digit

Digit Total Protect Policy

UIN: GODPAIP21489V022021

Visit us at www.godigit.com or call 1800-258-4242, anytime, for more information.

Let's get started!

You're already awesome because you decided to opt for this Policy which will compensate in case of Your Disability or Death caused by accidents. 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 **1800-258-4242** or mail us at **hello@godigit.com.**

A. PREAMBLE

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 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/Limits mentioned against each Section, 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. The benefit under each Section will be payable, provided that an event or occurrence described under the Sections/Covers occurs during the Policy Period mentioned in Your Policy Schedule.

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 the 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.

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B. 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.

I. STANDARD DEFINITIONS:

1. **Accident**, **Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **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.

3. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

4. **Congenital Anomaly:**

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

   b. External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body

5. **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 the benefit Sections. For example, Accidental Death, Critical Illness and Daily Hospital Cash Cover)

6. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

7. **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 criteria as under:

   a. Has qualified nursing staff under its employment;

   b. Has qualified medical practitioner/s in charge;

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

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

8. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

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

   b. Which would have otherwise required hospitalization of more than 24 hours.
   Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (wherever appropriate), crowns, extractions and surgery.

10. 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, misdescription or non-disclosure of any material fact.

(However, as per Condition No. 7 – Non-Disclosure or Misrepresentation mentioned under General Conditions applicable to all Sections, We may, at Our sole discretion, modify the Policy upon 30 days' notice by sending an endorsement to Your address shown in the Policy Schedule)

11. Domiciliary Hospitalization:

Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

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

12. 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.

13. 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 period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

14. 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:

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

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

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

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

e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

15. 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.

16. 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 for 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

17. **Injury/Bodily 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.

18. **In-patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

19. **Intensive Care Unit (ICU)** 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.

20. **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.

21. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

22. **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.

23. **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.

24. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

    a. Is required for the medical management of the illness or injury suffered by the insured;

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

    c. Must have been prescribed by a medical practitioner;

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

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

26. **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.

27. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.

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

29. **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.

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

31. **Pre-Existing Disease**

Pre-Existing Disease means any condition, ailment, injury or disease:

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

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

32. **Pre-hospitalization Medical Expenses**

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

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

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

33. **Post-hospitalization Medical Expenses**

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:

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

b. The in-patient hospitalization claim for such hospitalization is admissible by the insurance company.

34. **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.

35. **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.

36. **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.

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

38. **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.

39. **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.

II. SPECIFIC DEFINITIONS

40. Activities of daily/independent living means:

a. **Washing**: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

b. **Dressing**: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

c. **Transferring**: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheelchair and vice versa;

d. **Toileting**: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

e. **Feeding**: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

f. **Mobility**: The ability to move indoors from room to room on level surfaces at the normal place of residence.

41. Adventure Sports 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 is not limited to Insured Person's engaging in abseiling, aerial safari, ballooning, black water rafting, bouldering, bushwalking, canoeing, go-karting, hiking/trekking, ice skating, jet boating, jet skiing, kayaking, mountain biking (cross country), mountain biking on tracks and trails, parasailing, parascending (over water only), rafting, river boarding, rock climbing, rowing/sculling, sea canoeing, sea kayaking, snorkelling, speed boating, surf boat rowing, surfing, tubing, wakeskating, wakeboarding, windsurfing, yachting, bungee jumping, motorbiking, sandboarding, sand skiing, scuba diving, skidoos, skiing/ snowboarding, snowmobiling, snow rafting, zip-lining, zorbing, triathlon, gliding, hang gliding, parachuting, paragliding, parapenting, skydiving, free solo climbing, base jumping, wingsuit flying, big wave surfing, cave diving, white water rafting, highlining, ice climbing, BMX racing, free fall, base jumping, free soloing, motor racing, glacier walking, motor racing including speed and trial runs.

42. Allopathic Treatment or Medicine or Allopathy is a pejorative used by proponents of alternative medicine to refer to modern scientific systems of medicine, such as the use of pharmacologically active agents or physical interventions to treat or suppress symptoms or pathophysiologic processes of diseases or conditions.

43. Alternative/Ayush Treatment means forms of treatments other than treatment 'Allopathy' or 'Modern Medicine' and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

44. Common Carrier means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.

45. 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.

46. Fracture means a complete or incomplete break in a bone resulting from the application of excessive force.

47. Permanent Total Disablement shall mean either of the following:

a. Total Paralysis

b. Total and irrecoverable loss of sight of both eyes, or

c. Actual Loss by physical separation of two Limbs (both hands or both feet or one hand and one foot), or

d. Total and irrecoverable loss of use of two Limbs (both hands or both feet or one hand and one foot),

e. Total and irrecoverable loss of sight of one eye and physical separation of or Total and irrecoverable loss of use a limb (either one hand or one foot), or

f. Total and irrecoverable loss of speech and hearing of both ears
For the purpose of this benefit,

1. Total Paralysis means complete and irreversible loss of motor function leading to the total loss of function of the entire body from neck down due to an accidental injury to the spinal cord.

2. Limb means a hand at or above the wrist or foot above the ankle.

3. Physical separation means separation of limb(s) from the body above the wrist and/or ankle.

4. Total & irrecoverable loss of Use of limb(s) means complete and irreversible loss of functional, normal or characteristic use of the hand or, provided, loss of use continues for a period of 180 days, from the onset of loss of use and at the expiry of 180 days there is no reasonable medical hope of improvement.

48. **Policy** means the Proposal, the Policy Schedule (and any endorsement attaching to or forming part thereof) and the Policy Wordings.

49. **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.

50. **Professional Sports** means the sports in which the sportsperson or the athlete receives payment for their performance.

51. **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.

52. **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 Persons for a Floater Policy.

53. **Terrorism or Act of Terrorism** means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any member or group(s) of members, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes.

54. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super-specialist consultants like Neuro Surgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.

55. **Time Excess** means a cost-sharing requirement that provides that the insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer.

56. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited.

57. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule who has concluded this Policy with Us.

C. BENEFITS COVERED UNDER THIS POLICY

I. COVERAGE

SECTION 1. ACCIDENTAL DEATH

Digit Simplification: The day bad luck strikes

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Death within twelve (12) months from the date of accident, then We will pay 100% of the Sum Insured, as opted by You and mentioned in Your Policy Schedule against this Section.

I. Additional Inbuilt Benefits:

Below are the additional inbuilt benefits under **Section 1. Accidental Death** and We will pay 100% of the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section, in the below events:

a. **Disappearance:** We shall be liable to pay you? under this benefit, if the Insured Person's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Person was known to have been travelling as a fare-paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such Insured Person has died as a result of an Accidental Injury.

b. **Drowning:** We shall be liable to pay you under this benefit, if the Insured Person's full-body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Policy Period, where it is reasonable to believe that such Insured Person has died as a result of drowning.

For both (a) and (b) above, We will only pay, when the nominee or the legal heir provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, if at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be repaid in full to Us.

Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage Expense for Children", "Section 7. Orphan Benefit for Children", "Section 8. Funeral Expenses", "Section 9. Transportation Expenses", "Section 10. Trauma Counselling", "Section 22. Compassionate Visit"** wherever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

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

SECTION 2. PERMANENT TOTAL DISABLEMENT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your "**Permanent Total Disablement**" within twelve (12) months from the Date of accident, then We will pay 100% of Sum Insured, as opted by You and mentioned in Your Policy Schedule against this Section.

Specific Conditions:

1. If the Insured Person suffers Accidental Injuries resulting in more than one of the Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned against this Section.

2. Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage**

Expense for Children", "Section 10. Trauma Counselling", "Section 20. Lifestyle Modification Benefit", "Section 21. Expense for External Aids & Appliances", "Section 22. Compassionate Visit" wherever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

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

SECTION 3. PERMANENT PARTIAL DISABLEMENT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Permanent Partial Disablement within twelve (12) months from the Date of accident, then We will pay the percentage of Sum Insured, as opted by You and mentioned in Your Policy Schedule against this Section, as per the following Scale.

Permanent Partial Disablement –Table of Benefits

Nature of Injury	% of Sum Insured
Loss of each arm at the shoulder joint	**70%**
Loss of each leg above centre of the femur	**70%**
Loss of each arm to a point above elbow joint	**65%**
Loss of each leg up to a point below the femur	**65%**
Loss of each arm below elbow joint	**60%**
Loss of each hand at the wrist	**55%**
Complete and irrecoverable loss of sight of an eye	**50%**
Loss of each leg to a point below the knee	**50%**
Loss of each leg up the centre of tibia	**45%**
Loss of each foot at the ankle	**40%**
Loss of hearing in each ear	**30%**
Loss of each thumb	**20%**
Loss of each index finger	**10%**
Loss of sense of smell	**10%**
Loss of each other finger	**5%**

Loss of each big toe	**5%**
Loss of sense of taste	**5%**
Loss of each other toe	**2%**

For the purpose of this Cover, Loss means:

a. The physical separation of a body part, or

b. The total loss of functional use of body part or organ mentioned in the above Table of Benefits, provided this has continued for at least 180 days from the onset of loss of functional use of body part or organ and at the expiry of 180 days, We have a certification from independent Medical Practitioner empanelled by Us stating that there is no reasonable medical hope for improvement.

