

Welcome to the 'I Feel Good' policy

aka

The Digit Health Care Plus Policy

UIN: GODHLIP19045V011920

Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Think of Digit as your running or gym buddy, keeping pace with you all the way. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-5956 or mail us at hello@godigit.com

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured, during the policy period mentioned in your Policy Schedule. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule are applicable.

Disclaimer: The Description mentioned under "Digit Simplification"/ "Examples" throughout the Insurance Policy is only to aid Your understanding of the Coverage / Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule shall prevail.

DEFINITIONS

***Digit Simplification:** You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them.*

Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Alternative/Ayush Treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
3. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
4. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Insurer to the extent Pre-authorization is approved.
5. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

6. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
 - a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
 - b. External Congenital Anomaly means a 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 ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis
8. **Co-Payment** means a cost sharing requirement under a Health Insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured. Co-Payment will not be applicable to benefit Policies - Daily Hospital Cash Cover & Critical Illness Benefit, Cancer Benefit.
9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
10. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
 - i. has qualified nursing staff under its employment;
 - ii. has qualified medical practitioner/s in charge;
 - iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
 - iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
11. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
 - i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
 - ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.
12. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Daily Hospital Cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
14. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
15. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
 - i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
 - ii) the patient takes treatment at home on account of non-availability of room in a hospital.
16. **Emergency / Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
17. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

- 18. Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport/activity includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighting/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.
- 19. 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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said Act Or complies with all minimum criteria as under:
- i) has qualified nursing staff under its employment round the clock;
 - ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
 - iii) has qualified medical practitioner(s) in charge round the clock;
 - iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
 - v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
- 20. Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
- 21. Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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 rehabilitation for the patient or for the patient to be specially trained to cope with it
 4. it continues indefinitely
 5. it recurs or is likely to recur
- 22. Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
- 23. 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** 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. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
26. **Maternity expenses** means;
- a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
 - b) expenses towards lawful medical termination of pregnancy during the policy period.
27. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
28. **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.
29. **Medical Practitioner/Dentist** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
- The registered practitioner should not be the insured or close member of the family.
30. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
- i) is required for the medical management of the illness or injury suffered by the insured;
 - ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - iii) must have been prescribed by a medical practitioner;
 - iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
31. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
32. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.
33. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
34. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
35. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
36. **Policy** means the Proposal, the Policy Schedule (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
37. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule and includes both the commencement date as well as the expiry date.
38. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
39. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
40. **Psychiatric Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation

which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

41. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
- Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
 - The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
42. **Portability** means transfer by an individual health insurance Policy Holder (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.
43. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
44. **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.
45. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
46. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
47. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
48. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy.
49. **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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
50. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neuro Surgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
51. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
52. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
53. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule Members who has concluded this Policy with Us.

COVERAGE

SECTION 1. HOSPITALIZATION COVER

Digit Simplification: Hospital stays are never fun. And the less said about hospital food, the better! That said, it's good to know that Digit will try and make it easy, should you need to spend some time in a hospital, before you're back on your feet.

A. Accidental Hospitalization Cover

Digit Simplification: The day bad luck strikes.

If You have opted for this Cover and You suffer an Accidental Injury during the Policy Period that requires Hospitalization as an inpatient, we'll be there for you. We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim. The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: If You have opted for a Limit on “Accommodation/Room Rent” and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule. <i>Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i>
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

A1. Day Care Procedures

Digit Simplification: *Why stay unnecessarily in a hospital when the required procedure requires just a day!*

If You suffer an Accidental Injury during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement, We will pay the Medical Expenses Incurred for such Day Care Procedures.

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

A2. Pre-Hospitalization Expenses

Digit Simplification: *We all know that sometimes you need to shell out money way before you are actually hospitalised; smile, you're covered.*

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule against this Cover, prior to the date of Your admission in a hospital, provided that:

- Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
- We have accepted an Inpatient Accidental Hospitalization Claim under **Section 1.A. Accidental Hospitalization Cover** of this Policy.

A3. Post-Hospitalization Expenses

Digit Simplification: *This covers for expenses incurred by You after you get discharged!*

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule against this Cover, from the date of Your Discharge from the hospital, provided that:

- a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
- b) We have accepted an Inpatient Accidental Hospitalization Claim under **Section 1. A. Accidental Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum benefit, which shall be a percentage of the claim amount approved under **Section 1.A. Accidental Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

A4. Dental Treatment

***Digit Simplification:** Because you need to open your mouth and your wallet wide, at the dentist's.*

We will pay for the medical expenses incurred by You for any necessary Dental Treatment needed after an accident. A claim here is valid if the accident resulted in an admissible inpatient Hospitalization Claim under **Section 1. A. Accidental Hospitalization Cover**.

A5. Road Ambulance

***Digit Simplification:** Emergencies will and shall always be a top priority.*

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency arising out of an Accident, provided that:

- a) We have accepted a claim under **Section 1. A. Accidental Hospitalization Cover**.
- b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule against this Cover.
- c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

A6. Second Medical Opinion

***Digit Simplification:** We want nothing but the best for You. Which is why we encourage you to go in for a second opinion, wherever necessary!*

We shall arrange and bear the cost for Second Opinion from our panel of Medical Practitioners. This is for times when there has been a major accidental injury that requires your hospitalisation in a tertiary care facility during the Policy Period, provided that:

- 1. We have received Your request to arrange for a Second Opinion.
- 2. You have the option to choose any One of Our Panel Medical Practitioners.
- 3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

All the above Covers are Subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

B. Accidental & Illness Hospitalization Cover

***Digit Simplification:** The day bad luck strikes.*

If You have opted for this Cover and You suffer an Accidental Injury or Illness during the Policy Period that requires Hospitalization as an inpatient, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim. The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: If You have opted for a Limit on “Accommodation/Room Rent” and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule. <i>Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i>
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

B1. Day Care Procedures

Digit Simplification: Why stay unnecessarily in a hospital when the required procedure requires just a day!

If You suffer an Accidental Injury or Illness during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for stay less than 24 hrs because of technological advancement, We will pay the Medial Expenses Incurred for such Day Care Procedure.

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

B2. Pre-Hospitalization Expenses

Digit Simplification: Before you get hospitalized, there might be some expenses. This takes care of those!

