, rehabilitation and respite care (Code- Excl05)**

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

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

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

32. **Investigation & Evaluation (Code- Excl04)**

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

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

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

34. **Obesity/ Weight Control: (Code- Excl06)**

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities

following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apn
iv. Uncontrolled Type2 Diabetes

35. **Unproven Treatments: (Code- Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

36. Disease / illness or injury whilst performing duties as a serving member of a military or police force.

37. Any kind of, surcharges, admission fees / registration charges etc levied by the hospital.

38. 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.

## VI. CONDITIONS PRECEDENT: -

1. **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.

2. **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 ofany 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)

3. **Due care:** where this Policy requires Insured to do or not to do something, then the complete satisfaction of that requirement by the Insured or someone claiming on Insured's behalf is a condition precedent to any obligation under this Policy. If the Insured or someone claiming on Insured's behalf fails to completely satisfy that requirement, then Insurer may refuse to consider Insured's claim. Insured will cooperate with Insurer at all times.

4. **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 may be, 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.

5. **Free look period**

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

6. **Notices:** Any notice, direction or instruction under this Policy shall be in writing and if it is to:

   a. Any Insured, then it shall be sent to Proposer's address specified in the Schedule to this Policy and Proposer shall act for all Insureds for these purposes.

   b. Insurer, it shall be delivered to Insurer's address specified in the Schedule to this Policy. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Insurer's behalf unless Insurer has expressly stated to the contrary in writing.

   Insured must notify Insurer of any change in address.

7. **Mis-description: -** this Policy shall be void and premium paid shall be forfeited to Insurer in the event of misrepresentation, mis-description or non-disclosure of any materials facts pertaining to the proposal form, written declarations or any other communication exchanged for the sake of obtaining the insurance policy by the Insured. Non-disclosure shall include non-intimation of any circumstances which may affect the insurance cover granted. The misrepresentation, mis-description and non-disclosure is related to the information provided by the proposer/Insured to the Insurer at any point of time starting from seeking the insurance cover in the form of submitting the filled in Proposal form, written declarations or any other communication exchanged for the sake of obtaining the insurance policy and ends only after all the contractual obligations under the Policy are exhausted for both the parties under the contract.

8. **Reasonable Care:** We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured had taken reasonable care, or that is brought about or contributed to by the Insured failing to follow the directions, advice or guidance provided by a Medical Practitioner.

9. **Package service expenses:** as defined under the Policy will be payable only if prior approval for the said package service is provided by administrator / Insurer upon the request of the Insured.

10. **Unhindered access:** the Insured shall extend all possible support & co-operation including necessary authorisation to the Insurer for accessing the medical records and medical practitioners who have attended to the patient.

11. **Claims Procedures :**

    **a. Claims Procedure for Reimbursement :**

    i. The Insured shall without any delay consult a doctor and follow the advice and treatment recommended, take reasonable steps to minimize the quantum of any claim that might be made under this Policy and intimation to this effect must be forwarded to administrator accordingly.

    ii. The Insured must provide intimation to administrator immediately and in any event within 48 hours from the date of Hospitalisation. However the administrator at his sole discretion may relax this condition subject to a justifiable reason/evidence being produced by the Insured on the reasons for such a delay beyond the stipulated 48 hours up to a maximum period of 7 days.

    iii. The Insured has to file the claim with all necessary documentation within 15 days of discharge from the hospital, provide administrator with written details of the quantum of any claim along with all the original bills, receipts and other documents upon which a claim is based and shall also give

administrator such additional information and assistance as administrator may require in dealing with the claim. In case of delayed submission of claim and in absence of a justified reason for delayed submission of claim, the administrator would have the right of not considering the claim for reimbursement.

iv. In respect of post hospitalization claims, the claims must be lodged within 15 days from the completion of post hospitalisation treatment subject to maximum of 105 days from the date of discharge from hospital.

v. The Insured shall submit himself for examination by the administrator's medical advisors as often as may be considered necessary by the administrator for establishing the liability under the Policy. The administrator will reimburse the amount towards the expenses incurred for the said medical examination to the Insured.

vi. The Insured must submit all original bills, receipts, certificates, information and evidences from the attending medical practitioner /hospital /diagnostic laboratory as required by administrator.

vii. On receipt of intimation from the Insured regarding a claim under the Policy, administrator is entitled to carry out examination and obtain information on any alleged Injury or disease requiring hospitalisation if and when Insurer may reasonably require.