Specific Conditions:

1. If the Insured Person suffers Accidental Injuries resulting in more than one Permanent Partial Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

2. If the Insured Person suffers from a Permanent Partial Disablement not listed in the above table then an external medical advisor will determine the disablement percentage.

3. On acceptance of a claim under this Benefit, the Insured Person's Cover under this Benefit and Other Benefit opted under this Policy shall continue, subject to the availability of the Sum Insured, terms, conditions and Exclusion of this Policy.

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

SECTION 4. LOSS OF INCOME BENEFIT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of a Temporary Total Disablement and which completely prevents You from performing each and every duty pertaining to Your employment or occupation on a temporary basis, then We will pay a weekly benefit, amount of which is mentioned in Your Policy Schedule against this Section, provided that:

1. The Temporary Total Disablement is certified by a Medical Practitioner and submission of supporting documents/reports with respect to clinical examination, radiological scanning or imaging and/or neurological fallout testing as submitted to US, failing which We shall not be liable for any claim under this Section.

2. We will stop making payments when We are satisfied that You can engage in Your occupation again or when We have made payments for number of weeks as opted by You and mentioned in Your Policy Schedule for any one injury calculated from the date of commencement the temporary total disablement as certified by the treating Medical Practitioner, whichever is earlier.

3. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the Total Number of weeks as opted by You and mentioned in Your Policy Schedule for any and all claims arising within the Policy Period under this Benefit.

4. The benefit shall not be paid for the Time Excess mentioned in Your Policy Schedule i.e. for the number of days as opted by You and mentioned in Your Policy Schedule calculated from the date of commencement of Temporary Total Disablement.

5. In case the Temporary Total Disablement is for a period less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.

6. We will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation.

7. In case of any dispute with respect to the duration of Temporary Total Disablement, the duration shall be finally determined by a Doctor/Medical Practitioner mutually appointed by the Insured and Insurer, who certifies the final date upon which the Insured recovered and fit to perform each and every duty pertaining to his/her employment or occupation.

This Cover is subject to terms, conditions, time excess, limitations and exclusions mentioned in the Policy.

SECTION 5. CHILDREN EDUCATION BENEFIT

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"** and/or **"Section 2. Permanent Total Disablement"**, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, towards the cost of education of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.

2. The dependent child (children) pursuing an education course is a full-time student at an educational institution.

3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule.

4. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.

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

SECTION 6. MARRIAGE EXPENSE FOR CHILDREN BENEFIT

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"** and/or **"Section 2. Permanent Total Disablement"**, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, towards the marriage expenses of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.

2. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule.

3. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.

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

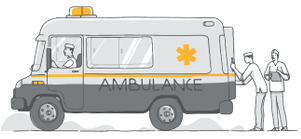
SECTION 7. ORPHAN BENEFIT FOR CHILDREN

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"** for the Insured Person who is a parent and while as a result of same accident or separate accident occurring during the Policy Period, the Insured Person's Spouse (who may or may not be an Insured Person) has also died, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section to Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. The dependent child (children) does not have any independent source of income.
3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule.
4. Any Claim under this Section that becomes admissible where the Dependent Child (Children) is a minor, shall be payable to the legal guardian/heirs.
5. For the purposes of this Section, Child (Children) means those who has/have been born out of a marriage which is legally valid as on the date of the accident and/or those who has/have been adopted in accordance with Indian Law.

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

SECTION 8. FUNERAL EXPENSES



If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"**, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, towards funeral, cremation and/or burial of the body of the deceased Insured Person.

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

SECTION 9. TRANSPORTATION EXPENSES

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"**, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, towards the expenses of transporting the mortal remains of the Insured Person from the place of death to a cremation ground or burial ground or to the residence of the Insured Person.

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

SECTION 10. TRAUMA COUNSELLING

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accidental Death"** and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"**, and the treating Medical Practitioner advises Professional Counselling sessions for the psychological upliftment, changes in daily diet or nutrition intake, Psychotherapy or Medications, then We will reimburse up to the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, towards the expenses incurred for the counselling session, provided that, Coverage needs to be availed within Six months from the date of incident covered under this Section and is applicable to:

a. Insured Person's Parents, Spouse and Children – In case of **accidental death** of the Insured Person.

b. Insured Person – In case of **Permanent Total Disablement** and/or **Permanent Partial Disablement** sustained by the Insured during the Policy Period.

This Cover is subject to terms, conditions, Co-Payment, limitations and exclusions mentioned in the Policy.

SECTION 11. ACCIDENTAL HOSPITALIZATION COVER

Digit Simplification: The day bad luck strikes.

I. Hospitalization Expenses

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.

What all is covered under this:

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room.
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

II. Day Care Procedures

Digit Simplification: Why stay unnecessarily in a hospital when the required procedure requires less than 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 in-patient 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.

III. 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:

1. Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.

2. We have accepted an in-patient Accidental Hospitalization Claim under **Section 11.A. Hospitalization Expenses Cover of this Policy**.

IV. 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:

1. The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.

2. We have accepted an in-patient Accidental Hospitalization Claim under **Section 11.A. Hospitalization Expenses Cover of this Policy.**

V. 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 in-patient Hospitalization Claim under **Section 11. A. Hospitalization Expenses Cover.**

VI. 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:

1. We have accepted a claim under **Section 11. A. Hospitalization Expenses Cover**.

2. The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule against this Cover.

3. 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.

VII. 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, co-payment, limitations and exclusions mentioned in the Policy.

VIII. Transportation of Imported Medicine

We will reimburse the costs incurred by You for freight charges for importing medicines to India, provided that:

1. We have accepted a claim under **Section 11. A. Hospitalization Expenses Cover**.
2. Such medicines, formulations or their alternatives are not available in India.
3. Such medicines are necessary for the medical or surgical treatment of the Insured Person in a Hospital following the Accident.
4. Such medicines shall not include any drugs under clinical trials or medicines, formulations or molecules of unproven efficacy.
5. The Medicines are recommended by the treating Medical Practitioner.

Sum Insured Basis

Claim settlement would be done on the basis of Sum Insured Options selected by You and mentioned in Your Policy Schedule. The two Sum Insured Basis are as mentioned below:

Basis 1: This is the percentage as opted by You and mentioned in Your Policy Schedule against this Section applied on the admissible claim amount of **"Section 1. Accident Death"** and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"** and/or **"Section 4. Loss of Income Benefit"** as per the Sections opted by You.

Basis 2: This is the amount opted by You and mentioned Your Policy Schedule against this Section.

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

SECTION 12. 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 Medical Expenses incurred by You for accidental bodily Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, up to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section and provided that:

1. The condition of the patient is such that she/he is not in a condition to be moved to a Hospital or
2. The patient takes treatment at home on account of non-availability of room in a Hospital, and
3. 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
4. No Payment will be made if the condition for which You require medical treatment is due to any reason other than an accidental bodily injury.

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

SECTION 13. LONG HOSPITALIZATION CASH BENEFIT

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

If You have opted for this Cover and You suffer an Accidental Injury during the Policy Period that requires Hospitalization as an inpatient 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 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, limitations and exclusions mentioned in the Policy.

SECTION 14. DAILY HOSPITAL CASH COVER

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

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 accidental bodily injury 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.

This Cover is subject to terms, conditions, time excess, limitations and exclusions mentioned in the Policy.

SECTION 15. 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 and You sustain accidental bodily injury, We will pay the Reasonable and Customary Charges for below-mentioned expenses incurred by You as an Allopathic Out-patient when OPD treatment is taken from a Medical Practitioner to the extent of the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any injury.
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	Any Out-patient dental treatment arising out of an accidental injury.
Rehabilitation	Physiotherapy, Psychiatric Counselling and Therapy.

This cover excludes expenses incurred towards Hearing Aids, Spectacles, Implants, Contact Lenses, Vaccinations other than those required for animal bite, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

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

SECTION 16. EMERGENCY AIR AMBULANCE

Digit Simplification: Every minute counts. Sometimes when You meet with an Accident and have an Emergency, time is of a lot of importance.

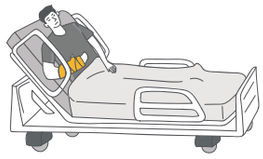
If You have opted for this Cover, We will pay You the expenses incurred for Your transportation in an airplane or helicopter for emergency life threatening health conditions which requires immediate and rapid ambulance transportation to the nearest hospital.

This transportation will be from the location where the accident happened the first time and subject to availability of Sum Insured mentioned in Your Policy Schedule against **Section 11. Accidental Hospitalization Cover** and provided that such Transportation in an airplane or helicopter has been prescribed or certified by a Medical Practitioner and/or is Medically Necessary.

Provided that, We have accepted a claim under **Section 11. Accidental Hospitalization Cover**.

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

SECTION 17. COMA BENEFIT COVER



If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your hospitalization in an Intensive Care Unit of a Hospital in a state of Coma, within 30 days of date of accident, then We will pay You the Sum Insured as opted by You and mentioned in Your Policy Schedule against this Section, provided that:

1. The Coma is confirmed by a specialist Medical Practitioner in writing which includes:
   a. No response to external stimuli continuously for at least 96 hours; and
   b. Life support systems and measures are necessary to sustain life
2. Permanent neurological deficit must be assessed at least 30 days after the onset of the coma and the reports to be submitted to Us for any benefit to be payable under this Section.
3. Coma resulting directly from alcohol or drug abuse or any other illness other than Accidental Bodily Injury is excluded.