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule against this Cover, prior to the date of Your admission in a hospital, provided that:

- Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
- We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

B3. Post-Hospitalization Expenses

***Digit Simplification:** This covers expenses incurred by You after You get discharged!*

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule against this Cover, from the date of Your Discharge from the hospital, provided that:

- a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
- b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum which shall be a percentage of the claim amount approved under **Section 1.B. Accidental & Illness Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

B4. Dental Treatment

***Digit Simplification:** The dentist's chair is never fun, but we make sure you smile.*

We will pay for the Medical Expenses incurred in respect of any necessary Dental Treatment from a dentist provided the Dental Treatment is required as a result of an Accident that results in an admissible inpatient Hospitalization Claim under **Section 1. B. Accidental & Illness Hospitalization Cover**.

B5. Road Ambulance

***Digit Simplification:** In an emergency, getting to the hospital quickly is paramount!*

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency, provided that:

- a) We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover**.
- b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule against this Cover.
- c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

B6. Bariatric Surgery Cover

***Digit Simplification:** Tackling obesity may require more than healthy eating and exercise.*

Therefore, if You are hospitalized for a Bariatric Surgery which is medically necessary, on the advice of a Medical Practitioner, we cover the related Medical Expenses subject to the following conditions:

- a) The Insured Person undergoing the surgery is minimum 18 Years old.
- b) The Medical Practitioner / Bariatric Surgeon confirms that Your Existing Body Mass Index (BMI) and health conditions fall within the below qualification requirements for Bariatric Surgery:
 - Class III Obesity (extreme obesity)- [Body Mass Index (BMI) $\geq$ 40 kg/m²];
 - Class II Obesity- (Body Mass Index (BMI) 35-39.9 kg/m²) along with any of the following co-morbidities:
 - Uncontrolled Diabetes Mellitus
 - Cardiovascular Disease [*Example: Stroke, Myocardial Infarction, Poorly Controlled Hypertension*]

- History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
 - Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.
- c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
- Gastric Bypass-
 - The Roux-en-Y Gastric Bypass
 - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
 - Sleeve Gastrectomy
 - Laparoscopic Gastric Banding
- d) This particular cover has a waiting period. Waiting period shall be as per the “**Specific Waiting Period**” Section stated in Your Schedule against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.
- e) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. **Example: Endocrine disorder.**
- f) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
- g) A prior approval should be taken from us before the Bariatric Surgery is performed.
- h) Our maximum liability under this benefit is restricted to the Limit as opted by You and mentioned in Your Policy Schedule against this Cover.

Bariatric surgery for the following reasons is not covered:

- a) For Cosmetic/Aesthetic reasons.
- b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity. **Digit Simplification: This is in such cases, treatment of the cause that has caused the obesity, will be more beneficial than treating obesity itself.**

B7. Psychiatric illness Cover

Digit Simplification: In a holistic health policy, mental health is as important as physical health.

We will pay for the Medical Expenses, related to Psychiatric Illness, provided that:

- a) The first diagnosis and Hospitalization, as an inpatient, was during the Policy Period.
- b) This also has a waiting period and Sub-Limit as opted by You and mentioned in Your Policy Schedule for specific Psychiatric illnesses or disorders listed in the table below. Waiting period shall be as per the “**Specific Waiting Period**” Section stated in Your Schedule against this Cover which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Psychiatric as a benefit since inception of the first policy.

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

- c) Hospitalization under this benefit shall be subject to prior approval from Us, except in cases of emergencies.

B8. Complimentary Health Check Up

Digit Simplification: Prevention is always better than cure!

If You Renew Your Policy with Us without a break, then at every Policy Renewal We will pay the expenses incurred towards cost of health check-up up to the Limits Per Policy (excluding any cumulative bonus) mentioned in Your Policy Schedule. This shall be paid, provided that:

- a. You are above 18 Years of age at the time of Health Check Up.
- b. You submit a duly filled and signed claim form along with original bills and copy of medical reports.

Please Note- Payment under this benefit won't be deducted from Your Sum Insured. It is additional.

B9. Second Medical Opinion

Digit Simplification: Any major illness (like cancer) dictates a second opinion.

When it comes to Cancer or any major Illness and You are required to get hospitalized in a tertiary care facility during the Policy Period, We will arrange and bear the cost for a Second Opinion provided that:

1. We have received Your request to arrange for Second Opinion.
2. You have option to choose any one of Our Panel Medical Practitioners.
3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

SECTION 2. INFERTILITY TREATMENT COVER

Digit Simplification: We make your road to parenthood easier.

If You have opted for this Cover, We will pay the Medical Expenses if You are hospitalized on the advice of the Medical Practitioner for Infertility/ Subfertility Treatments. This includes, though not limited to, IVF, IUI, ZIFT, ICSI. Make sure the following conditions are met:

- a) A waiting period as opted by you and mentioned in your Policy Schedule will apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with this cover, without a break, with 'Infertility Treatment Cover' as a benefit since inception of the first policy.
- b) Our maximum liability per Hospitalization shall be restricted to the amount as mentioned in Your Policy Schedule against this Section.
- c) The benefit is payable only once to an Insured Person during the Policy Tenure.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 3. ORGAN DONOR

Digit Simplification: Organ transplantation is the gift of life itself, and we are happy to be a part of it.

If You have opted for this Cover, We will pay You for the following incurred Medical Expenses in respect of organ transplantation:

- a) For the harvesting of the donated organ subject to availability of the Sum Insured under **Section 1. B. Accidental & Illness Hospitalization Cover.**
- b) There are strict guidelines when it comes to organ transplantation, therefore the organ donor whose organ has been made available should be in accordance and in compliance with the Transplantation of Human Organs Act 1994 (as amended) and the organ is donated for Your use only.
- c) We will pay the donor's Pre and Post Hospitalization expenses. This is up to 5% of the claim amount approved in respect of harvesting expenses.
- d) We will not pay any other medical treatment for the donor consequent on the harvesting.
- e) This also has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with ORGAN DONOR Cover as a benefit since inception of the first policy.