**b. Claims procedure for Cashless:**

i) Prior to taking treatment and/or incurring medical expenses at a network hospital, Insured must call administrator and request pre-authorisation by way of the written form administrator will provide.

ii) After considering Insured's request and after obtaining any further information or documentation administrator has sought, administrator may if satisfied send Insured or the network hospital, an authorisation letter. The authorisation letter, the ID card issued to Insured along with this Policy and any other information or documentation that administrator has specified must be produced to the network hospital identified in the pre-authorisation letter at the time of Insured's admission to the same.

iii) If the procedure above is followed, Insured will not be required to directly pay for the medical expenses in the network hospital that Insurer is liable to indemnify under cover IV.1 above and the original bills and evidence of treatment in respect of the same shall be left with the network hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. administrator reserves the right to review each claim for medical expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. Insured will, in any event, be required to settle all other expenses directly.

**c. Claims Submission:**

The Insured will submit the claim documents to administrator. Following is the document list for claim submission:

i) Duly filled Claim form,

ii) Valid Photo Identity Card, residence proof and 2 recent photos of Insured and/or his nominee.

iii) Original Discharge card/certificate/ death summary

iv) Copies of prescription for diagnostic test, treatment advise, medical references

v) Original set of investigation reports

vi) Itemized original hospital bill and receipts Hospital and related original medical expense receipt Pharmacy bills in original with prescriptions

**d. Claims processing:** on receipt of claim documents from Insured, administrator shall assess the

admissibility of claim as per policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of claim as per the contract only in Indian Rupees and within India only. In case if the claim is repudiated Insurer will inform the claimant about the same in writing with reason for repudiation.

**e. Penal interest provision:**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2%bove the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

**f. Position after a claim:** As from the day of receipt of the claim amount by the Insured, the Sum Insured for the remainder of the Policy Period shall stand reduced by a corresponding amount.

12. **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 pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured
person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge
or belief of the fact;
c) any other act fitted to deceive; and

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

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

13. **Nomination:** The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no

subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

**14. Multiple Policies**

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

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

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

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

15. **Cancellation:**

i. The policyholder may cancel this policy by giving 1Sdays'written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

| Period on risk | Rate of premium refunded |
|---|---|
| Up to one month | 75% of annual rate |
| Up to three months | 50%of annual rate |
| Up to six months | 25% of annual rate |
| Exceeding six months | Nil |

Notwithstanding anything contained herein or otheruise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

**ii.** 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 or misrepresentation, non-**disclosure of material facts or fraud.**

**Cancellation of long term Policies:**

If a long term Policy issued with Policy period above 1 year is cancelled, than premium for the year which is fully utilised by insured will be retained in full by the Company. For current year, the premium will be refunded either on short period scale (If cancelled by the Insured) or on prorate basis (If cancelled by the Company). For the year which has not commenced, the premium will be refunded in full. Long term discount allowed on the Policy will be readjusted.

16. **Termination of Policy:** this Policy terminates on earliest of the following events-

a. Cancellation of Policy as per the cancellation provision.

b. On the Policy expiry date.

17. **Arbitration & Conciliation:** if any dispute or difference shall arise as to the quantum to be paid under this Policy ( liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the arbitration and conciliations act 1996.

    It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore provided, if the Insurer has disputed or not accepted liability under or in respect of this Policy.

    It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

    The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.

18. **Renewal**

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

    I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
    II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
    III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
    IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
    V. No loading shall apply on renewals based on individual claims experience.

19. **Withdrawal of 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.

**20. 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 policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link

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

21. **Portability:**

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link .

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

22. **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.

23. Moratorium Period

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

24. **Disclaimer:** if Insurer shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify Insurer in writing that he does not accept such disclaimer and intends to recover his claim from Insurer then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

25. **Jurisdiction: -** The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Insurer, which approval shall be evidenced by an endorsement on the Schedule.

    The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

26. **Loading and Discount: -**In case family is covered on floater basis maximum 20% discount will be given. Maximum 7.5% discount will also be given for long term policy and to cover family on non floater basis. Premium will be loaded by 5% each for habit of smoking, alcohol and any other type of tobacco including betel nut in any form.

27. **Tax Relief under Income-Tax Act:** deduction under Income -Tax Act will be allowed on premium and amount eligible of deduction under Income-Tax Act is separately specified in Policy Schedule.