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

SECTION 18. FRACTURE COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Fracture(s) of Bone(s), then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

Fracture Cover - Table of Benefits

Nature of Fracture	% of Sum Insured
Hip or Pelvis (excluding thigh or coccyx)	
Open Fracture of more than one bone with flail pelvis	100%
Open Fracture of more than one bone without flail pelvis	50%
Open Fracture of one bone	50%
Closed Fracture of more than one bone with flail pelvis	50%
Closed Fracture of more than one bone without flail pelvis	25%
Closed Fracture of one bone	15%
Thigh	
Open Fracture of neck of Femur	60%
Open Fracture of shaft of femur	45%
Closed Fracture of neck of Femur	25%
Closed Fracture of shaft of Femur	25%
Fracture of condyles/patella	15%
Lower Leg	
Open Fracture of more than one bone	60%
Open Fracture of one bone	45%
Closed Fracture of more than one bone	25%
Closed Fracture of one bone	15%
Fracture Ribs	
Fracture of Multiple Ribs with Flail Chest	25%
Fracture of Multiple Ribs with/without Flail Chest	20%
Fracture of Single rib/Fracture of sternum	10%
Elbows, Arm (including wrist but excluding Colles type fractures)	
Open Fracture of more than one bone	45%

Open Fracture of one bone	35%
Closed Fracture of more than one bone	20%
Closed Fracture of one bone	15%
Colles type fracture of the lower arm	
Open Fracture	25%
Closed Fracture	10%
Skull	
Fracture of the skull needing surgical Intervention	60%
Fracture of the skull not needing surgical Intervention	20%
Shoulder Blade, Rib(s), Knee cap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes or heel)	
Open Fracture	30%
Closed Fracture	15%
Spinal Column (Vertebrae but excluding coccyx)	
Compression fractures of more than one vertebrae	40%
Spinous, transverse process of pedicle fractures of more than one vertebrae	40%
Permanent Spinal Cord damage	40%
Fractures of Single Vertebrate	15%
Lower Jaw	
Open Fracture	25%
Closed Fracture	10%
Cheekbone, Clavicle, Coccyx, Upper Jaw, Nose, Toe(s), Finger(s), Ankle, Heel	
Open Fracture of more than one bone	15%
Open Fracture of one bone	12%
Closed Fracture of more than one bone	4%
Closed Fracture of one bone	2%
Dislocations requiring surgery under Anaesthesia	
Spine	35%
Back (Excluding slipped disc)	35%
Hip	25%
Knee (left or right)	20%

Wrist (left or right)	15%
Elbow (left or right)	15%
Ankle (left or right)	10%
Shoulder Blade (left or right)	10%
Collar bone	10%
Fingers (left or right hand)	5%
Toes (left or right foot)	5%
Jaw	5%
Internal Injuries	
Internal injuries resulting in open abdominal or Thoracic Surgery	25%
Intracranial haemorrhage and/or physical brain injury	25%

Specific Conditions:

1. If You suffer a Fracture not specified in the below table but the fracture is due to an injury solely and directly due to an accident, then Our Medical Practitioner will decide the amount payable, if any.

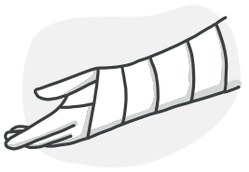
2. A fracture which results due to any illness or disease (including malignancy) or due to osteoporosis shall not be payable under this benefit.

3. A fracture where the broken bone penetrates the skin is an Open Fracture and where the broken bone does not penetrate the skin is a Closed Fracture.

4. If the Insured Person suffers Accidental Injuries resulting in more than one fractures, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

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

SECTION 19. BURNS COVER



If You have opted for this Cover and You sustain Second Degree Burns or Third Degree Burns solely and directly due to an accident, then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

Burns Cover - Table of Benefits

Nature of Burns	% of Sum Insured
SECOND DEGREE BURNS	
Head	
Second degree burns of 30% or more of the total head surface area	50%
Second degree burns of 20% or more, but less than 30% of the total head surface area	40%
Second degree burns of 10% or more, but less than 20% of the total head surface area	30%
Rest of the Body	
Second degree burns of 20% or more of the total body surface area	50%
Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
Second degree burns of 5% or more, but less than 10% of the total body surface area	10%
THIRD DEGREE BURNS	
Head	
Third degree burns of 30% or more of the total head surface area	100%
Third degree burns of 20% or more, but less than 30% of the total head surface area	80%
Third degree burns of 10% or more, less than 20% of the total head surface area	60%
Rest of the Body	
Third degree burns of 20% or more of the total body surface area	100%
Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
Third degree burns of 10% or more, less than 15% of the total head body area	60%
Third degree burns of 5% or more, less than 10% of the total head body area	20%

For the purpose of this cover,

1. **Burns** means an injury caused by exposure to heat or flame including chemical and electric burns.

2. **Second Degree Burns** means Burns which involve the epidermis and part of the dermis layer of skin, causing the burn site to appear red, blistered, and may be swollen and painful.

3. **Third Degree Burns** (full-thickness burns) means the burns that destroy the outer layer of the skin (epidermis) and the entire layer beneath i.e. the dermis. It also affects deeper tissues resulting in white or blackened, charred skin that may cause numbness, loss of fluid and sometimes shock.

Specific Conditions:

1. The burns that are self-inflicted by You in any way will not be covered under this Benefit;

2. A Medical Practitioner has to confirm the percentage of the surface area of the burn and the diagnosis of the burn to Us in writing.

3. If the Insured Person suffers Accidental Injuries resulting in more than one of the nature of burns mentioned in the above table of benefits, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

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

SECTION 20. LIFESTYLE MODIFICATION BENEFIT

If You have opted for this Cover and We have accepted a claim under **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"**, then We will reimburse the Reasonable and Customary Charges/Expenses incurred for improvements to be carried out in the Insured Person's residence and/or vehicle which are certified in writing by a Medical Practitioner to be necessary and following the accident, up to the Sum Insured opted by You and mentioned in Your Policy Schedule against this Section.

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

SECTION 21. EXPENSE FOR EXTERNAL AIDS & APPLIANCES

If you have opted for this Cover and we have accepted a claim under **"Section 2. Permanent Total Disablement" and/or "Section 3. Permanent Partial Disablement"**, then we will reimburse the Reasonable and Customary Charges incurred towards purchase of support items such as artificial limbs, crutches, stretcher, tricycle, wheelchairs or any other item which is prescribed by a Medical Practitioner following an injury sustained in the accident, up to the Sum Insured opted by you and mentioned in your Policy Schedule against this Section

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

SECTION 22. COMPASSIONATE VISIT

If you have opted for this Cover and we have accepted a claim under **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement"** and/or **"Section 11. Accidental Hospitalization"** due to an accident in a location situated outside the City/Town of your usual place of residence mentioned in your Policy Schedule, then we will reimburse the actual cost incurred for to and fro economy class transportation by the most direct route via a common carrier, up to the Sum Insured opted by you and mentioned in your Policy Schedule against this Section, for one of the Insured's "Immediate Family Member" to travel to the place of accident or the Hospital in which the Insured Person is hospitalized.

For the purpose of this Section, the term "**Immediate Family Member"** would mean the Insured Person's spouse, siblings, children above the age of 18 years, parents or parents in law.

Specific Conditions:

The benefit is payable under this Section subject to:

1. The Insured Person's treating Medical Practitioner has advised in writing the personal attendance of an Immediate Family Member.

2. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.

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

SECTION 23. MISCARRIAGE DUE TO ACCIDENTAL INJURY

If you have opted for this Cover and you sustain accidental bodily injury which solely and directly results in **Miscarriage** of a Pregnant Insured Person within 15 days of such accident, then we will pay a lump sum amount as opted by you and mentioned in your Policy Schedule, provided that:

a. The miscarriage shall not be attributed to any natural causes and/or sickness relating to pregnancy or childbirth.

b. We shall not be liable for voluntary termination of pregnancy.

c. This benefit is applicable only to the female Insured Person covered under this Policy.

For the purpose of this Cover, **Miscarriage** shall mean the spontaneous or unplanned expulsion of a foetus from the womb within the first 20 weeks of gestation.

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

SECTION 24. ADVENTURE SPORTS COVER

If you have opted for this Cover and you sustain accidental bodily injury, whilst engaged in Adventure Sports listed below in a non-professional capacity and under the supervision of a trained professional, which solely and directly results in your

a. "**Death**" and/or "**Permanent Total Disablement**" within twelve (12) months from the Date of accident; then we will pay 100% of Sum Insured opted by you and mentioned in your Policy Schedule against this Section for "**Death**" and/or "**Permanent Total Disablement**";

and/or

b. "**Accidental Hospitalization**", then we will Pay Up to the Sum Insured opted by you and mentioned in your Policy Schedule against this Section for "**Accidental Hospitalization**". We will pay the expenses Incurred in respect of the below items under "**Accidental Hospitalization**":

Accommodation/RoomRent	Hospital accommodation in a ward, shared or private room.
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.
Day Care Procedures	Medical Expenses incurred for Medical treatment and/or surgical procedure as an in-patient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement.