Provided that, We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER

***Digit Simplification:** If you believe in the power of Alternate treatments, here's more power to you.*

If You have opted for this Cover, we will pay the Medical Expenses for Your In-patient Treatment, taken under Ayurveda, Unani, Siddha or Homeopathy. This is up to the Sum Insured mentioned in Your Policy Schedule against **Section 1. B. Accidental & Illness Hospitalization Cover**. This is paid provided that treatment has been undergone in:

1. A government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health.
2. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
3. AYUSH hospitals having registration with Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
 - i) has at least 15 in-patient beds
 - ii) has minimum 5 qualified and registered AYUSH Doctors;
 - iii) has qualified paramedical staff under its employment round the clock;
 - iv) has dedicated AYUSH therapy sections;
 - v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

You should also be aware what We won't pay for:

- a) Pre-Hospitalisation & Post-Hospitalisation Expenses, Day Care Procedure and Outpatient Medical Expenses.
- b) All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 5. EMERGENCY AIR AMBULANCE

***Digit Simplification:** When every minute counts. Sometimes when You meet with an Accident or have an Emergency Illness, time is of a lot of importance.*

If You have opted for this Cover, We will pay You the expenses incurred for Your transportation in an airplane or helicopter for emergency life threatening health conditions which requires immediate and rapid ambulance transportation to the nearest hospital.

This transportation will be from the location where the illness /accident happened the first time and subject to availability of Sum Insured mentioned in Your Policy Schedule against **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and provided that such Transportation in an airplane or helicopter has been prescribed by a Medical Practitioner and/or is Medically Necessary.

Provided that, We have accepted a claim under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 6. LONG HOSPITALIZATION CASH BENEFIT

***Digit Simplification:** If even ward boys seem to know You by name, this cover is for You.*

If You are Hospitalized for a minimum number of consecutive days as Opted by You and mentioned in the Policy Schedule against this Section, We will give you a lump sum amount as mentioned in the Policy Schedule. Provided that:

- a) We have accepted a claim under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, and
- b) The benefit is payable only once to an Insured Person during the Policy Period.

For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER

A. Maternity Benefit

Digit Simplification: One of the rare times when going to the hospital is for a little bundle of joy.

If You have opted for this Cover, We will pay the Maternity Expenses incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary termination. This is up to the Sum Insured opted by You and as mentioned in Your Policy Schedule against this Section, during the Policy Period provided that:

- a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply***). This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
- b) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
- c) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule applied to the increased part of the Sum Insured.
- d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.

Digit Simplification: Sticking with us has its advantages

If we had already accepted a claim for Maternity Expenses for your first living child under this benefit, then for the subsequent Maternity Expenses i.e. for the delivery of Your Second child, we shall pay up to the percentage of the Sum Insured opted under this Section and mentioned in Your Policy Schedule provided the Policy is renewed with Us continuously without break with Maternity Benefit & New Born Baby Cover benefit.

We shall not pay for the following under this Section:

- a) Expenses for the harvesting and storage of stem cells when carried out as a preventive measure against possible future illness.
- b) Medical Expenses for Ectopic Pregnancy will be covered under **Section 1. B. In-patient Accidental & Medical Treatment** and not under the Maternity Benefit.
- c) Pre-natal and Post-natal Medical Expenses are not covered unless leading to Your Hospitalization.

B. New Born Baby Benefit

***Digit Simplification:** Your babies need all the love, care and cover they can get.*

Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 7. A Maternity Benefit Section** of the Policy, provided that We have accepted a claim under **Section 7. A. Maternity Benefit**, incurred towards:

- a) The medical treatment of the Insured Person's New Born Baby while the Insured Person is hospitalised as an inpatient for delivery.
- b) The New Born Baby's hospitalisation charges as a result of any medical complications, up to 90 Days from the date of delivery.
- c) Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India, up to 90 Days from the date of delivery. However, once the New Born Baby is added as an Insured Person under the Policy, We will pay the Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India until the New Born Baby attains 5 Years of age, provided that the Policy is continuously renewed with Us without break and with **Maternity Benefit and New Born Baby Cover** as a benefit since inception of the first policy.
- d) If the Policy Expires before 90 days from the date of delivery, the New Born Baby will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of any additional premium.
- e) After 90 Days from the date of delivery, the New Born Baby will be covered under the existing Policy only if it is Endorsed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of the Pro-Rata Additional Premium, for the balance period.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 8. OUT-PATIENT (OPD) BENEFIT

***Digit Simplification:** Expenses like doctor's consultation fees, health check-ups, pharmacy bills, dental treatment, diagnostic tests, etc... when You are not hospitalized are covered under this!*

If You have opted for this Cover, We will pay the Reasonable and Customary Charges for below mentioned expenses incurred by You as an Allopathic Out-patient when treatment is taken from a Network Medical Practitioner to the extent of the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section and subject to the Co-Payment Basis Opted by You.

Basis 1: Co-payment of 25% in the First Year of this Section being Opted, 10% on First Renewal. From the Second Renewal, there will be no Co-payment, provided the Policy is renewed with Us continuously without a break with this benefit.

Basis 2: Nil Co-payment

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any Illness.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner

Out-Patient Dental Treatment	Out-patient dental treatment for the immediate relief of dental Pain; taken by You from a dentist, provided that We will pay only for X-rays, Extractions, Amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.
Hearing Aids	One pair of hearing aids (Excluding Batteries), provided that: ▪ These have been prescribed by an ENT specialist or Network Medical Practitioner. ▪ You have continuously renewed the Policy with Us without break for a period of 36 months with Out-Patient (OPD) Benefit as a benefit, since inception of the first policy.
Psychiatric Illness	Specialist Consultation, assessment, treatment and medication for Psychiatric Disorders.

This cover excludes expenses incurred towards Spectacles, Contact Lenses and Physiotherapy, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION

Digit Simplification: Sometimes, admitting the patient in a hospital is not possible!

If You have opted for this Cover, We will pay the Medial Expenses incurred by You for any illness or Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, provided that:

- The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
- The patient takes treatment at home on account of non-availability of room in a Hospital, and
- The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period
- No Payment will be made if the condition for which You require medical treatment is due to:
Asthma, Bronchitis, Tonsillitis, Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, Arthritis, Gout and Rheumatism, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin.
- Subject to availability of the sum insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 10. SUM INSURED REFILL BENEFIT

Digit Simplification: We refill Your Sum Insured after You completely exhaust it.

If you have opted for this Cover, We will refill 100% of the Sum Insured specified and utilized under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** for that particular Policy Period, provided that:

- The refilled Sum Insured would be triggered only if the cause of the Hospitalization is not related to /arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during

the same policy period for the same Insured Person, unless this condition is specifically waived by us and mentioned in Your Policy Schedule.