28. **Redressal of Grievance**

    In case of any grievance the insured person may contact the company through

    Website: www.sbigeneral.in

Toll free: 1800 22 1111 / 1800 102 1111 Monday to Saturday (8 am - 8 pm).

E-mail: customer.care@sbigeneral.in

Fax : 1800 22 7244 / 1800 102 7244

Courier:

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at gro@sbigeneral.in

For updated details of grievance officer, kindly refer the link https://www.sbigeneral.in/portal/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods**,** the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

| **Office of Insurance the Ombudsman** | **Areas of Jurisdiction** |
|---|---|
| AHMEDABAD - Shri Kuldip Singh<br>Office of the Insurance Ombudsman,<br>Jeevan Prakash Building, 6th floor,<br>Tilak Marg, Relief Road,<br>Ahmedabad – 380 001.<br>Tel.: 079 - 25501201/02/05/06<br>Email: bimalokpal.ahmedabad@ecoi.co.in | Gujarat, Dadra & Nagar Haveli,Daman and Diu. |
| BENGALURU - Smt. Neerja Shah<br>Office of the Insurance Ombudsman,<br>Jeevan Soudha Building,PID No. 57-27-N-19<br>Ground Floor, 19/19, 24th Main Road,<br>JP Nagar, Ist Phase,<br>Bengaluru – 560 078.<br>Tel.: 080 - 26652048 / 26652049<br>Email: bimalokpal.bengaluru@ecoi.co.in | Karnataka. |
| BHOPAL - Shri Guru Saran Shrivastava<br>Office of the Insurance Ombudsman,<br>JanakVihar Complex, 2nd Floor,<br>6, Malviya Nagar, Opp. Airtel Office,<br>Near New Market,<br>Bhopal – 462 003.<br>Tel.: 0755 - 2769201 / 2769202<br>Fax: 0755 - 2769203<br>Email: bimalokpal.bhopal@ecoi.co.in | Madhya Pradesh, Chhattisgarh. |

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|---|---|
| BHUBANESHWAR - Shri Suresh Chnadra Panda<br>Office of the Insurance Ombudsman,<br>62, Forest park,<br>Bhubneshwar – 751 009.<br>Tel.: 0674 - 2596461 /2596455<br>Fax: 0674 - 2596429<br>Email: bimalokpal.bhubaneswar@ecoi.co.in | Orissa. |
| CHANDIGARH - Dr. Dinesh Kumar Verma<br>Office of the Insurance Ombudsman,<br>S.C.O. No. 101, 102 & 103, 2nd Floor,<br>Batra Building, Sector 17 – D,<br>Chandigarh – 160 017.<br>Tel.: 0172 - 2706196 / 2706468<br>Fax: 0172 - 2708274<br>Email: bimalokpal.chandigarh@ecoi.co.in | Punjab,Haryana,<br>Himachal Pradesh,<br>Jammu & Kashmir,<br>Chandigarh. |
| CHENNAI - Shri M. Vasantha Krishna<br>Office of the Insurance Ombudsman,<br>Fatima Akhtar Court, 4th Floor, 453,<br>Anna Salai, Teynampet,<br>CHENNAI – 600 018.<br>Tel.: 044 - 24333668 / 24335284<br>Fax: 044 - 24333664<br>Email: bimalokpal.chennai@ecoi.co.in | Tamil Nadu,<br>Pondicherry Town and<br>Karaikal (which are part of UT of Pondicherry). |
| DELHI - Shri Sudhir Krishna<br>Office of the Insurance Ombudsman,<br>2/2 A, Universal Insurance Building,<br>Asaf Ali Road,<br>New Delhi – 110 002.<br>Tel.: 011 - 23232481/23213504<br>Email: bimalokpal.delhi@ecoi.co.in | Delhi. |
| GUWAHATI - Shri Kiriti .B. Saha<br>Office of the Insurance Ombudsman,<br>Jeevan Nivesh, 5th Floor,<br>Nr. Panbazar over bridge, S.S. Road,<br>Guwahati – 781001(ASSAM).<br>Tel.: 0361 - 2632204 / 2602205<br>Email: bimalokpal.guwahati@ecoi.co.in | Assam, Meghalaya,<br>Manipur, Mizoram,<br>Arunachal Pradesh,<br>Nagaland and Tripura. |