Depending upon the option opted by you and mentioned in your Policy Schedule

Option 1: a. **"Death"** and/or **"Permanent Total Disablement"** and b. **"Accidental Hospitalization"**

Option 2: a. **"Death"** and/or **"Permanent Total Disablement"**

Option 3: b. **"Accidental Hospitalization"**

List of Adventure Sports Activities Covered:

If you have opted for this Section, we will cover you against the below-listed Adventure Sports only: "abseiling, aerial safari, ballooning, black water rafting, bouldering, bushwalking up to 3,000 mts, canoeing, go karting, hiking/trekking up to 3,000 mts, ice skating (indoor only), jet boating, jet skiing, kayaking, mountain biking (cross country), mountain biking on tracks and trails, parasailing, parascending (over water only), rafting, river boarding, rock climbing up to 3,000 mts, rowing/sculling, sea canoeing, sea kayaking (coastal waters only), snorkelling, speed boating, surf boat rowing, surfing, tubing, wakeskating, wakeboarding, windsurfing (coastal waters within 3 nautical miles only), yachting (coastal waters only), bungee jumping, motorbiking, sandboarding, sand skiing, skidoos, skiing/snowboarding, snowmobiling, snow rafting, zip lining, zorbing, triathlon, gliding, hang gliding, parachuting, paragliding, parapenting, skydiving with a professional trainer, scuba diving to 50 metres, unless any of the activities are modified/added/deleted and are specifically mentioned in your Policy Schedule against this Section."

SPECIFIC CONDITIONS:

1. The cover for the Insured Person under this Section shall terminate immediately once a claim is admitted and paid under the Adventure Sports Cover for "**Death**" or "**Permanent Total Disablement**".

2. Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by you and mentioned in your Policy Schedule against this Section.

3. We will not pay any claim under this Cover, whilst you are Training for or Taking part in sport as a:

   a. Professional for which you are paid or funded by sponsorship or grant; or

   b. As an amateur sportsperson; or

   c. You are not performing the activity under the supervision of a trained professional.

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

SECTION 25. CRITICAL ILLNESS

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 per the Plan Opted by you and mentioned in your Policy Schedule 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 from the date of inception of first "Digit Total Protect Policy" with Us covering Critical Illness.

   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. No Claim under this Section shall be admissible if the Critical Illness or the Surgical Procedure 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.

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.

Plan-wise Covered Critical Illnesses

Sr.	No. Category	Critical Illness	Plan A	Plan B	Plan C
1	**Malignancy**	Cancer of Specified Severity	Covered	Covered	Covered
2	**Cardiovascular system**	Myocardial Infarction	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered
7		Cardiomyopathy	Not Covered	Not Covered	Covered
8	**Cardiovascular system**	Pulmonary artery graft surgery	Not Covered	Not Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered
10	**Major Organ Transplant**	End-stage Lung Failure	Covered	Covered	Covered
11		End-stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered
14	**Nervous System**	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered
17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered

22	**Nervous System**	Muscular Dystrophy	Not Covered	Not Covered	Covered
23		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered
24		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered
25		Bacterial Meningitis	Not Covered	Not Covered	Covered
26		Alzheimer's disease	Not Covered	Not Covered	Covered
27		Encephalitis	Not Covered	Not Covered	Covered
28		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered
29	**Others**	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

CRITICAL ILLNESS DEFINITIONS APPLICABLE TO BENEFIT COVER 25 ABOVE:

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

I. STANDARD DEFINITIONS:

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 –

a. 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.

b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

c. Malignant melanoma that has not caused invasion beyond the epidermis;

d. 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

e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

f. Chronic lymphocytic leukaemia less than RAI stage 3

g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain).

b. New characteristic electrocardiogram changes.

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

a. Other Acute Coronary Syndromes.

b. Any type of angina pectoris.

c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

a. 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.

b. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures.

4. 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.

5. 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:

a. No response to external stimuli continuously for at least 96 hours;

b. Life support measures are necessary to sustain life; and

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

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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.

7. 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:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

a. Other stem-cell transplants

b. Where only Islets of Langerhans are transplanted

9. 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.

10. 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.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. 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. Neurological damage due to SLE is excluded.

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.

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

b. 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. END-STAGE LUNG FAILURE

I. End-stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

d. Dyspnoea at rest.

14. END-STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

a. Permanent jaundice; and

b. Ascites; and

c. Hepatic encephalopathy.

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

15. 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 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:

a. 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;

b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

d. Mobility: the ability to move indoors from room to room on level surfaces;

e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

f. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

a. Spinal cord injury;

16. 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 Cauterization. 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:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. 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.

II. SPECIFIC DEFINITIONS:

17. SURGERY TO AORTA

a. 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.

18. ABDOMINAL AORTA ANEURYSM

An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.

a. The diagnosis must be supported by CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.

b. Congenital conditions are excluded.

19. CARDIOMYOPATHY

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

The following conditions are excluded:

• Cardiomyopathy secondary to alcohol or drug abuse.

• All other forms of heart disease, heart enlargement and myocarditis.

20. PULMONARY ARTERY GRAFT SURGERY

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

21. APALLIC SYNDROME

a. 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.

22. PARKINSON'S DISEASE

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

The diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication;

b. Signs of progressive impairment; and

c. Inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

Parkinson's Disease secondary to drug and/or alcohol abuse is excluded.

23. MUSCULAR DYSTROPHY

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:

a. Family history of muscular dystrophy;

b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;

c. Characteristic electromyogram; or

d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

24. PROGRESSIVE SUPRANUCLEAR PALSY

A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

25. CREUTZFELDT-JAKOB DISEASE (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

Mental functioning would mean functions/processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

26. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

27. ALZHEIMER'S DISEASE

Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuroradiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

The following conditions are however not covered:

a. Non-organic diseases such as neurosis and psychiatric Illnesses;

b. Alcohol-related brain damage; and

c. Any other type of irreversible organic disorder/dementia.

28. ENCEPHALITIS

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist).

The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

Exclusions:

• Encephalitis in the presence of HIV infection is excluded.

29. LOSS OF INDEPENDENT EXISTENCE

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 Activities of Daily Living.

30. SYSTEMIC LUPUS ERYTHEMATOSUS

A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. Systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

a. Class I: Minimal change – Negative, normal urine.

b. Class II: Mesangial – Moderate proteinuria, active sediment.

c. Class III: Focal Segmental – Proteinuria, active sediment.

d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.

e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE'S SYNDROME

Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for a continuous period of at least 30 Days. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist or Nephrologist).

32. FULMINANT HEPATITIS

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;

b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

c. Rapid deterioration of liver function tests;

d. Deepening jaundice; and

e. Hepatic encephalopathy.
Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

33. PNEUMONECTOMY

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

• Removal of a lobe of the lungs (lobectomy)

• Lung resection or incision

34. APLASTIC ANEMIA

I. Irreversible persistent bone marrow failure which results in anemia, 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 anemia 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 26. HIV 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 first diagnosed to be suffering from an HIV Infection during the Policy Period and provided that HIV Infection is caused by any of the reasons other than Transmission through unprotected sex (Heterosexual, Homosexual or Bisexual).

For the purpose of this cover,

"HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating characteristics.

and/or;

a positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

I. **Special Terms and Conditions Applicable to this Section:**

a. Coverage under this Section shall terminate in respect of the Insured Person against whom a claim has been accepted. However, the coverage under the Policy for other Sections (if opted) for that Insured Person shall continue under this Policy.

b. Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Policy Start Date or during Initial Waiting Period as opted by You and mentioned in Your Policy Schedule is excluded from the Scope of the Cover provided under this Section.

SECTION 27. EMI PROTECTION COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your "**Death**" or "**Permanent Total Disablement**" or "**Permanent Partial Disablement**" within twelve (12) months from the Date of accident or suffer from "**Critical Illness**" as per the cover opted by You and mentioned in Your Policy Schedule against this Section and this completely prevents You from performing each and every duty pertaining to Your employment or occupation mentioned in Your Policy Schedule for a minimum period of 1 month, We will pay an amount equivalent to Your contribution in EMI of Your Loan from a Financial Institution, up to the Sum Insured and Number of Months opted by You and mentioned in Your Policy Schedule against this Section, provided that:

a. Satisfactory proof is submitted confirming that "**Permanent Total Disablement**" or "**Permanent Partial Disablement**" or "**Critical Illness**" has completely prevented You from engaging in Your Employment or Occupation mentioned in Your Policy Schedule.

b. We will stop making payments when We have a certification from Independent medical practitioner empanelled by Us stating that You can engage in Your Employment or Occupation again or when We have made payments for a maximum period of months, as opted by You and mentioned in Your Policy Schedule, beginning from the date You met with the Accidental Bodily Injury or were first Diagnosed with Critical Illness or first underwent Surgical Procedures mentioned under Critical Illness, whichever is earlier.

c. The EMI amount would not include any arrears/payment that are overdue and unpaid by the Insured Person prior to the date of accident, due to any reasons whatsoever.