- b) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
- c) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**.
- d) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule against this Section during each Policy Period.
- e) In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 11. DAILY HOSPITAL CASH COVER

Digit Simplification: Staying is Hospital has expenditure beyond Hospital bill!

A) Accidental Hospitalization Cover

If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident for a maximum number of days as mentioned in Your Policy Schedule against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule against this Section.

Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule against this Section.

B) Accidental & Illness Hospitalization Cover

If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this will be mentioned in your Policy Schedule against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident or illness for a maximum number of days as mentioned in Your Policy Schedule against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule against this Section.

Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule against this Section.

SECTION 12. CRITICAL ILLNESS BENEFIT COVER

Digit Simplification: We are with you for the best of times, and the worst of times.

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule against this Section, in case You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below Provided that,

- a) This Critical illness or covered surgical procedure has happened to you for the first time in your life.

- b) We will not make any payment if You are diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
- c) You survive for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us
- d) The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease
- e) Once a claim has been Paid under Critical Illness and / or Surgical Procedure, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.

Critical Illness means the following major disease, which You have been diagnosed during the Policy Period to have suffered from and which requires Hospitalisation and are specifically defined as below:

Sr. No.	Category	Critical Illness
1	Malignancy	Cancer of Specified Severity
2	Cardiovascular system	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	Major Organ Transplant	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	Nervous System	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	Others	Loss of Independent Existence
20		Aplastic Anaemia

SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER

Digit Simplification: In times like these, You'll need all the help You can get.

If You have opted for this Cover and You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below, during the Policy Period, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible hospitalization claim, up to the Sum Insured mentioned in Your Policy Schedule against this Section.

Provided that,

- a) This Critical illness or covered surgical procedure has happened to you for the first time in your life

- b) We will not make any payment if You are diagnosed as suffering from Critical Illness and hospitalized within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us.
- c) No Claim under this option shall be admissible if the Critical Illness or the Surgical Procedure is a consequence of or arising out of any pre-existing condition/disease.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Section. Note: If You have opted for a Limit on “Accommodation/Room Rent” and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables. <i>Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor’s fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i>
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient’s Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

Critical Illness means the following major disease, which You have been diagnosed during the Policy Period to have suffered from and which requires Hospitalisation and are specifically defined as below:

Sr. No.	Category	Critical Illness
1	Malignancy	Cancer of Specified Severity
2	Cardiovascular system	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	Major Organ Transplant	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	Nervous System	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma

15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	Others	Loss of Independent Existence
20		Aplastic Anaemia

Critical Illness Definitions Applicable to Section 12 & Section 13 Above:

Digit Simplification: What all is covered and what is not. Everything in black and white for You!

1. CANCER OF SPECIFIED SEVERITY

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
 - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - vi. Chronic lymphocytic leukaemia less than RAI stage 3
 - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
 - ix. All tumors in the presence of pre-existing HIV infection.

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - ii. New characteristic electrocardiogram changes
 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
 - i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris
 - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. SURGERY TO AORTA

- I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

5. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

- I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
- II. The NYHA Classification of Cardiac Impairment are as follows:
 - i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
 - ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
- III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

6. OPEN CHEST CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

7. END STAGE LUNG FAILURE

- I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
 - i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
 - ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
 - iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
 - iv. Dyspnoea at rest.

8. END STAGE LIVER FAILURE

- I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
 - i. Permanent jaundice; and
 - ii. Ascites; and

iii. Hepatic encephalopathy.

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

9. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

10. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

vi. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. **The following are excluded:**

i. Other stem-cell transplants

ii. Where only Islets of Langerhans are transplanted

11. APALIC SYNDROME

I. Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

12. BENIGN BRAIN TUMOR

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

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

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are **excluded**:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

14. MAJOR HEAD TRAUMA

- I. Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
 - vii. Spinal cord injury;

15. PERMANENT PARALYSIS OF LIMBS

- I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

16. STROKE RESULTING IN PERMANENT SYMPTOMS

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
- II. The following are excluded:
 - iii. Transient ischemic attacks (TIA)
 - iv. Traumatic injury of the brain
 - v. Vascular disease affecting only the eye or optic nerve or vestibular functions.

17. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

- I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

18. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

- I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- II. Other causes of neurological damage such as SLE and HIV are excluded.

19. LOSS OF INDEPENDENT EXISTENCE

- I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.

20. APLASTIC ANAEMIA

- I. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
 - (a) Blood product transfusion;
 - (b) Marrow stimulating agents;
 - (c) Immunosuppressive agents; or
 - (d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 14. CANCER BENEFIT COVER

Digit Simplification: The big C requires another C: Cover

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule against this Section, in case You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life. Provided that,

- a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..

- b) You survive for a minimum period of at least 30 days from the date of diagnosis of such Cancer for Specified Severity, unless this condition is specifically waived by Us
- c) No Claim under this option shall be admissible if the Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.
- d) Cover under this Section shall cease upon payment of the compensation on the happening of a Cancer for Specified Severity and no further payment will be made for any consequent disease or any dependent disease.

For this Cover, "CANCER OF SPECIFIED SEVERITY" means:

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
 - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - vi. Chronic lymphocytic leukaemia less than RAI stage 3
 - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
 - ix. All tumors in the presence of pre-existing HIV infection.

SECTION 15. CANCER HOSPITALIZATION COVER

Digit Simplification: There is life after cancer. And we make sure you have quality of life.

If You have opted for this Cover and You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life during the Policy Period , We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible hospitalization claim for Cancer for Specified Severity up to the Sum Insured mentioned in Your Policy Schedule against this Section.

Provided that,

- a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity and hospitalized within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
- b) No Claim under this option shall be admissible if Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Section. Note: If You have opted for a Limit on “Accommodation/Room Rent” and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables. <i>Example, If You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i>
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

For this Cover, “CANCER OF SPECIFIED SEVERITY” means:

- I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
- II. The following are excluded –
 - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
 - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
 - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
 - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - vi. Chronic lymphocytic leukaemia less than RAI stage 3
 - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
 - ix. All tumors in the presence of pre-existing HIV infection.

SECTION 16. WELLNESS BENEFIT PROGRAM

Our Wellness Benefit Program provides the benefits listed below and shall be available to the Insured Person as mentioned in the Policy Schedule/Certificate of Insurance. Through this Program, We intend to incentivize the Insured Person(s) for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.

