Welcome to the 'I Feel Good' policy

aka

Digit Health Care Plus Policy

UIN: GODHLIP21013V032223

Policy Wordings

Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Think of Digit as your running or gym buddy, keeping pace with you all the way. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-4242 or mail us at healthclaims@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 health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

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

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

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

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. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Insurer to the extent Pre-authorization is approved.
5. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
6. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly means a Congenital anomaly which is in the visible and accessible parts of the body
7. **Co-Payment** means a cost sharing requirement under a Health Insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
   (Co-Payment will not be applicable to benefit Policies - Daily Hospital Cash Cover & Critical Illness Benefit, Cancer Benefit)
8. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
9. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
   i. has qualified nursing staff under its employment;
   ii. has qualified medical practitioner/s in charge;
   iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
   iv. maintains daily records of patients and will make these accessible to the insurance company's

authorized personnel.

10. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
11. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital Cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

    Deductible specific to Section 1 A. Accidental Hospitalization and Section 1B. Accidental and illness Hospitalization will be applicable in aggregate towards the hospitalization expenses incurred during policy period.
12. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
13. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
14. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.
15. **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.
16. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
17. **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) of the said Act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
18. **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.
19. **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 needsongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        2. it needs ongoing or long-term control or relief of symptoms

3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

20. **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.
21. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
22. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
23. **ICU (Intensive Care Unit) 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.
24. **Maternity expenses** means;
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
25. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
26. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
27. **Medical Practitioner/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.
28. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i)is required for the medical management of the illness or injury suffered by the insured;
    ii)must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii)must have been prescribed by a medical practitioner;
    iv)must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
29. **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.
30. **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.
31. **New-born Baby** means baby born during the Policy Period and is aged upto 90 days.
32. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
34. **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.
35. **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.

36. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
37. **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.
38. **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:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
39. **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.
40. **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.
41. **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.
42. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
43. **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.
44. **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

45. **Alternative/Ayush Treatment** means forms of treatments other than "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.
46. **Contribution**
    Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis.
47. **Hazardous Sports** means any sport, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling snow and ice sports or involving a naval military or air force operation. Insured

Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.

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. **Psychiatric Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.
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 members for a Floater Policy.
    Unlimited Sum Insured option provided under the product refers to Sum Insured more than INR 3 crore without any limitation. Premium for Unlimited Sum Insured will be calculated by multiplying 1.15 to the premium of Sum Insured INR 3 crore.
53. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neurosurgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
54. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
55. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule Members who has concluded this Policy with Us.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

SECTION 1. HOSPITALIZATION COVER

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

A. Accidental Hospitalization Cover

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

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

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.*** Inbuilt Cover: Daily Cash for choosing shared accommodation ***Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!*** If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule. Please note: a. Your claim must be admissible under Section 1 Hospitalization Cover b. Your hospitalization must exceed 48 hours unless specifically agreed by Us c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days d. Daily cash will be provided only for the days You were hospitalized in shared accommodation. e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU. f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet,

	Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

A1. Day Care Procedures

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

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

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

A2. Pre-Hospitalization Expenses

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

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

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

A3. Post-Hospitalization Expenses

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

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

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Accidental Hospitalization Claim under **Section1. A. Accidental Hospitalization Cover** of this Policy.

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

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

A4. Dental Treatment

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

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

A5. Road Ambulance

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

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

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

A6. Second Medical Opinion

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

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

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

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

B. Accidental & Illness Hospitalization Cover

Digit Simplification: The day bad luck strikes.

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

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.*** Inbuilt Cover: Daily Cash for choosing shared accommodation ***Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!*** If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily

	Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule. Please note: a. Your claim must be admissible under Section 1 Hospitalization Cover b. Your hospitalization must exceed 48 hours unless specifically agreed by Us c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days d. Daily cash will be provided only for the days You were hospitalized in shared accommodation. e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU. f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

B1. Day Care Procedures

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

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

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

B2. Pre-Hospitalization Expenses

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

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

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

B3. Post-Hospitalization Expenses

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

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

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

b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

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

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

B4. Dental Treatment

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

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

B5. Road Ambulance

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

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

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

B6. Bariatric Surgery Cover

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

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

a) The Insured Person undergoing the surgery is minimum 18 Years old.
b) The Medical Practitioner / Bariatric Surgeon confirms that Your Existing Body Mass Index (BMI) and health conditions fall within the below qualification requirements for Bariatric Surgery:
   - Class III Obesity (extreme obesity)- [Body Mass Index (BMI) ≥ 40 kg/m2)];
   - Class II Obesity- (Body Mass Index (BMI) 35-39.9 kg/m2) along with any of the following co-morbidities:
     - Uncontrolled Diabetes Mellitus
     - Cardiovascular Disease [***Example: Stroke, Myocardial Infarction, Poorly Controlled Hypertension***]
     - History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
     - Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.
c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
   - Gastric Bypass-
     - The Roux-en-Y Gastric Bypass
     - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
   - Sleeve Gastrectomy
   - Laparoscopic Gastric Banding

d) This particular cover has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.
e) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. ***Example: Endocrine disorder***.
f) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
g) A prior approval should be taken from us before the Bariatric Surgery is performed.
h) Our maximum liability under this benefit is restricted to the Limit as opted by You and mentioned in Your Policy Schedule against this Cover.