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| HYDERABAD - Shri I. Suresh Babu<br>Office of the Insurance Ombudsman,<br>6-2-46, 1st floor, "Moin Court",<br>Lane Opp. Saleem Function Palace,<br>A. C. Guards, Lakdi-Ka-Pool,<br>Hyderabad - 500 004.<br>Tel.: 040 - 67504123 / 23312122<br>Fax: 040 - 23376599<br>Email: bimalokpal.hyderabad@ecoi.co.in | Andhra Pradesh,<br>Telangana,<br>Yanam and<br>part of Territory of UT of Pondicherry. |
| JAIPUR - Smt. Sandhya Baliga<br>Office of the Insurance Ombudsman,<br>Jeevan Nidhi – II Bldg., Gr. Floor,<br>Bhawani Singh Marg,<br>Jaipur - 302 005.<br>Tel.: 0141 - 2740363<br>Email: Bimalokpal.jaiur@ecoi.co.in | Rajasthan. |
| ERNAKULAM - Ms. Poonam Bodra<br>Office of the Insurance Ombudsman,<br>2nd Floor, Pulinat Bldg.,<br>Opp. Cochin Shipyard, M. G. Road,<br>Ernakulam - 682 015.<br>Tel.: 0484 - 2358759 / 2359338<br>Fax: 0484 - 2359336<br>Email: bimalokpal.ernakulam@ecoi.co.in | Kerala, UT of (a) Lakshadweep, (b)<br>Mahe-a part of UT of Pondicherry. |
| KOLKATA - Shri P. K. Rath<br>Office of the Insurance Ombudsman,<br>Hindustan Bldg. Annexe, 4th Floor,<br>4, C.R. Avenue,<br>KOLKATA - 700 072.<br>Tel.: 033 - 22124339 / 22124340<br>Fax : 033 - 22124341<br>Email: bimalokpal.kolkata@ecoi.co.in | West Bengal,<br>Sikkim,<br>UT of Andaman & Nicobar Islands. |
| LUCKNOW -Shri Justice Anil Kumar Srvastava<br>Office of the Insurance Ombudsman,<br>6th Floor, Jeevan Bhawan, Phase-II,<br>Nawal Kishore Road, Hazratganj,<br>Lucknow - 226 001.<br>Tel.: 0522 - 2231330 / 2231331<br>Fax: 0522 - 2231310<br>Email: bimalokpal.lucknow@ecoi.co.in | Districts of Uttar Pradesh :<br>Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar. |
| MUMBAI - Shri Milind A. Kharat<br>Office of the Insurance Ombudsman,<br>3rd Floor, Jeevan SevaAnnexe,<br>S. V. Road, Santacruz (W), | Goa,<br>Mumbai Metropolitan Region<br>excluding Navi Mumbai & Thane. |

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|---|---|
| Mumbai - 400 054.<br>Tel.: 022 - 26106552 / 26106960<br>Fax: 022 - 26106052<br>Email: bimalokpal.mumbai@ecoi.co.in | |
| NOIDA - Shri Chandra Shekhar Prasad<br>Office of the Insurance Ombudsman,<br>BhagwanSahai Palace<br>4th Floor, Main Road,<br>Naya Bans, Sector 15,<br>Distt: Gautam Buddh Nagar,<br>U.P-201301.<br>Tel.: 0120-2514250 / 2514252 / 2514253<br>Email: bimalokpal.noida@ecoi.co.in | State of Uttaranchal and the following Districts of Uttar Pradesh:<br>Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur. |
| PATNA - Shri N. K. Singh<br>Office of the Insurance Ombudsman,<br>1st Floor,Kalpana Arcade Building,,<br>Bazar Samiti Road,<br>Bahadurpur,<br>Patna 800 006.<br>Tel.: 0612-2680952<br>Email: bimalokpal.patna@ecoi.co.in | Bihar,<br>Jharkhand. |
| PUNE - Shri Vinay Sah<br>Office of the Insurance Ombudsman,<br>Jeevan Darshan Bldg., 3rd Floor,<br>C.T.S. No.s. 195 to 198,<br>N.C. Kelkar Road, Narayan Peth,<br>Pune – 411 030.<br>Tel.: 020-41312555<br>Email: bimalokpal.pune@ecoi.co.in | Maharashtra,<br>Area of Navi Mumbai and Thane<br>excluding Mumbai Metropolitan Region. |