There are total 12 services under Wellness Benefit Program. Services applicable for Your Policy are as shown in Your Policy Schedule . Only services mentioned in your Policy Schedule/Certificate of Insurance are available for You.

1. Doctor on Call

Upon Your request, We will facilitate an appointment, through Our empanelled Service Provider, with a Medical Practitioner who can help You by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.

2. Wellness Coach

In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs and online platform provide You information on wellness coaching in areas such as:

- a) Weight Management
- b) Activity and Fitness
- c) Nutrition
- d) Tobacco Cessation
- e) Alcohol Abuse de-addiction Program
- f) Information on various diseases
- g) Dietary Plans

3. Lab Services (Home Collection)

Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc from Your home address for further testing and analysis.

The cost of these tests and reports will have to be borne by You.

4. Pharmacy (Home Delivery)

Upon Your request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.

The cost of the medication will have to be borne by You.

5. Vital/Physical Activity Monitoring Services

Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s) such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device.

It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.

6. Reminder Notifications

Upon Your request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You-

7. Medical Wallet

Upon Your request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You.

8. Report Aggregation

Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical records/reports shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.

9. Home Care Services

Upon Your request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for You in case You are in need of any of the following:

- a. Home Care Nursing
- b. Patient Assistant
- c. Physiotherapy
- d. Yoga Trainer
- e. Psychologist
- f. Palliative Care
- g. Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.

The cost of the Services/Equipment will have to be borne by You.

10. Ambulance Arrangement Services

Upon request, We will facilitate, through Our Empanelled Service Provider, ambulance services for Your transportation subject to availability of ambulance in the area where such service needs to be arranged.

The cost of the transportation will have to be borne by You.

11. Pick-up and Drop Services for Consultation

Upon Your request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for Your transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged.

The cost of the transportation will have to be borne by You.

12. Prioritizing Appointments

Upon Your request, We will facilitate, through Our Empanelled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary treatment/diagnostics subject to availability of the service(s).

The cost of the Consultancy/Diagnostic will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by You shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services.
3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Person may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Person.
4. We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person/You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

Digit Simplification: At work, and in insurance premiums, bonuses are always good.

Cumulative Bonus

If You've been safe and healthy and have had No Claims made under the **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness**

Hospitalization Cover and/or **Section 15. Cancer Hospitalization Cover** in the expiring Policy Period, You would be eligible for Cumulative Bonus at the time of renewal as mentioned in Your Policy Schedule , provided that:

1. There is an upper limit to the Cumulative Bonus You can earn. In any Policy period, the accrued Cumulative Bonus (including any carried forward Cumulative Bonuses from the previous policy) shall not exceed the limit mentioned in Your Policy Schedule .
2. For a Floater Policy, the Cumulative Bonus shall be available only on Floater Basis. It shall accrue only if no claim has been made for any of the Insured Members during the expiring Policy Period.
3. In the event of a claim in the expiring policy period, the Cumulative Bonus will reduce in the same way as it was accrued in the policy at the time of renewal.
4. If You discontinue the Policy or fail to renew the Policy within the Grace Period of 30 days from the due date of renewal, the entire Cumulative Bonus will be lost.
5. The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with Us.
6. The Cumulative Bonus will be Calculated on the Sum Insured as opted by You under **Section 1. A. Accidental Hospitalization Cover** and/or **Section 1. B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover**.

Note: Cumulative bonus opted at the inception of the first policy with us can't be changed during the policy period and subsequent renewals.

WAITING PERIODS

Digit Simplification: Some covers have a defined period in which you cannot make claims. Read on:

We are not liable to pay for any expenses arising out of any treatment which begins during waiting periods except if You suffer an Accident.

A. Initial Waiting Period

Any disease contracted by You during the initial (First) number of days as opted by You and mentioned in Your Policy Schedule from the commencement date of this Policy unless:

1. You have been insured under this Policy continuously and without any break in the previous Policy Year, or
2. As Per Portability Guidelines, You have been insured continuously and without interruption for at least 1 Year under any other Indian Insurer's health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, and you are able to submit relevant documents to establish that you were unaware of and had not taken any advice or medication for such Illness or treatment.

If on renewal or portability, the Sum Insured is increased, there is a fresh waiting period applied to the increased part of the Sum Insured only.

This Waiting Period is not applicable to **Section 1 - A. Accidental Hospitalization Cover**

B. Pre-existing Disease

Pre-existing Disease as defined in this Policy shall not be covered until the number of months of continuous coverage as opted by You and mentioned in Your Policy Schedule , have elapsed since inception of the first Policy with Us.

However:

If You are presently covered and have been continuously covered without any break under:

- (ii) an individual health insurance plan with an Indian insurer for the reimbursement of medical costs for inpatient treatment in a Hospital, OR
- (iii) any other similar health insurance plan from Us,

then, Pre-existing disease exclusion of the Policy shall apply as below:

- a) The waiting period of all Pre-existing disease shall be reduced by the number of Your continuous preceding years of coverage under the previous health insurance Policy.

Example, if a disease has a waiting period of 2 years and one year is already completed according to Your last policy, then when You renew with us, the Waiting Period will not be 2 years, it will only be 1 Year.

- b) If the Proposed Sum Insured for You is more than the Sum Insured applicable under the previous health insurance Policy, then the reduced waiting period shall only apply to the extent of the Sum Insured under the previous health insurance Policy.

Example, if you have increased the Sum Insured by 2 lakhs while renewing Your Policy, fresh waiting period for Pre-existing Disease, will be applied to this increased part of Sum Insured.

C. Specific Waiting Periods

1. Specific Illness

The Illnesses and treatments listed below will be covered subject to a waiting period as opted by You and mentioned in Your Policy Schedule as long as the Insured Person has been insured continuously under the Policy without any break:

- a. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
- b. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
- c. Cataract, Glaucoma and Disorder of retina
- d. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
- e. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
- f. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
- g. Hernia of all sites,
- h. Varicose veins of lower extremities,
- i. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,
- j. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),
- k. Internal Congenital Anomaly,
- l. Psychiatric illness and Disorders listed below:

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

- m. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease.

