Registered Office: 101, 201, 301, Natraj, Junction of Western Express Highway & Andheri - Kurla Road, Andheri East, Mumbai -400069

AROGYA PLUS 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. **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

3. **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.

4. **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.

5. **Condition Precedent**

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

6. **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

7. **Contribution**

Contribution is essentially the right of an Insurer to call upon other Insurers liable to the same Insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

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

8. **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.

9. **Cumulative Bonus**

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

10. **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

11. **Day Care Treatment**

Day care treatment refers to medical treatment, and/or surgical procedure 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 a hospitalization of more than 24 hours.

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

12. **Deductible**

Deductible is 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.

13. **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.

14. **Disclosure to information norm**

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

15. **Domiciliary Hospitalisation**

Domiciliary hospitalisation 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.

16. **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.

17. **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.

18. **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.

19. **Hospitalisation**

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

20. **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:—it needs

ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

21. **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.

22. **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.

23. **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.

24. **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.

25. **Medical Advise**

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

26. **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.

27. **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.'

28. **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.

29. **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.

30. **Newborn baby**

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

31. **Non- Network**

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

32. **Notification of Claim**

Notification of claim is the process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

33. **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.

34. **Portability**

Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

35. **Post-hospitalization Medical Expenses**

Medical Expenses incurred immediately after the Insured person is discharged from the hospital provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured person's hospitalization was required and
b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

36. **Pre-Existing Disease**

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the Insurer.

37. **Pre-hospitalization Medical Expenses**

Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

38. **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.

39. **Reasonable and Customary Charges**

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

40. **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 all waiting periods.

41. **Room Rent**

Means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

42. **Subrogation**

Subrogation shall mean the right of the Insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

43. **Surgery**

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

44. **Unproven/Experimental treatment**

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

45. **"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.

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

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

48. **"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").

49. **"Family"** means the legal spouse, dependent children, parents and parents in law.

50. **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.

51. **"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.

52. **"Insured"** means a person named as Insured in the policy schedule.

53. **"Insurer"** means SBI General Insurance Company Limited.

54. **"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.

55. **"Other Insurer"** means any of the registered Insurers in India other than SBI General Insurance Company Limited.

56. **"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.

57. **"Policy"** means the complete documents consisting of the policy wording, schedule and endorsements and attachments if any.

58. **"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.

59. **"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.

60. **"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.

61. **"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.

62. **"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.

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
   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. **OPD treatment: -** expenses for OPD consultation and treatment up to limit specified in policy schedule on advice of a medical practitioner because of illness/disease and/or injury sustained or contracted during the Policy.

3. **Pre-hospitalisation expenses: -** the maximum amount that can be claimed under this head is limited to 60 days for each of the admitted hospitalisation claim under the Policy.

4. **Post-hosptalisation expenses: -** the maximum amount that can be claimed under this head is limited to 90 days for each of the admitted hospitalisation claim under the Policy.

5. **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.

6. **Ambulance expenses: -** Actual ambulance expenses or INR 1500 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.

7. **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.

8. **Domiciliary hospitalisation: -** Insurer will cover reasonable and customary charges towards domiciliary hospitalisation.

9. **Maternity Expenses:** - are covered but only under OPD section and up to OPD Limit specified in policy schedule.

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)**

EXCLUSIONS: -

Following exclusions will apply on the claim arising under hospitalisation.

1. Pre existing diseases exclusion:- Any illness/disease/injuries/health condition which are pre-existing (treated/untreated, declared/not declared in the proposal form), when the cover incepts for the first time are excluded up to 4 years of this Policy being in force continuously.

   However this exclusion would not be applicable from forth continuous renewal up to minimum of sum insured and/or limit under four previous policies.

2. Without derogation from above exclusion 1, during the first year of operation of the insurance cover any Medical Expenses incurred on below treatment of illness. However this exclusion would not be applicable in case of continuous renewal within grace period, up to sum insured and/or limit under previous policy.

   - Any types of gastric or duodenal ulcers;
   - Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;
   - Surgery on all internal or external tumor /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;
   - Hypertension, Heart Disease and related complications;
   - Diabetes and related complications;
   - Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;
   - Surgery of Genitourinary tract;
   - Calculus Diseases;
   - Sinusitis, nasal disorders and related disorders;
   - 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.

3. Exclusions applicable to first 30 days of cover from commencement of policy:- Insurer shall not be liable to make any payment under this Policy in connection with or in respect of Insured's hospitalisation due to disease/illness/injury, as stated in this section, arising within the first 30 days of the commencement of the Policy Period.

   However this exclusion would not be applicable

   a. For hospitalisation due to injury within first 30 days of commencement of cover.
   b. In case of continuous renewal within grace period, up to sum insured and/or limit under previous policy.

4. Treatment taken outside India.

5. Epidemic disease recognized by WHO or Indian government

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. Cosmetic or aesthetic treatments of any description, lasik treatment for refractive error. Any form of plastic surgery (unless necessary for the treatment of illness or accidental bodily injury).