For the Purpose of this Cover;

a. "Permanent Partial Disablement" means:

- Loss of arm at the shoulder joint
- Loss of leg above centre of the femur
- Loss of arm to a point above elbow joint
- Loss of leg up to a point below the femur
- Loss of arm below elbow joint
- Loss of hand at the wrist
- Complete and irrecoverable loss of sight of an eye
- Loss of leg to a point below the knee
- Loss of leg up the centre of tibia
- Loss of foot at the ankle

b. "Critical Illness" shall mean the below-listed illnesses that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life.

Provided that:

1. 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 from the date of inception of first "Digit Total Protect Policy" with Us covering Critical Illness.

2. 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.

3. No Claim under this Section shall be admissible if the Critical Illness or the Surgical Procedure 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.

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 Anemia

CRITICAL ILLNESS DEFINITIONS APPLICABLE TO COVER 27 ABOVE:

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

I. STANDARD DEFINITIONS:

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 :

a. 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.

b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

c. Malignant melanoma that has not caused invasion beyond the epidermis;

d. 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;

e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

f. Chronic lymphocytic Leukemia less than RAI stage 3;

g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;

h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain).

b. New characteristic electrocardiogram changes.

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

a. Other Acute Coronary Syndromes.

b. Any type of angina pectoris.

c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

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:

a. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

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:

a. No response to external stimuli continuously for at least 96 hours;

b. Life support measures are necessary to sustain life; and

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

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

a. Other stem-cell transplants

b. Where only Islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. 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. Neurological damage due to SLE is excluded.

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.

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

b. 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. END-STAGE LUNG FAILURE

I. End-stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

d. Dyspnoea at rest.

14. END-STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

a. Permanent jaundice; and

b. Ascites; and

c. Hepatic encephalopathy.

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

15. 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 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:

a. 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;

b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

d. Mobility: the ability to move indoors from room to room on level surfaces;

e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

f. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

a. Spinal cord injury;

16. 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 Cauterization. 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:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. 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.

II. SPECIFIC DEFINITIONS:

17. APLASTIC ANEMIA

Irreversible persistent bone marrow failure which results in anemia, 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 anemia 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.

18. APALLIC SYNDROME

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.

19. LOSS OF INDEPENDENT EXISTENCE

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 Activities of Daily Living.

20. SURGERY TO AORTA

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.

II. CUMULATIVE BONUS

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

If you've been safe and healthy and have had No Claims made under the **"Section 1. Accidental Death" and/or "Section 2. Permanent Total Disablement"** and/or "**Section 3. Permanent Partial Disablement" and/or "Section 11. Accidental 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:

a. 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.

b. For **"Section 11. Accidental Hospitalization Cover"** opted on 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 of the Family during the expiring Policy Period.

c. 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.

d. 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.

e. The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with Us.

The Cumulative Bonus will be Calculated on the Sum Insured as opted by you under **"Section 1. Accidental Death" and/or "Section 2. Permanent Total Disablement"** and/or "**Section 3. Permanent Partial Disablement" and/or "Section 11. Accidental Hospitalization Cover".**

D. EXCLUSIONS

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

I. STANDARD DEFINITIONS:

1. 30-day Waiting Period / Initial Waiting Period (Code-Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

However, such waiting Period can be amended to the number of days as opted by you and mentioned in your policy schedule.

2. Investigation & Evaluation (Code-Excl04)

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

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

3. Rest Cure, Rehabilitation and Respite Care (Code-Excl05)

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

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

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs except to the extent covered under **Section 12. Home (Domiciliary) Hospitalization**, if opted by You.

4. Cosmetic or Plastic Surgery (Code-Excl08)

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

5. Hazardous or Adventure Sports (Code- Excl09)

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

(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)

This exclusion will be deleted to the extent of the coverage provided under "**Section 24 – Adventure Sports Cover**", provided this section is opted by You.

6. Breach of Law (Code-Excl10)

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

7. Excluded Providers (Code-Excl11)

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

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

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

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

11. Refractive Error (Code-Excl15)

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

12. Unproven Treatments (Code-Excl16)

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

II. SPECIFIC EXCLUSIONS

13. Artificial Life Maintenance

Artificial Life Maintenance, including life support machine used, where such treatment is used to maintain the Insured/Patient in a vegetative state. However, expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the Policy.

14. 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 narcotics or intoxicating drugs or alcohol or solvent.

b. Intentional self-injury.

c. Use or consumption of narcotics or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner).

15. Pre-Existing Disability

a. Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first of this Policy.

b. Any additional Hospitalization Expenses not resulting from an accidental Injury.

16. Circumcision

Circumcision unless necessitated by an Accident;

17. Defence Operation/Aviation Activities

We will not pay any claim under this Policy, arising out of Your

a. Whilst engaging in aviation or whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare-paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world and except to the extent covered under "**Section 24 – Adventure Sports Cover**", provided this section is opted by you.

b. Whilst the Insured person is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft, or Scheduled Airlines.

c. Involvement in naval, military, air force operation.

18. 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 additives, 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 refer to Annexure A provided in the Policy document or visit our website for complete list of non-medical items)

19. Insufficient Document

Under "**General Condition No. 35 - Claims Notification and Procedure**", We have provided Section-wise list of relevant necessary documents to be submitted at the time of claim. We shall not be liable to pay any claim in case all the relevant necessary documents are not submitted to Us and further We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last necessary document.

20. Spectacles, Hearing Aids & Related Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy.

21. Eyesight & Optical Services

We do not cover treatment for:

a. 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.

b. Intravitreal injection including but not limited to Lucentis, Macugen or any other similar treatment in excess of 5% of Sum Insured opted under **Section 11 Accidental Hospitalization Cover**.

22. Preventive Treatment

We do not cover inoculations, vaccinations of any kind unless forming part of treatment for accidental bodily Injury as prescribed by the Medical Practitioner.

23. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy or observation service.

24. Substance Abuse and Addictions

a. Any claim resulting from an event where You were under the influence of Alcohol, opioids or nicotine or drugs.

b. Any claim as a result of Withdrawal and de-addiction of Alcohol, opioids or nicotine or drugs, unless the drugs are prescribed by a medical practitioner and supported by a prescription.

c. Any injury resulting from event strictly prohibited or not advised by Your treating medical practitioner.

25. War and Hazardous Substances

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

a. 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

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

c. Any acts of terrorism, unless specifically agreed by Us and mentioned in Your Policy Schedule.

26. 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.

27. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

28. Specific Treatments

We will not pay for expenses related to administration of medications or procedures mentioned below:

a. Hyaluronic acid, Remicade or Botulinum Toxin, Lucentis, Avastin.

b. Intra-articular/intrathecal or corticosteroid injections.

c. Robotic surgeries however expenses will be covered up-to-the conventional procedure cost.

d. Predictive Genome testing.

29. 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 and except to the extent covered under **Section 15. Out-Patient (OPD) Benefit**, if opted.

30. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment.

31. Mental Disorders

Accidental "**Death**" or "**Permanent Total Disablement**" or "**Permanent Partial Disablement**" due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES

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.

1. DISCLOSURE OF INFORMATION

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 by the policyholder.

'Material facts' for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

2. CONDITION PRECEDENT TO ADMISSION OF LIABILITY

The terms and conditions of the policy must be fulfilled by the insured person for the company to make any payment for claim(s) arising under the policy.

3. NOMINATION

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

CONDITION APPLICABLE DURING THE CONTRACT

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

4. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

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

5. WITHDRAWAL OF PRODUCT

a. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the Policy.

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

6. MORATORIUM PERIOD

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

7. SPECIAL CONDITIONS APPLICABLE FOR POLICIES ISSUED WITH PREMIUM PAYMENT ON INSTALLMENT BASIS

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

a. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.

b. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.

c. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

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

e. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled.

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

g. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

h. Where Premium Payment is on Installment Basis, there will be no refund of premium in case of Policy Cancellation requested by You.

IMPORTANT NOTE (ECS OR NACH MODE):

1. Installment can also be paid through ECS or NACH mode. In cases where monthly installment is allowed by NACH or ECS mandate, three (3) installments need to be paid at the inception of the Policy.

2. We shall inform You in case of any change either in the terms and conditions of the Policy Contract or in the Premium Rate and afresh ECS authorization needs to be submitted by You.

3. You can withdraw from the ECS mode of payment at least fifteen days prior to the due date of instalment premium payable as per the ECS/NACH mandate form submitted by You, by submitting written communication to Us as well as Your Bank.

8. CANCELLATION

A. Cancellation by You

The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Short Period Scale

Period in Risk	Premium Refund based on Policy Term		
	Up to 1 Year	2 Year	3 Year
Within 3 months	60%	60%	60%
Exceeding 3 months but less than 6 months	40%	50%	55%
Exceeding 6 months but less than 9 months	25%	40%	50%
Exceeding 9 months but less than 12 months	0%	35%	45%
Exceeding 12 months but less than 15 months	NA	25%	40%
Exceeding 15 months but less than 18 months	NA	20%	30%
Exceeding 18 months but less than 21 months	NA	10%	25%
Exceeding 21 months but less than 24 months	NA	0%	20%
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%

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

B. Cancellation by Company

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

C. IN CASE OF DEATH OF INSURED PERSON

i. Individual Policy
In case, no claim has been made, and termination takes place on account of death of the insured person, We shall refund a portion of the premium as per short term premium mentioned in 8.A.1, subject to the terms and conditions of the Policy. There will be no change in premium for other family members covered under the policy for the remaining duration of the policy.

ii. Family Floater Policy.
In case of death of Insured Family Member, cover shall continue for the remaining family members till the end of Policy Period. Provided no claim has been made, revised premium would be calculated basis new family composition and revised premium would be calculated on short-term basis as per table mentioned in 8.A.1, subject to the terms and conditions of the Policy. Difference between short-term premium of new family composition with old family composition shall be considered for refund.