2. Joint Replacement, Bariatric Surgery and Organ Transplant

Any Medical Expenses incurred as a result of Joint Replacement, Bariatric Surgery and Organ Transplant Surgery will be covered subject to a waiting period as opted by You and mentioned in Your Policy Schedule as long as the Insured Person has been insured continuously under the Policy without any break, unless due to an accident.

If on renewal with Us or on transfer from any other insurer, the Sum Insured is increased, there will be a fresh waiting period applied to the increased part of Sum Insured.

You will be given the portability credit of the waiting period based on the number of years of continuous and uninterrupted insurance cover.

Note:

- a. Waiting Period for other Sections opted by You would be as mentioned in Your Policy Schedule against the respective Sections.
- b. Waiting period, wherever mentioned and applicable for different Sections are applicable for each individual insured person separately

GENERAL EXCLUSIONS

Digit Simplification: We believe in being transparent with you, no hidden terms and conditions. So, here's what you are not covered for:

We shall not be liable to make any claim payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless specifically agreed and mentioned elsewhere in the Policy Schedule:

STANDARD ONES

1. Artificial Life Maintenance

Artificial Life Maintenance, including life support machine used, where such treatment where such treatment is used to maintain the Insured/Patient in a vegetative state.

2. Breach of Law with Criminal Intent, Suicide and Self-Injury

We do not cover treatment arising from or contributed or aggravated or accelerated by any of the following:

- a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
- b. Intentional self-injury
- c. Participation in any illegal or unlawful or criminal act
- d. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

3. Cosmetic, Aesthetic and Re-Shaping Treatment & Surgeries

- a. Plastic Surgery or Cosmetic Surgery or Treatments to change Your appearance (*Example a tummy tuck, facelift, tattoo, ear piercing*), unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or burns.
- b. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
- c. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
- d. Aesthetic or change-of-life- treatments of any description such as sex transformation operations.

4. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

5. Geographical Limits

This Policy covers all treatments received within India and Our liability will be to make Payment Indian Rupees Only. However, on payment of additional premium, the Geographical Limits can be extended to Asia / Worldwide Excluding USA & Canada / Worldwide Including USA & Canada, subject to:

1. Additional Co-payment Opted by You and mentioned in Your Policy Schedule for treatments outside India which will be over and above the Section Wise Co-payment Opted.
2. Prior intimation should be given and approval should be taken from Us for any treatment taken Outside India.

6. Hazardous Activities /Professional Sports/Defence Operation

We will not pay any claim under this Policy, whilst You are:

- a. Training for or Taking part in sport as a professional for which You are paid or funded by sponsorship or grant. However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional.
- b. Involved in naval, military, air force operation
- c. Involved in any Hazardous Activity.

7. Non-Medical Expenses

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please visit our website for complete list of non-medical items)

8. Home Care Nursing

Convalescence/ recovery, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care except to the extent covered under **SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION** if opted by You.

9. Insufficient Document

We have tried to reduce the number of documents you need to share but we shall not be liable to pay any claim in case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us.

10. Preventive Treatment

We do not cover inoculations, vaccinations or other treatment, for example drugs or Surgery, which aims to prevent a disease or illness except:

- a. For an active vaccination for dog or animal bite;
- b. To the extent covered under **SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER** if opted by You.

11. Reproductive Medicine & Other Maternity Expenses

Any assessment or treatment method for:

- a. Birth Control
Any type of contraception, sterilization, abortions, voluntary termination of pregnancy (except under Maternity Expenses for Medical Termination of Pregnancy (MTP) as governed by MTP Act 1971 under Section 7 above) or family planning.
- b. Infertility
Unless you have opted for **SECTION 2. INFERTILITY TREATMENT COVER**, We shall not be liable to make any payment in respect of expenses incurred towards Infertility/Subfertility including but not limited to IVF, IUI, ZIFT, ICSI Procedures and similar methods of assisted conception.
- c. Sexual disorder and Erectile Dysfunction
Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.
- d. Any Costs or expense related to pregnancy, complications arising from pregnancy or medical termination of pregnancy unless You have specifically opted for **SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER**.

12. Sexually Transmitted Infections & Disease

Screening, prevention and treatment for sexually transmitted infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis is not covered.

13.Sleep Disorders and Sleep Problems

We do not cover treatment directly or indirectly related to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep) including but not limited to expense related to purchase of CPAP, BIPAP or similar instruments except as mentioned by Us and covered under **Section1.B6. Bariatric Surgery Cover**

14.Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

15.Unproven or Experimental treatment

We do not cover any kind of Unproven or Experimental Treatment:

- a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.
- b. Stem Cell Transplant: Any stem cell transplant other than for Bone Marrow Transplant.

16.Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section1 - A. Accidental Hospitalization Cover** and/or **B. Accidental & Illness Hospitalization Cover**.

17.Vitamins/ Nutritional Supplements

Vitamins, tonics, nutritional supplements unless they form part of the treatment for Injury or disease as certified by the attending Medical Practitioner, are not covered.

18.War and hazardous substances

We do not cover treatment directly or indirectly arising from or required as a consequence of:

War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government or any acts of terrorism.

Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.

19.Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

20.Substance abuse and Addictions by the Insured

1. Expenses incurred for the treatment of any Illness or accidental Injury caused due to:
 - a) Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured unless associated with Psychiatric Illness.
 - b) Withdrawal and de-addiction treatment taken by the Insured.
2. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

SPECIFIC ONES (CAN'T BE WAIVED)

21.Behavioural and Neurodevelopment Disorders

Medical Expenses related to Behavioural and Neurodevelopment delays and disorders such as:

- a. Disorders of adult personality including gender related problems, gender change
- b. Learning disability including but not limited to speech and language including stammering, dyslexia, Attention Deficit Hyperactive Disorder;
- c. Neurodevelopmental disorders including but not limited to cerebral palsy, autism spectrum disorder.