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

11. 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.

12. 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.

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

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

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

16. Treatment for de-addiction from drug or alcohol or other substance.

17. Any condition directly or indirectly 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.

18. Venereal disease or any sexually transmitted disease or sickness.

19. Any fertility, sub fertility or assisted conception operation or sterilization procedure and related treatment.

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

21. Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending medical practitioner.

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

23. Treatment for any mental illness or psychiatric or psychological ailment / condition.

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

25. All medical expenses which results from or is in any way related to sex change.

26. Any treatment arising from Insured’s participation in any hazardous activity including but not limited to all forms of skiing, scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurer.

27. Genetic disorders and stem cell implantation / surgery/storage.

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 in health hydro, spas, nature care clinics and the like.

31. Treatments taken at any institution which is primarily a rest home or convalescent facility or a place for custodial care or a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental disorders; even if the institution has been registered as a hospital or nursing home with the appropriate authorities

32. Expenses incurred primarily for diagnostics, x-ray or laboratory examinations, or other diagnostics studies not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a hospital or nursing home or at home under domiciliary hospitalization as defined.

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

34. Treatment for obesity, weight reduction or weight management.

35. Experimental and unproven treatment.

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.

V. CONDITIONS PRECEDENT: -

1. **Due care:** where this Policy requires Insured to do or not to do something, then the complete satisfaction of that requirement by Insured or someone claiming on Insured's behalf is a condition precedent to any obligation under this Policy. If 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.

2. **Free look period:** the Insured will be allowed a period of at least 15 days from the date of receipt of the Policy 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-

   a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the Insureds and the stamp duty charges or;
   b. Where the risk has already commenced and the option of return of the Policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

3. 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.

4. 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. Nondisclosure 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.

5. 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.

6. 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.

7. 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.

8. 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 step to minimize the quantum of any claim that might be made under this Policy and intimation to this effect must be forwarded to Insurer accordingly.

ii) Insured must provide intimation to Insurer immediately and in any event within 48 hours from the date of Hospitalisation. However the Insurer 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) Insured has to file the claim with all necessary documentation within 15 days of discharge from the hospital, provide Insurer 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 Insurer such additional information and assistance as Insurer 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 Insurer 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 Insurer's medical advisors as often as may be considered necessary by the Insurer for establishing the liability under the Policy. The Insurer will reimburse the amount towards the expenses incurred for the said medical examination to the Insured.

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

vii) On receipt of intimation from Insured regarding a claim under the Policy, Insurer/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 Insurer and request pre-authorisation by way of the written form Insurer will provide.

ii) After considering Insured's request and after obtaining any further information or documentation Insurer has sought, Insurer 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 Insurer 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. Insurer 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:

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, Insurer/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: upon acceptance of an offer of settlement by the Insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of delay in the payment, the Insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

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. In case claim is made for maternity benefit or OPD, then both Sum insured and OPD limit will get reduced by corresponding amount.

9. Fraud: if the Insured or any of their family members make or progress any claim knowing it to be false or fraudulent in any way, then the coverage for this Insured and his family members will be void and all claims or payments due under it shall be lost and the premium paid shall become forfeited.

10. Nomination and assignment: this Policy is not assignable and no person(s) other than Insured or Insured's nominee(s) as mentioned in the schedule or legal representatives, wherever is applicable, can claim or sue the Insurer under this Policy. The payment by the Insurer to the Insured, his/her nominee or legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Insurer.

11. Subrogation: Insured shall at their own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Insurer

for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which Insurer would become entitled upon Insurer making reimbursement under this Policy, whether such acts or things shall be or become necessary or required before or after our payment.

Insured shall not prejudice these subrogation rights in any manner and shall at their own expense provide Insurer with whatever assistance or co-operation is required to enforce such rights.

Any recovery Insurer make pursuant to this clause shall first be applied to the amounts paid or payable by Insurer under this Policy and our costs and expenses of effecting a recovery, where after Insurer shall pay any balance remaining to the Insured.

12. Contribution: if two or more policies are taken by an Insured during a period from one or more Insurers to indemnify treatment costs, Insured shall have the right to require a settlement of his claim in terms of any of his policies.

a. In all such cases where Insured opts the settlement of claim under this Policy, Insurer will be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the Policy.
b. If the amount to be claimed exceeds the Sum insured under Policy issued by Insurer after considering the deductibles or co-pay, the Insured shall have the right to choose other Insurers by whom the claim to be settled. In such cases, Insurer will settle the claim with contribution clause.
c. Except in benefit policies, in cases where an Insured has policies from other Insurer(s) 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 Policy.

Contribution clause shall not be applicable where the cover/benefit offered is on benefit basis.