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

9. Free Look Period

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

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

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

a. A refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

b. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

Please note KYC documents (Photo ID card) shall be required if 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.

10. COMPLETE DISCHARGE

Any payment to the Policyholder, insured person or his/ her nominee or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

11. MULTIPLE POLICIES (Applicable to Indemnity Sections under this Policy)

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

b. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

c. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

e. The contribution clause shall not be applicable where the cover/benefit offered:

- Is fixed in nature (For example, Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover).

- Does not have any relation to the treatment costs;

12. FRAUD

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

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

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

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

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

c. Any other act fitted to deceive; and

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

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

13. Claim Settlement (Provision for Penal Interest)

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

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

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

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

"Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

CONDITIONS FOR RENEWAL OF THE CONTRACT

14. RENEWAL OF POLICY

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

b. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

c. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

d. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

e. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

f. No loading shall apply on renewals based on individual claims experience.

g. 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 (For Example, Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover).

15. PORTABILITY

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

For Detailed Guidelines on portability, kindly refer to the link **Click Here**

https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf

16. MIGRATION

The insured person will have the option to migrate the policy to other health insurance products/ plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer to the **Click Here**

https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf

17. CUSTOMER GRIEVANCE REDRESSAL POLICY

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

Website: **https://www.godigit.com**

Toll-Free: **1-800-258- 4242**

Email: **hello@godigit.com**

Senior citizens can contact us on **1-800-258-4242** or write to us at **seniors@godigit.com**

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at **grievance@godigit.com**

For updated details of grievance officer, kindly refer the link: **Click Here**

https://d2h44aw7l5xdvz.cloudfront.net/claims/GRO-list.pdf

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

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

The contact details of the Insurance Ombudsman Centers are mentioned in Annexure B.

II. SPECIFIC TERMS AND CLAUSES

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.

18. POLICY PERIOD

The Policy can be issued for tenure of 1 year, 2 years and 3 years.

19. OBSERVANCE OF TERMS AND CONDITIONS

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.

20. ASSIGNMENT (IF OPTED)–IT IS HEREBY DECLARED AND AGREED THAT:

a. From the Policy Start Date, the monies payable by the Company to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of the Bank or Financial Institution as named in the Policy Schedule;

b. Upon any monies becoming payable under this Policy the same shall be paid by the Company to the Bank or Financial Institution as named in Policy Schedule, without any reference/ notice to the Insured, but not exceeding the Principal Outstanding as defined under the Policy. In the event of any monies payable under this Policy exceeding the Principal Outstanding, the Company shall pay such monies as exceeding the Principal Outstanding to the Insured;

c. The receipt of such monies in the manner aforesaid by the Bank or Financial Institution as named in the Policy Schedule and the Insured shall completely discharge the Company from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

21. 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 Policy Schedule;

c. The claim under such Policy if any, shall be rejected/repudiated forthwith.

22. ELECTRONIC TRANSACTIONS

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions

when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

23. SHORT PERIOD COVER

Short Period Policy can be issued for period of less than one year for all Sections.

24. ON-DUTY COVER

On-Duty Cover can be provided for a restricted time period of the day i.e. work duty hours only for all Sections, except for "**Section 25. Critical Illness**" and "**Section 26. HIV Cover**".

25. GEOGRAPHICAL COVERAGE

Geographical Coverage for each Section is as per the below table and Claims under the Policy will be paid in accordance with the same. All claims will be payable in INR only.

Section with Benefits	Geography Coverage
Section 1. Accidental Death	Worldwide
Section 2. Permanent Total Disablement	Worldwide
Section 3. Permanent Partial Disablement	Worldwide
Section 4. Loss of Income Benefit	Worldwide
Section 5. Children Education Benefit	Worldwide
Section 6. Marriage Expense for Children Benefit	Worldwide
Section 7. Orphan Benefit for Children	Worldwide
Section 8. Funeral Expenses	Worldwide
Section 9. Transportation Expenses	Worldwide
Section 10. Trauma Counselling	Within India
Section 11. Accidental Hospitalization Cover	Within India
Section 12. Home (Domiciliary) Hospitalization	Within India
Section 13. Long Hospitalization Cash Benefit	Within India
Section 14. Daily Hospital Cash Cover	Within India
Section 15. Out-patient Benefit	Within India
Section 16. Emergency Air Ambulance	Within India
Section 17. Coma benefit cover	Worldwide

Section 18. Fracture Cover	Worldwide
Section 19. Burns cover	Worldwide
Section 20. Lifestyle Modification	Worldwide
Section 21. Expense for External Aids and Appliances	Worldwide
Section 22. Compassionate Visit	Worldwide
Section 23. Miscarriage Due to Accidental Injury	Worldwide
Section 24. Adventure Sports Cover	-
A. Death/Permanent Total Disablement	Worldwide
B. Accidental Hospitalization	Within India
Section 25. Critical Illness	Worldwide
Section 26. HIV Cover	Worldwide
Section 27. EMI Protection Cover	Worldwide (Claim Payment Can be done only if loan is availed from Indian Financial Institutions in INR)

CONDITION APPLICABLE DURING THE CONTRACT

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

26. ALTERATIONS TO THE POLICY

This Policy constitutes the complete contract of insurance between the Policyholder and Us. 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 Insured Person.

27. MATERIAL CHANGE/CHANGE OF OCCUPATION

The Insured/ Insured Person shall immediately notify the Company in writing of any material change in the risk or change in business or occupation during the Policy Period. Insured should also at his own expense take precautions as circumstances may require ensuring safety thereby containing the circumstances that may give rise to a claim. The Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

The above notification is not mandatory when only the employer changes, but the nature of occupation does not change.

28. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in Our possession other than that information expressly disclosed in the Proposal Form or otherwise to Us, shall not be held to be binding or prejudicially affect Us.

29. LAW AND JURISDICTION

It is hereby declared and agreed that this contract of insurance and all claims thereunder shall be governed by Indian Law and any legal proceeding in respect thereof shall be raised a competent court of India. All claims shall be paid in Indian Rupees only.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

30. PHYSICAL EXAMINATION

Any medical official or other agent of the company shall be allowed to examine the Insured Person(s) in case of alleged injury or disablement when and as often as may be reasonably be required on behalf of the Company.

31. 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.

32. RECORDS TO BE MAINTAINED

You shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

33. POLICY DISPUTE

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

34. AUTOMATIC TERMINATION OF COVER FOR INSURED PERSON

The cover for the Insured Person shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under **"Death" or "Permanent Total Disablement".**

35. CLAIMS NOTIFICATION AND PROCEDURE

If the Insured Person meets any accidental injury or suffers from Critical illness or any specific condition covered under the Policy 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:

1. Cashless Claim Process (Applicable Only for "Section 11. Accidental Hospitalization Cover"):

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 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.

2. Reimbursement Claim Process

A. For all Sections with Accidental Hospitalization Cover

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

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

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

   d. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
   'Bank rate' shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

   e. 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.

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 and A.2.a above may be considered where the reason for delay is proved to our satisfaction.

B. For All Other Covers without Accidental Hospitalization Cover

Upon the occurrence of any event that may result in a Claim under this Policy, then as a condition precedent to our liability:

a. Policyholder or the Insured Person or someone claiming on his/her behalf must inform Us in writing immediately and in any event within 30 days from the date of occurrence any accident/incident that may result in a claim and submit all documents to us within 30 days from the date of intimation.

b. Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends, where ever required.

c. Insured Person must take reasonable steps to lessen the consequence of Bodily injury.

d. Insured Person should allow examination by our medical advisors if we ask for this.

e. Policyholder or Insured Person or someone claiming on his/her behalf must promptly give us documentation and other information we ask for to investigate the claim or our obligation to make payment for it.

f. In case of the Insured Person's death, someone claiming on his/her behalf must inform us in writing immediately and send us a copy of the post mortem report (if conducted) within 30 days.

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

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

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

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

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 and f above may be considered where the reason for delay is proved to our satisfaction.