22. Ear, Eye Sight & Optical Services

- a) We do not cover treatment for:
 - 1. Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery.
 - 2. Intravitreal injection including but not limited to Lucentis, Macugen or any other similar treatment.
- b) We do not cover Femto Laser Procedure and multifocal lenses.
- c) Our Maximum Liability in respect of Cochlear Implant Procedure will be restricted to 50% of the Sum Insured opted under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**

23. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

24. Specific Treatments

- 1. We will not pay for expenses related to administration of below medications or procedures in excess of 5% of Sum Insured opted under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**:
 - a. Hyaluronic acid, Remicade or similar medications
 - b. Intra-articular/intra thecal or cortico-steroid injections, Immunotherapy/hormonal therapy.
- 2. We will not pay for expenses related to administration of medications or procedures including but not limited to expense related to:
 - a. Robotic surgeries however expenses will be covered up-to the conventional procedure cost.
 - b. Predictive Genome testing

SPECIFIC ONES (CAN BE WAIVED IN LIEU OF ADDITIONAL PREMIUM)

***Digit Simplification:** We have tried to make the plans as customized as possible for you; therefore, you can choose certain covers, with additional premium!*

25. Dental Treatment

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva, unless requiring Hospitalisation due to Accident or if You have opted for **SECTION 8. OUT-PATIENT (OPD) BENEFIT**.

26. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment. However, We will pay for treatments mentioned under **SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER**, if You have specifically opted for it.

27. Organ Donor

The Expenses incurred by You on organ donation, except for those covered under **SECTION 3. ORGAN DONOR**, if opted by You.

28. Weight loss Surgery

We do not cover treatment that is directly or indirectly related to:

Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue, unless You have specifically opted for **SECTION 1.B. Accidental & Illness Hospitalization Cover which covers Bariatric Surgery.**

GENERAL CONDITIONS

CONDITIONS PRECEDENT TO THE CONTRACT

Digit Simplification: *There are some more conditions you should be aware of that we considered before we issued you the policy.*

Zone wise Classification

Based on your city of residence, we have classified you within three Zones. In case of family floater policies, a single zone shall be applied to all the members covered under the policy. The three Zones are defined below: -

Zone A Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan),

Zone B Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.

Zone C Rest of India apart from Zone A and Zone B cities are classified as Zone C.

Zone opted by you is mentioned in your Policy Schedule .

Note:

2. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.
3. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% Co-pay would be applicable on admissible claim amount.
4. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.

Alterations to the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Proposer/Insured Member.

Condition Precedent

The adherence to the terms and conditions of this Policy by You or any Insured Person including the payment of premium by the due dates mentioned in the Policy Schedule is necessary for us to be liable to pay you the claim money.

Non-Disclosure or Misrepresentation:

Digit Simplification: *In one line, this condition means, make sure all the information you share with us is correct!*

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form either physically or electronically or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured

Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

- a) cancelled ab initio i.e. from the inception date or the renewal date (as the case may be),
- b) or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance;

- c) the claim under such Policy if any, shall be rejected/repudiated forthwith.

Insured Person

- a. Only those persons named as an Insured Person in the Policy Schedule shall be covered under this Policy.
- b. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (where ever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

Nominee

You can, at the inception or at any time before the expiry of the Policy, make a nomination for the purpose of payment of claims under the Policy. This is paid in the event of death of the Insured.

Any change of nomination should be communicated to Us in writing and such change shall apply only when an endorsement on the Policy is made by Us.

In case of any Insured Person other than You under the Policy, for the purpose of payment of claims in the event of death, the default nominee would be You.

CONDITION APPLICABLE DURING THE CONTRACT

Digit Simplification: There are some more conditions you should be aware of during the contract!

Special Conditions Applicable for Policies issued with premium Payment on Instalment basis

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

1. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
2. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by US.
3. The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of default being payment received within the Grace Period.
4. No interest will be charged If the instalment premium is not paid on due date.
5. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled and a fresh policy would be issued with fresh waiting periods.

Revision/Modification of the Policy

There is a possibility of revision/ modification of terms, conditions, coverages and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, We will inform you at least 3 months prior to the date of such revision/modification comes into effect.

Withdrawal of Product

There is possibility of withdrawal of this product at any time in future with appropriate approval from IRDAI, as We reserve Our right to do so with an intimation of 3 months to all the existing insured members. In such an event of withdrawal of this product, at the time of Your seeking extension of this Policy, you can choose, among Our available similar and closely similar Health Insurance Products. Upon Your so choosing Our new product, you will be charged the Premium as per Our Underwriting Policy for such chosen new product, as approved by IRDAI.

Cancellation

A. Cancellation by You

1. You can choose to cancel the policy, giving us a 15 days’ notice period by recorded delivery. This is provided there is no claim under the policy. The insured shall be entitled for premium refund at the Company’s Short Period Scale provided in table below.

Short Period Scale

Period on Risk	Premium Refund based on Policy Term		
	1 Year	2 Year	3 Year
Within 15 days	As Per Free Look Cancellation Mentioned Below		
Exceeding 15 days but less than 3 months	65.0%	65%	60%
Exceeding 3 months but less than 6 months	45.0%	55%	55%
Exceeding 6 months but less than 9 months	25.0%	45%	50%
Exceeding 9 months but less than 12 months	0.0%	35%	45%
Exceeding 12 months but less than 15 months	NA	30%	40%
Exceeding 15 months but less than 18 months	NA	20%	35%
Exceeding 18 months but less than 21 months	NA	10%	30%
Exceeding 21 months but less than 24 months	NA	0%	25%
Exceeding 24 months but less than 27 months	NA	NA	15%
Exceeding 27 months but less than 30 months	NA	NA	10%
Exceeding 30 months but less than 33 months	NA	NA	5%
Exceeding 33 months	NA	NA	0%

2. Free Look Period

We shall give You a Free Look Period at the inception of the first Policy and:

1. You 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.
2. If You have not made any claim during the Free Look period, You shall be entitled to
 - a) A refund of the premium paid less any expenses incurred by Us on Your medical examination and the stamp duty charges or;
 - b) where the risk has already commenced and the option of return of the Policy is exercised by You, 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.
 - d) Free Look Period is not applicable for renewals.

B. Cancellation by Us

Policy may be cancelled by Us on the grounds of misrepresentation, fraud or non-disclosure of material facts by sending to You fifteen days' notice by recorded delivery at last known address/e-mail ID without refund of premium.

Please note KYC documents (Photo ID card) shall be required at the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

Digit Simplification: What You should know when You are about to claim.