13. Cancellation: in case of any fraud, misrepresentation, or suppression of any material fact either at the time of taking the Policy or any time during the currency of the earlier policies, Insurer may at any time cancel this Policy by sending the Insured 15 days notice by registered letter, at the Insured's last known address and in such event Insurer shall refund to the Insured a pro-rata' premium for unexpired Policy period subject to no claim having occurred up to date of cancellation. Insurer shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this Policy by giving a written notice to the Insurer and in such event Insurer shall allow refund of premium at Insured’s short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

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

14. **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.

15. **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 and 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.

16. **Renewal:** this Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to Insurer on or before the date of expiry of the Policy or of the subsequent renewal thereof. However Insurer shall not be bound to give notice that such renewal premium is due. Also Insurer may exercise Insurer's option not to renew the Policy on grounds of fraud misrepresentation, or suppression of any material fact either at the time of taking the Policy or any time during the currency of the earlier policies.

    A grace period of 30 days is allowed for renewal of the Policy. This will be counted from the day immediately following the premium due date during which a payment can be made to renew or continue the Arogya Plus Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. The continuity of coverage for all the covers under the expiring policy will be subject to receiving appropriate premium for the same. Coverage is not available for the period for which no premium is received and Insurer has no liability for the claims arising during this period.

17. **Withdrawal of product:** in case of withdrawal of this product Insurer will communicate to Insured at least 3 months prior to the withdrawal. Existing policy will continue to remain in force till its expiry, and at the time of renewal, Insured will have option to

migrate to Insurer's existing OPD health products available at that time subject to portability condition.

18. **Portability:** this Policy is portable as per Insurance Regulatory And Development Authority (Health Insurance) Regulation, 2013 and intended Insured should initiate action to approach another Insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delay in acceptance of the proposal by the other Insurer.

19. **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.

20. **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.

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

22. **Deduction under section 80D income-tax act –** deduction under section 80D income-tax act will be allowed on premium and amount eligible of deduction under section 80D income-tax is separately specified in policy schedule.

23. **Grievance redressal procedure:** the Grievance Redressal cell of the Insurer looks into complaints from the Insured. If the Insured has a grievance that the Insured wishes the Insurer to redress, the Insured may approach the person nominated as 'Grievance Redressal Officer' with the details of his grievance.

Name, address, e-mail id and contact number of the Grievance Redressal Officer will appear in the policy document as well as on Insurer's website.

Further, the Insured may approach the nearest insurance ombudsman for redressal of the grievance. List of ombudsman offices with contact details are attached for ready reference. For updated status, please refer to website www.irdaindia.org.

CONTACT DETAILS	JURISDICTION
AHMEDABAD - Shri. / Smt. Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: ins.omb@rediffmail.com	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.
BENGALURU - Shri. M. Parshad Office of the Insurance Ombudsman, Jeevan Mangal Bldg., 2nd Floor, Behind Canara Mutual Bldgs., No.4, Residency Road, Bengaluru – 560 025. Tel.: 080 - 22222049 Fax: 080 - Email: insombudbng@gmail.com	New Centre.
BHOPAL - Shri. Raj Kumar Srivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpalbhopal@gmail.com	States of Madhya Pradesh and Chattisgarh.
BHUBANESHWAR - Shri. B. N. Mishra Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: ioobbsr@dataone.in	State of Orissa.
CHANDIGARH - Shri. Manik B. Sonawane Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: ombchd@yahoo.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
CHENNAI - Shri Virander Kumar Office of the Insurance Ombudsman, Fatima Akhtar Court,	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).

4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: chennaiinsuranceombudsman@gmail.com	
DELHI - Smt. Sandhya Baliga Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237539 Fax: 011 - 23230858 Email: iobdelraj@rediffmail.com	States of Delhi and Rajasthan.
GUWAHATI - Sh. / Smt. Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: ombudsmanghy@rediffmail.com	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri. G. Rajeswara Rao Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: insombudhyd@gmail.com	States of Andhra Pradesh, Karnataka and Union Territory of Yanam - a part of the Union Territory of Pondicherry.
Jaipur - Shri. Ashok K. Jain Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - Fax: 0141 - Email:	New Centre.
KOCHI - Shri. P. K. Vijay Kumar Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.

Email: iokochi@asianetindia.com	
KOLKATA - Shri. K. B. Saha Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: insombudsmankolkata@gmail.com	States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.
LUCKNOW - Shri. N. P. Bhagat Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: insombudsman@rediffmail.com	States of Uttar Pradesh and Uttaranchal.
MUMBAI - Shri. A. K. Dasgupta Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: ombudsmanmumbai@gmail.com	States of Maharashtra and Goa.
Pune - Shri. A. K. Sahoo Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - Fax: 020 - Email:	New Centre.

Annexure A

List of Administrators (TPAs) authorised by SBI General

Sr. No.	Name	Contact Details

Insurance is the subject matter of the solicitation

Annexure B

Standard List of Excluded expenses in Hospitalisation indemnity policies (as per IRDA health Insurance guidelines)