Bariatric surgery for the following reasons is not covered:
a) For Cosmetic/Aesthetic reasons.
b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity. ***Digit Simplification: This is in such cases, treatment of the cause that has caused the obesity, will be more beneficial than treating obesity itself.***

B7. Psychiatric illness Cover

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

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

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

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

B8. Complimentary Health Check Up

Digit Simplification: Prevention is always better than cure!

If You Renew Your Policy with Us without a break, then at every Policy Renewal We will pay the expenses incurred towards cost of health check-up up to the Limits Per Policy (excluding any cumulative bonus) mentioned in Your Policy Schedule. This shall be paid, provided that:
a. You are above 18 Years of age at the time of Health Check Up.
b. You submit a duly filled and signed claim form along with original bills and copy of medical reports.

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

B9. Second Medical Opinion

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

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

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

SECTION 2. INFERTILITY TREATMENT COVER

Digit Simplification: ***We make your road to parenthood easier.***

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

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

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

SECTION 3. ORGAN DONOR

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

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

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

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

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

SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER

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

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

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

a) Pre-Hospitalisation & Post-Hospitalisation Expenses, Day Care Procedure and Outpatient Medical Expenses.

b) All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.

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

SECTION 5. EMERGENCY AIR AMBULANCE

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

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

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

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

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

SECTION 6. LONG HOSPITALIZATION CASH BENEFIT

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

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

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

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

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

SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER

A. Maternity Benefit

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

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

a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply***). This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.

b) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
c) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule applied to the increased part of the Sum Insured.
d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.

Digit Simplification: Sticking with us has its advantages

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

We shall not pay for the following under this Section:

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

B. New Born Baby Benefit

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

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

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

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

SECTION 8. OUT-PATIENT (OPD) BENEFIT

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

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

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

Basis 2: Nil Co-payment

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any Illness.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner
Out-Patient Dental Treatment	Out-patient dental treatment for the immediate relief of dental Pain; taken by You from a dentist, provided that We will pay only for X-rays, Extractions, Amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.
Hearing Aids	One pair of hearing aids (Excluding Batteries), provided that: ▪ These have been prescribed by an ENT specialist or Network Medical Practitioner. ▪ You have continuously renewed the Policy with Us without break for a period of 36 months with **Out-Patient (OPD) Benefit** as a benefit, since inception of the first policy.
Psychiatric Illness	Specialist Consultation, assessment, treatment and medication for Psychiatric Disorders.

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

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

SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION

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

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

a) The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
b) The patient takes treatment at home on account of non-availability of room in a Hospital, and
c) 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

d) No Payment will be made if the condition for which You require medical treatment is due to:
Asthma, Bronchitis, Tonsillitis, Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, Arthritis, Gout and Rheumatism, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin.

e) Subject to availability of the sum insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**

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

SECTION 10. SUM INSURED REFILL BENEFIT

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

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

a) The refilled Sum Insured would be triggered only if the cause of the Hospitalization is not related to /arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy period for the same Insured Person, unless this condition is specifically waived by us and mentioned in Your Policy Schedule.

b) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.

c) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**

d) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule against this Section during each Policy Period.

e) In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.

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

SECTION 11. DAILY HOSPITAL CASH COVER

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

A) Accidental Hospitalization Cover

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

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

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

B) Accidental & Illness Hospitalization Cover

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

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

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

SECTION 12. CRITICAL ILLNESS BENEFIT COVER

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

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

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

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

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

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

SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER

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

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

Provided that,

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

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

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

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity

2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

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

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

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 –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

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

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

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. 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:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

5. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

6. 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.

7. END STAGE LIVER FAILURE

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

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

8. 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.

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. 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

10. BENIGN BRAIN TUMOR

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are **excluded:**
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

11. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

12. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

IV. The following are excluded:

i. Spinal cord injury;

13. 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.

14. 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.

15. 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.

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

II. Specific Definitions:

17. 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.