A. List of Claim Documents:

In addition to the Duly Completed Claim Form signed by the Insured/Insured's Nominee/Legal Heir & NEFT Details or Cancelled Cheque of the Insured/Insured's Nominee/Legal Heir, ID proof (KYC document) of insured and Nominee, address proof wherever applicable, We need to have the below documents, wherever applicable:

Section	Documents
Section 1. Accidental Death Section 24. Adventure Sports Cover Section 7. Orphan Benefit For Children	• Copy of Address Proof (Ration Card or Electricity Bill Copy). • Attested Copy of Death Certificate. • Death Summary/Certificate from the hospital authority (wherever applicable). • Burial Certificate (wherever applicable). • Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable). • Attested Copy of FIR/Panchanama/Inquest Panchanama. (wherever applicable). • Attested Copy of Post Mortem Report (Only if conducted). • Attested Copy of Viscera report if any (Only if Post Mortem is conducted). • For Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider/Pre-participation fitness certificate (wherever applicable). • Attested Copy of Passport or any other valid document which will suffice as a proof of relationship between the insured, insured's spouse and orphan child. (Applicable only for Orphan Benefit).
Section 2. Permanent Total Disablement Section 3. Permanent Partial Disablement Section 24. Adventure Sports Cover	• Attested Copy of disability certificate from relevant government Medical authority. • Attested copy of FIR (If required). • All Investigation reports confirming the disability. • Complete Treatment record with follow-up documentation. • For Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider/Pre-participation fitness certificate (wherever applicable). • Disability assessment report from Digit empanelled medical specialist (if required).
Section 4. Loss of Income Benefit	• Attested copy of FIR. (If required) • All Investigation reports confirming the disability. • For Employed persons: Certificate from HR with details of medical leave availed during the period of Injury. • Certificate from the treating doctor mentioning the extent of Injury along with the period of disability. • Certificate from Treating doctor with date of full recovery & resuming of duties.
Section 5. Children Education Benefit	• Bonafide Certificate from School/College or Certificate from the Educational Institution.
Section 6. Marriage Expense for Children Benefit	• Proof of Relationship with the Insured Person. • Photo Identity Proof of Child. • Age Proof of the Dependent Child.
Section 8. Funeral Expenses	• Original Invoice of Expenses Incurred during Funeral.
Section 9. Transportation Expenses	• Original Invoices of expenses incurred for Carriage of Dead Body/ repatriation of mortal remains.
Section 10. Trauma Counselling	• Documents as mentioned under Section 1. Accidental Death and/or Section 2. Permanent Total Disablement and/or Section 3. Permanent Partial Disablement. • Original Invoice of Expenses Incurred for Counselling. • Medical Practitioner's letter advising Counselling. • Treatment plan for Counselling from Specialist.

Section 11. Accidental Hospitalization Cover Section 13. Long Hospitalization Cash Benefit Section 14. Daily Hospital Cash Cover	• Discharge Summary • Original Hospital Main Bill • Original Hospital Bill Break Up of Various Expenses • Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital. • Consultation Papers • Investigation Reports • Digital Images/CDs of the Investigation Procedures (if required) • MLC/FIR Report (If applicable) • Original Invoice/Sticker (If applicable) • Post Mortem Report (If applicable) • Attending Physician Certificate (If applicable) • Death Certificate (If applicable)
Section 12. Home (Domiciliary) Hospitalization	• Attending Physician Certificate mentioning the need for Home (Domiciliary Hospitalization). • Original Pharmacy Bills • Consultation Papers • Original Investigation bills and Reports • Original Invoices in respect of payment made to the treating Medical Practitioner.
Section 15. Out-patient Benefit	• Consultation Papers • Original Investigation bills and Reports • Digital Images/CDs of the Investigation Procedures (if required). • Original Pharmacy Bills
Section 16. Emergency Air Ambulance	• Original bills and receipts paid for the transportation from Registered Ambulance Service Provider. • Letter from Medical Practitioner indicating emergency need for such transportation and fitness for transportation.
Section 17. Coma Benefit Cover	• Certificate from the Treating Medical Practitioner certifying the cause and severity of Coma. • All relevant medical summary leading to Coma
Section 18. Fracture Cover	• X-Ray Confirming the Fracture & site of Fracture • Pre and post-operative radiological imaging reports with films confirming the extent of the fracture. • Certificate from Treating Medical Practitioner with extent of Injury, Cause of injury, Site of Injury & Date of Injury. • Treatment Details • Discharge Summary (if Hospitalized)
Section 19. Burns cover	• Certificate from Treating Medical Practitioner with extent of Burns Injury/Cause of Burns. • Treatment Details • Medico-Legal Certificate copy/First Information Report Copy (If applicable). • Discharge Summary (if Hospitalized)
Section 20. Lifestyle Modification	• Certification from Medical Practitioner necessitating the Modification. • Original Invoices of actual expenses incurred for the Modifications.

Section 21. Expense for External Aids and Appliances	• Prescription of treating Medical Practitioner for use of External Aids and Appliance. • Original Invoices of actual expenses incurred for the purchase of External Aids and Appliance.
Section 22. Compassionate Visit	• Letter from Medical Practitioner advising presence of Immediate Family member. • Original travel tickets/bills and receipts mentioning the actual expenses of the travel with the date of booking & date of travel. • Age Proof of the Person who has visited the Insured
Section 23. Miscarriage Due to Accidental Injury	• Treating Medical Practitioners Certificate mentioning reason for Miscarriage and date of accidental injury. • Medical Reports & Investigations Done • Discharge Summary (if applicable)
Section 25. Critical Illness Section 26. HIV Cover	• Medical Reports/ Records • Investigation Tests Report • Copy of Hospital Summary/Discharge Card • Medical Practitioner's Certificate confirming the Illness /Treatment Advise/Medical Reference.
Section 27. EMI Protection cover	• Current Outstanding Loan Certificate from Financer • Loan Disbursement Letter along with the payment record till the date of Accident or first diagnosis of Critical Illness or first underwent surgical procedure. • Certificate from HR with details of medical leave availed during the period of Injury. • Copy of Address Proof (Ration Card or Electricity Bill Copy). • In Case of Death o Attested Copy of Death Certificate o Death Summary/Certificate from the hospital authority (wherever applicable) o Burial Certificate (wherever applicable) o Attested Copy of Statement of Witness, if any lodged with police authorities (wherever applicable) o Attested Copy of FIR/Panchanama/Inquest Panchanama. (wherever applicable) o Attested Copy of Post Mortem Report (Only if conducted) o Attested Copy of Viscera report if any (Only if Post Mortem is conducted) • In case of Permanent Total Disablement, Permanent Partial Disablement o Attested Copy of disability certificate from relevant government Medical authority o Attested copy of FIR (If required) o All Investigation reports confirming the disability o Complete Treatment record with follow-up documentation o Disability assessment report from Digit empanelled medical specialist (if required)

For the purpose of Claims clarification, we may require additional documents in case of any insured event arising leading to claim.

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

CONDITIONS FOR RENEWAL OF THE CONTRACT

36. SUM INSURED ENHANCEMENT

a. Sum Insured enhancement can be done only at the time of renewal. You need to submit fresh proposal for Sum Insured Enhancement.

b. The acceptance of enhancement of Sum Insured would be at Our discretion, based on the income, health condition of the insured members & claim history of the policy.

c. All waiting periods (if any) 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.

37. CONTINUITY BENEFITS

We will grant continuity of benefits which were available to the Insured Persons under a health insurance policy which provides similar benefits in the immediately preceding Year of Coverage provided that:

a. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period etc) which are applicable under this Policy;

b. Any other waiting period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

ANNEXURE

LIST OF DAY CARE PROCEDURES

Sr. No	Day Care Procedures for Accidental Injuries
1	Surgery for ligament tear
2	Surgery for meniscus tear
3	Surgery for Hemarthrosis/Pyoarthrosis
4	Removal of fracture pins/nails
5	Removal of metal wire
6	Foreign body removal from nose
7	Suturing - CLW -under LA or GA
8	Surgical debridement of wound
9	Closed reduction on fracture, luxation
10	Reduction of dislocation under GA
11	Tennis elbow release
12	Arthroscopic knee aspiration
13	Aspiration of Hematoma
14	Incision and Drainage
15	Foreign body removal from cornea
16	Foreign body removal from posterior chamber of eye
17	Foreign body removal from lens of the eye
18	Foreign body removal from orbit and eyeball
19	Reduction of nasal fracture
20	Foreign body removal from conjunctiva

ANNEXURE – A

List I – Optional Items

SL No	Item
1.	BABY FOOD (Not Payable)
2.	BABY UTILITIES CHARGES (Not Payable)
3.	BEAUTY SERVICES (Not Payable)
4.	BELTS/BRACES (Payable incases where insured has undergone Surgery of thoracic or lumbar spine)
5.	BUDS (Not Payable)
6.	COLD PACK/HOT PACK (Not Payable)
7.	CARRY BAGS (Not Payable)
8.	EMAIL/ INTERNET CHARGES (Not Payable)
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) (Not Payable)
10.	LEGGINGS (Payable in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable)
11.	LAUNDRY CHARGES (Not Payable)
12.	MINERAL WATER (Not Payable)
13.	SANITARY PAD (Not Payable)
14.	TELEPHONE CHARGES (Not Payable)
15.	GUEST SERVICES (Not Payable)
16.	CREPE BANDAGE (Not Payable)
17.	DIAPER OF ANY TYPE (Not Payable)
18.	EYELET COLLAR (Not Payable)
19.	SLINGS (Reasonable costs for one sling in case of upper arm fractures should be considered)
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES (Part Of Cost Of Blood, Not Payable)
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges (Payable Under Room Charges Not if separately levied)
23.	SURCHARGES (Part of Room Charge Not Payable Separately)