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

**Annexure B**

List I — Items for which coverage is not available in the policy

| Sr No | Item |
|---|---|
| 1 | BABY FOOD |
| 2 | BABY UTILITIES CHARGES |
| 3 | BEAUTY SERVICES |
| 4 | BELTS/ BRACES |
| 5 | BUDS |

| | |
|---|---|
| 6 | COLD PACK/HOT PACK |
| 7 | CARRY BAGS |
| 8 | EMAIL / INTERNET CHARGES |
| 9 | FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) |
| 10 | LEGGINGS |
| 11 | LAUNDRY CHARGES |
| 12 | MINERAL WATER |
| 13 | SANITARY PAD |
| 14 | TELEPHONE CHARGES |
| 15 | GUEST SERVICES |
| 16 | CREPE BANDAGE |
| 17 | DIAPER OF ANY TYPE |
| 18 | EYELET COLLAR |
| 19 | SLINGS |
| 20 | BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES |
| 21 | SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED |
| 22 | Television Charges |
| 23 | SURCHARGES |
| 24 | ATTENDANT CHARGES |
| 25 | EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) |
| 26 | BIRTH CERTIFICATE |
| 27 | CERTIFICATE CHARGES |
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CERTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPIES CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING AIDS CHARGES |
| 35 | OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) |
| 36 | SPACER |
| 37 | SPIROMETRE |
| 38 | NEBULIZER KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/ SHORT/ HINGED) |
| 46 | KNEE IMMOBILIZER/SHOULDER IMMOBILIZER |
| 47 | LUMBO SACRAL BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |

| | |
|---|---|
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES |
| 53 | SUGAR FREE Tablets |
| 54 | CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |
| 58 | ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC] |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |
| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |

List II— Items that are to be subsumed into Room charges

| **Sl No** | **Item** |
|---|---|
| 1 | BABY CHARGES (UNLESS SPECIFIED/INDICATED) |
| 2 | HAND WASH |
| 3 | SHOE COVER |
| 4 | CAPS |
| 5 | CRADLE CHARGES |
| 6 | COMB |
| 7 | EAU-DE-COLOGNE / ROOM FRESHNERS |
| 8 | FOOT COVER |
| 9 | GOWN |
| 10 | SLIPPERS |
| 11 | TISSUE PAPER |
| 12 | TOOTH PASTE |
| 13 | TOOTH BRUSH |
| 14 | BED PAN |

| | |
|---|---|
| 15 | FACE MASK |
| 16 | FLEXI MASK |
| 17 | HAND HOLDER |
| 18 | SPUTUM CUP |
| 19 | DISINFECTANT LOTIONS |
| 20 | LUXURY TAX |
| 21 | HVAC |
| 22 | HOUSE KEEPING CHARGES |
| 23 | AIR CONDITIONER CHARGES |
| 24 | IM IV INJECTION CHARGES |
| 25 | CLEAN SHEET |
| 26 | BLANKET/WARMER BLANKET |
| 27 | ADMISSION KIT |
| 28 | DIABETIC CHART CHARGES |
| 29 | DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES |
| 30 | DISCHARGE PROCEDURE CHARGES |
| 31 | DAILY CHART CHARGES |
| 32 | ENTRANCE PASS / VISITORS PASS CHARGES |
| 33 | EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE |
| 34 | FILE OPENING CHARGES |
| 35 | INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED) |
| 36 | PATIENT IDENTIFICATION BAND / NAME TAG |
| 37 | PULSEOXYMETER CHARGES |

List III. Items that are subsumed into procedure charges.

| **Sl No.** | **Item** |
|---|---|
| 1 | HAIR REMOVAL CREAM |
| 2 | DISPOSABLES RAZORS CHARGES (for site preparations) |
| 3 | EYE PAD |
| 4 | EYE SHEILD |
| 5 | CAMERA COVER |
| 6 | DVD, CD CHARGES |
| 7 | GAUSE SOFT |

| | |
|---|---|
| 8 | GAUZE |
| 9 | WARD AND THEATRE BOOKING CHARGES |
| 10 | ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS |
| 11 | MICROSCOPE COVER |
| 12 | SURGICAL BLADES, HARMONICSCALPEL,SHAVER |
| 13 | SURGICAL DRILL |
| 14 | EYE KIT |
| 15 | EYE DRAPE |
| 16 | X-RAY FILM |
| 17 | BOYLES APPARATUS CHARGES |
| 18 | COTTON |
| 19 | COTTON BANDAGE |
| 20 | SURGICAL TAPE |
| 21 | APRON |
| 22 | TORNIQUET |
| 23 | ORTHOBUNDLE, GYNAEC BUNDLE |