Multiple Policies

- i. If two or more policies are taken by You during the period for which You are covered under this Policy from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:
 - is fixed in nature i.e. Critical Illness Benefit Cover, Cancer Benefit Cover and Daily Hospital Cash Benefit Cover,
 - does not have any relation to the treatment costs;
- ii. If You are covered under multiple policies providing Critical Illness Benefit, Cancer Benefit and Daily Hospital Cash Benefits, We shall make the claim payments independent of payments received under other similar policies in respect of the covered event.
- iii. If two or more policies are taken from one or more insurers by You during the time for which You are covered under this Policy for indemnification of Your Hospitalisation treatment costs, We shall not apply the Contribution clause and You shall have the following rights
 - You may choose to get the settlement of claim from Us as long as the claim is within the limits of and according to terms and conditions of the Policy.
 - If the amount to be claimed exceeds the Sum Insured under a single Policy after consideration of the deductible and co-pay, You shall have the right to choose any insurers including Us from whom You want to claim the balance amount.
 - Except for the Critical Illness Benefit, Cancer Benefit and Daily Hospital Cash Benefits, in case if You have taken policies from Us and one or more insurers to cover the same risk on indemnity basis, You shall only be indemnified the hospitalisation costs in accordance with the terms and condition of the Policy.

Fraudulent/Unfounded Claims

If any claim under this Policy is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recovered. In addition, all covers with respect to the Insured Person shall be cancelled from Policy Period start date without any refund of premiums.

Arbitration

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

Claims Notification and Procedure

In the event of any accidental injury or illness or condition that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

A. Cashless Claim Process:

Cashless Facility can be availed from our network hospitals only. This is facilitated by our Service Provider / Third Party Administrator (TPA) and we would make a direct payment to the Network Hospital to the extent of Our Liability provided that:

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
 - a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.

- b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
- c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
- d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
- e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
- f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
- g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
 - a. Within 30 Days from the date of discharge, You should submit all original documents pertaining to the hospitalization as mentioned is the List of Claim Documents.
 - b. On receipt of intimation from You regarding a claim under the Policy, We are entitled to investigate and obtain information on the alleged injury or illness requiring hospitalization, if required,
 - c. All Claims shall be settled/repudiated within 30 days from the date of receipt of the last necessary claim document subject to the Policy Terms and Conditions. In case of any delay in payment for all approved claims beyond 30 day from the receipt of the last necessary claim document, We 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 You.
 - d. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Hospitalization Claim	Out-Patient (OPD) Claim	Critical Illness/Cancer Claim	Daily Hospital Cash Claim
1	Duly Filled and Signed Claim form	√	√	√	√
2	Discharge Summary	√	×	×	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	×	√	×
4	Original Hospital Main Bill	√	×	×	×
5	Original Hospital Bill Break Up	√	×	×	×
6	Original Pharmacy Bills	√	√	×	×
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	×	×

8	Consultation Papers	√	√	√	×
9	Investigation Reports	√	√	√	×
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	×	×
11	MLC/FIR Report (If applicable)	√	×	√	×
12	Original Invoice/Sticker (If applicable)	√	×	×	×
13	Post Mortem Report (If applicable)	√	×	×	×
14	Disability Certificate (If applicable)	√	×	√	×
15	Attending Physician Certificate (If applicable)	√	×	√	×
16	Ante-natal Record (If applicable)	√	×	×	×
17	Birth discharge Summary (If applicable)	√	×	×	×
18	Death Certificate (If applicable)	√	×	√	×
19	*KYC (Photo ID card) (If applicable)	√	√	√	√
20	Bank Details with Cancelled Cheque	√	√	√	√

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1, B.1 and B.2.a may be considered where the reason for delay is proved to our satisfaction.

*KYC documents shall be required at the claim settlement stage where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim.

CONDITIONS FOR RENEWAL OF THE CONTRACT

Sum Insured Enhancement

- Sum Insured enhancement can be done only at the time of renewal. You need to submit fresh proposal for Sum Insured Enhancement.
- The acceptance of enhancement of Sum Insured would be at Our discretion, based on the health condition of the insured members & claim history of the policy.
- All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

Renewal

- Your policy shall ordinarily be renewable for lifetime except on grounds of fraud, moral hazard or misrepresentation or non- cooperation by You, provided the policy is not withdrawn.
- We shall not deny the renewal of Your policy on the ground that You had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates after the payment of Sum Insured under the viz Critical Illness Benefit, Cancer Benefit and Daily Hospital Cash Benefit Section of the Policy. following payment of Sum Insured.
- If you get delayed in renewing your policy, you can renew it within 30 days from the due date of renewal. Just that the coverage will not be available for such break in period.
- If the Policy is not renewed within the above Grace Period of 30 days from the due date of renewal, You can still renew the policy with Us. But it will then be issued as a fresh policy, subject to Our Underwriting criteria and no continuing benefits shall be available from the expired Policy.

Portability and Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides same coverage in the immediately preceding Cover Year provided that:

- i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period, wait period of Specific Diseases pre-existing disease etc) which are applicable under this Policy;
- ii. Any other wait period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.
- iii. Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by our company. The credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by our company. Application for this Policy is made within 45 days before, but not earlier than 60 days from the expiry of that insurance policy

Customer Grievance Redressal Policy:

We hope that We never leave You dissatisfied. However, if You ever wish to lodge a complaint, please feel free to call our Toll free number 1-800-103-4448 or email the customer service desk at hello@godigit.com.

Senior citizens can now contact us on 1-800-103-4448 or write to us at seniors@godigit.com.

After investigating the matter internally and subsequent closure, We will send You Our response. If You do not get a satisfactory response from Us and You wish to pursue other avenues for redressal of grievances, You may approach Insurance Ombudsman appointed by IRDAI under the Insurance Ombudsman Scheme. The contact details of the Insurance Ombudsman Centers are mentioned below: (Note: Address and contact number of Governing Body of Insurance Council).

Office Location	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 2550201/02/05/06 , Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 , Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL	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: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh, Chattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751009. Tel.: 0674 - 2596461/2596455 , Fax: 0674 - 2596429 , Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH	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: bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 , Fax: 044 - 24333664 , Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 , Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI	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: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Mo in Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 6550423 / 2331212 , Fax: 040 - 23376599 , Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 , Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM	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 , Email: bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA	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: bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	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: bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gaziipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareilly, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabinagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	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: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P.-201301. Tel.: 0120-2514250 / 2514252 / 2514253 , Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Orayya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Haridwar, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanishramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 , Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411030. Tel.: 020-41312555 , Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: GOVERNING BODY OF INSURANCE COUNCIL, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106889 / 671 / 980, Fax: 022 - 26106949, Email: inscoun@gbic.co.in