24.	ATTENDANT CHARGES (Part of Room Charge Not Payable Separately)
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) (Patient Diet provided by hospital is Payable)
26.	BIRTH CERTIFICATE (Not Payable)
27.	CERTIFICATE CHARGES (Not Payable)
28.	COURIER CHARGES (Not Payable)
29.	CONVEYANCE CHARGES (Not Payable)
30.	MEDICAL CERTIFICATE (Not Payable)
31.	MEDICAL RECORDS (Not Payable)
32.	PHOTOCOPIES CHARGES (Not Payable)
33.	MORTUARY CHARGES (Payable up to 24 Hours. Shifting charges not Payable)
34.	WALKING AIDS CHARGES (Not Payable)
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) (Not Payable)
36.	SPACER (Not Payable)
37.	SPIROMETRE (Device Not Payable)
38.	NEBULIZER KIT (Not Payable)
39.	STEAM INHALER (Not Payable)
40.	ARM SLING (Not Payable)
41.	THERMOMETER (Not Payable)
42.	CERVICAL COLLAR (Not Payable)
43.	SPLINT (Not Payable)
44.	DIABETIC FOOTWEAR (Not Payable)
45.	KNEE BRACES (LONG/ SHORT/ HINGED) (Not Payable)
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER (Not Payable)
47.	LUMBO SACRAL BELT (Payable only where Insured has undergone Surgery of Lumbar Spine)
48.	NIMBUS BED OR WATER OR AIR BED CHARGES (Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs. 200/day
49.	AMBULANCE COLLAR (Not Payable)

50.	AMBULANCE EQUIPMENT (Not Payable)
51.	ABDOMINAL BINDER (Not Payable)
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES (Post-hospitalization nursing charges not Payable)
53.	SUGAR-FREE Tablets (Payable. Sugar-free variants of admissible medicines are Not excluded)
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES (Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be Payable)
56.	GLOVES (Sterilized Gloves Payable/Unsterilized Gloves not payable)
57.	NEBULISATION KIT (Payable Reasonably only if used during Hospitalization)
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, etc.]
59.	KIDNEY TRAY (Not Payable)
60.	MASK (Not Payable)
61.	OUNCE GLASS (Not Payable)
62.	OXYGEN MASK (Not Payable)
63.	PELVIC TRACTION BELT (Not Payable)
64.	PAN CAN (Not Payable)
65.	TROLLY COVER (Not Payable)
66.	UROMETER, URINE JUG (Not Payable)
67.	AMBULANCE (Payable Reasonably only if used during Hospitalization up to sub-limit mentioned in the policy schedule)
68.	VASOFIX SAFETY (Not Payable)

List II - Items that are to be subsumed into Room Charges

SL No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED) (Not Payable)
2	HAND WASH (Not Payable)
3	SHOE COVER (Not Payable)
4	CAPS (Not Payable)
5	CRADLE CHARGES (Not Payable)
6	COMB (Not Payable)
7	EAU-DE-COLOGNE/ROOM FRESHENERS (Not Payable)
8	FOOT COVER (Not Payable)
9	GOWN (Not Payable)
10	SLIPPERS (Not Payable)
11	TISSUE PAPER (Not Payable)
12	TOOTHPASTE (Not Payable)
13	TOOTHBRUSH (Not Payable)
14	BED PAN (Not Payable)
15	FACE MASK (Not Payable)
16	FLEXI MASK (Not Payable)
17	HAND HOLDER (Not Payable)
18	SPUTUM CUP (Payable Under Investigation Charges, Not as Consumable)
19	DISINFECTANT LOTIONS (Not Payable-Part of Dressing Charges)
20	LUXURY TAX (Only Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits)
21	HVAC (Part of Room Charge Not Payable Separately)
22	HOUSEKEEPING CHARGES (Part of Room Charge Not Payable Separately)
23	AIR CONDITIONER CHARGES (Payable Under Room Charges Not if separately levied)
24	IM IV INJECTION CHARGES (Part of Nursing Charges, Not Payable)
25	CLEAN SHEET (Part of Laundry/housekeeping Not Payable Separately)
26	BLANKET/WARMER BLANKET (Not Payable- Part of Room Charges)

27	ADMISSION KIT (Not Payable)
28	DIABETIC CHART CHARGES (Not Payable)
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES (Not Payable)
30	DISCHARGE PROCEDURE CHARGES (Not Payable)
31	DAILY CHART CHARGES (Not Payable)
32	ENTRANCE PASS/ VISITORS PASS CHARGES (Not Payable)
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE (To be Claimed by Patient under Post-Hospitalization where admissible)
34	FILE OPENING CHARGES (Not Payable)
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED) (Not Payable)
36	PATIENT IDENTIFICATION BAND/ NAME TAG (Not Payable)
37	PULSEOXYMETER CHARGES (Not Payable)
38	Nursing, DMO/ RMO charges included in room rent under associated medical expenses (Not Payable)

List III - Items that are to be subsumed into Procedure Charges

SL No	Item
1	HAIR REMOVAL CREAM (Not Payable)
2	DISPOSABLES RAZORS CHARGES (for site preparations) (Payable for site preparations)
3	EYE PAD (Not Payable)
4	EYE SHIELD (Not Payable)
5	CAMERA COVER (Not Payable)
6	DVD, CD CHARGES (Payable only if CD is specifically sought by Insurer/TPA)
7	GAUZE SOFT (Not Payable)
8	GAUZE (Not Payable)
9	WARD AND THEATRE BOOKING CHARGE (Payable Under OT Charges, Not Payable Separately)
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS (Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)
11	MICROSCOPE COVER (Payable Under OT Charges, Not Payable Separately)

12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER (Payable Under OT Charges, Not Payable Separately)
13	SURGICAL DRILL (Payable Under OT Charges, Not Payable Separately)
14	EYE KIT (Payable Under OT Charges, Not Payable Separately)
15	EYE DRAPE (Payable Under OT Charges, Not Payable Separately)
16	X-RAY FILM (Payable Under Radiology Charges, Not as Consumable)
17	BOYLES APPARATUS CHARGES (Part Of OT Charges, Not Separately)
18	COTTON (Not Payable-Part of Dressing Charges)
19	COTTON BANDAGE (Not Payable-Part of Dressing Charges)
20	SURGICAL TAPE(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)
21	APRON (Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)
22	TOURNIQUET Not payable (service is charged by hospital, consumables cannot be separately charged.
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

List IV - Items that are to be subsumed into costs of treatment

SL No	Item
1	ADMISSION/REGISTRATION CHARGES (Not Payable)
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE Unless A Claim Is Accepted Under Section1-Hospitalization Cover
3	URINE CONTAINER (Not Payable)
4	BLOOD RESERVATION CHARGES AND ANTENATAL BOOKING CHARGES (Not Payable)
5	BIPAP MACHINE (Not Payable)
6	CPAP/CAPD EQUIPMENT (Device Not Payable)
7	INFUSION PUMP-COST (Device Not Payable)
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES (Patient diet provided by hospital is payable)
10	HIV KIT (Payable Only as Pre-Operative Screening)
11	ANTISEPTIC MOUTHWASH (Payable when prescribed)
12	LOZENGES (Payable when prescribed)

13	MOUTH PAINT (Payable when prescribed)
14	VACCINATION CHARGES (Not Payable)
15	ALCOHOL SWABS (Not Payable. Part of hospital's own internal cost)
16	SCRUB SOLUTIONISTERILLIUM (Not Payable. Part of hospital's own internal cost)
17	Glucometer & Strips (Not Payable pre-hospitalization or post-hospitalization/Reports and Charts required/ Device not payable)
18	URINE BAG (Payable where medically necessary till a reasonable cost-maximum 1 per 24 hrs)

List V – Additional Non Payable Items

SL No	List of Expenses Generally Excluded ("Non-medical")
1.	BRUSH
2.	COSY TOWEL
3.	MOISTURISER PASTE BRUSH
4.	POWDER
5.	BARBER CHARGES
6.	OIL CHARGES
7.	BED UNDER PAD CHARGES
8.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
9.	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
10.	HOME VISIT CHARGES
11.	DONOR SCREENING CHARGES
12.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES
13.	BLADE
14.	MAINTENANCE CHARGES
15.	PREPARATION CHARGES
16.	WASHING CHARGES
17.	MEDICINE BOX
18.	COMMODE
19.	DIGESTION GELS
20.	NOVORAPID

21.	VOLINI GEL/ANALGESIC GEL
22.	ZYTEE GEL
23.	AHD (ANCILLARY AND HOSPITAL DISINFECTION (EG.,BIOMEDICAL WASTE DISPOSAL/ MANAGEMENT, SANITATION, SANITIZATION/FUMIGATION CHARGES ETC.)
24.	VISCO BELT CHARGES
25.	EXAMINATION GLOVES
26.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27.	PAPER GLOVES
28.	REFERRAL DOCTOR'S FEES
29.	SOFTNET
30.	SOFTOVAC
31.	STOCKINGS

ANNEXURE – B

Address and contact number of Council For Insurance Ombudsman

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 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.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, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.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@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest Park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.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@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & 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@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, 'Moin Court', Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 – 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.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@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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@cioins.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@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, 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@cioins.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 Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.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, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar,Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, 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@cioins.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 – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: COUNCIL FOR INSURANCE OMBUDSMAN ,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: **022 – 69038801/03/04/05/06/07/08/09** Email: **inscoun@cioins.co.in**