List IV— Items that are to be subsumed into Cost of Treatment

| **Sl No.** | **Item** |
|---|---|
| 1 | ADMISSION/REGISTRATION CHARGES |
| 2 | HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE |
| 3 | URINE CONTAINER |
| 4 | BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES |
| 5 | BIPAP MACHINE |
| 6 | CPAP/ CAPD EQUIPMENTS |
| 7 | INFUSION PUMP– COST |
| 8 | HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC |
| 9 | NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES |
| 10 | HIV KIT |

| | |
|---|---|
| 11 | ANTISEPTIC MOUTHWASH |
| 12 | LOZENGES |
| 13 | MOUTH PAINT |
| 14 | VACCINATION CHARGES |
| 15 | ALCOHOL SWABES |
| 16 | SCRUB SOLUTION/STERILLIUM |
| 17 | Glucometer& Strips |
| 18 | URINE BAG |

**Annexure C - Day Care List**

The following are the listed Day care procedures and such other Surgical Procedures that necessitate less than 24 hours Hospitalisation due to medical/technological advancement/ infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the policy

Microsurgical operations on the middle ear

1. Stapedectomy
2. Revision of a stapedectomy
3. Other operations on the auditory ossicles
4. Myringoplasty (Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain

10. Incision of the mastoid process and middle ear
11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

18. Excision and destruction of diseased tissue of the nose
19. Operations on the turbinates (nasal concha)
20. Other operations on the nose
21. Nasal sinus aspiration

Operations on the eyes

22. Incision of tear glands
23. Other operations on the tear ducts
24. Incision of diseased eyelids
25. Excision and destruction of diseased tissue of the eyelid
26. Incision of diseased eyelids
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue

52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids

Trauma surgery and orthopaedics

73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration

Operations on the breast

78. Incision of the breast
79. Operations on the nipple

Operations on the digestive tract

80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.
87. Laparoscopic cholecystectomy

Operations on the female sexual organs

88. Incision of the ovary
89. Insufflation of the Fallopian tubes

90. Other operations on the Fallopian tube
91. Dilatation of the cervical canal
92. Conisation of the uterine cervix
93. Other operations on the uterine cervix
94. Incision of the uterus (hysterotomy)
95. Therapeutic curettage
96. Culdotomy
97. Incision of the vagina
98. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99. Incision of the vulva
100. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

101. Incision of the prostate
102. Transurethral excision and destruction of prostate tissue
103. Transurethral and percutaneous destruction of prostate tissue
104. Open surgical excision and destruction of prostate tissue
105. Radical prostatovesiculectomy
106. Other excision and destruction of prostate tissue
107. Operations on the seminal vesicles
108. Incision and excision of periprostatic tissue
109. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

110. Incision of the scrotum and tunica vaginalis testis
111. Operation on a testicular hydrocele
112. Excision and destruction of diseased scrotal tissue
113. Plastic reconstruction of the scrotum and tunica vaginalis testis
114. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

115. Incision of the testes
116. Excision and destruction of diseased tissue of the testes
117. Unilateral orchidectomy
118. Bilateral orchidectomy
119. Orchidopexy
120. Abdominal exploration in cryptorchidism
121. Surgical repositioning of an abdominal testis
122. Reconstruction of the testis
123. Implantation, exchange and removal of a testicular prosthesis
124. Other operations on the penis

Operations on the spermatic cord, epididymis und ductus deferens

125. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126. Excision in the area of the epididymis
127. Epididymectomy
128. Reconstruction of the spermatic cord
129. Reconstruction of the ductus deferens and epididymis
130. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

131. Operations on the foreskin
132. Local excision and destruction of diseased tissue of the penis
133. Amputation of the penis
134. Plastic reconstruction of the penis
135. Other operations on the penis

Operations on the urinary system

136. Cystoscopical removal of stones

Other Operations

137. Lithotripsy
138. Coronary angiography
139. Haemodialysis
140. Radiotherapy for Cancer
141. Cancer Chemotherapy