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 the following Activities of Daily Living Activities of Daily Living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

20. APLASTIC ANAEMIA

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

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

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

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

SECTION 14. CANCER BENEFIT COVER

***Digit Simplification:* The big C requires another C: Cover**

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

a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
b) You survive for a minimum period of at least 30 days from the date of diagnosis of such Cancer for Specified Severity, unless this condition is specifically waived by Us
c) No Claim under this option shall be admissible if the Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.
d) Cover under this Section shall cease upon payment of the compensation on the happening of a Cancer for Specified Severity and no further payment will be made for any consequent disease or any dependent disease.

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

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

SECTION 15. CANCER HOSPITALIZATION COVER

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

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

Provided that,

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

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

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

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

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

SECTION 16. WELLNESS BENEFIT PROGRAM

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

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

1. **Doctor on Call**
   Upon Your request, We will facilitate an appointment, through Our empanelled Service Provider, with a Medical Practitioner who can help You by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.
2. **Wellness Coach**
   In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs and online platform provide You information on wellness coaching in areas such as:
   a) Weight Management
   b) Activity and Fitness
   c) Nutrition
   d) Tobacco Cessation
   e) Alcohol Abuse de-addiction Program
   f) Information on various diseases
   g) Dietary Plans
3. **Lab Services (Home Collection)**
   Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc from Your home address for further testing and analysis.
   The cost of these tests and reports will have to be borne by You.
4. **Pharmacy (Home Delivery)**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.
   The cost of the medication will have to be borne by You.
5. **Vital/Physical Activity Monitoring Services**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s) such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device.
   It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.
6. **Reminder Notifications**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You.
7. **Medical Wallet**
   Upon Your request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You.
8. **Report Aggregation**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical records/reports shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.
9. **Home Care Services**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for You in case You are in need of any of the following:
   a. Home Care Nursing
   b. Patient Assistant
   c. Physiotherapy

d. Yoga Trainer
e. Psychologist
f. Palliative Care
g. Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.

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

10. Ambulance Arrangement Services

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

11. Pick-up and Drop Services for Consultation

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

12. Prioritizing Appointments

Upon Your request, We will facilitate, through Our Empanelled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary treatment/diagnostics subject to availability of the service(s).
The cost of the Consultancy/Diagnostic will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program

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

II. Optional Covers

***Digit Simplification:* True customization means you get an option to add covers that make sense to you!**

The covers listed below are optional covers and will be applicable only if you have selected them at the time of purchase and they are mentioned your Policy Schedule.

If the policy is issued on individual basis, each insured person can opt for the available optional covers as per requirement and if it is arranged on a floater basis, the optional covers will be applicable to all the insured person(s), without any individual selection.

In short in an individual policy, you will have to select these individually and in a floater/family policy it will be applicable for all.

S.No.	Optional Covers	Section Admissibility
1	Payment of Non-Medical Expenses	Section 1A. Accidental Hospitalization Cover

		Section 1B. Accidental & Illness Hospitalization Cover
2	Daily Cash for accompanying an Insured Child	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
3	Loss of Income Cover	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
4	Cumulative Bonus Protection Cover	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover Section 13. Critical Illness Hospitalization Cover Section 15. Cancer Hospitalization Cover
5	Unused Sum Insured Benefit	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
6	Network hospital Co-payment	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover Section 13. Critical Illness Hospitalization Cover Section 15. Cancer Hospitalization Cover

Please note, all the below covers are subject to terms, conditions, warranties, deductible, co-payment, limitations and exclusions mentioned in the Policy.

1) Payment of Non-Medical Expenses

***Digit Simplification:* Before, during & after hospitalization, there are many more medical aids & expenditures to be taken care of. This covers the ones that are otherwise excluded from the policy like walking aids, crepe bandages, belts & more.**

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If you have opted for this cover and your claim is approved under **Section 1- Hospitalization Cover**, we will compensate for Non-Medical expenses incurred by you (you can check them under Annexure A below). The compensation will be maximum upto a percentage of the approved claim amount. This percentage will be mentioned in the Policy Schedule.

Please note:

i. Coverage will be limited to the actual expenses incurred during the Hospitalisation but not paid under Section 1 – Hospitalisation Cover as Non-Medical expenses.
ii. In the General Exclusions section, you will see 'Non-medical Expenses' as exclusion no. 25, if you have this cover, that is not valid obviously☺ but since this is a standard document, it will be mentioned for people who don't opt for this cover.

2) Daily Cash for accompanying an Insured Child

***Digit Simplification:* Children need extra care! If a child is hospitalized, an adult is definitely required to take care, so extra cash for them!**

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If the Insured Person hospitalized is a child aged 14 years or less, then we will pay you a Daily Cash for an accompanying adult for every completion of 24 hours at the hospital. The daily cash amount is mentioned in your Policy Schedule. Please note:

a. The claim must be admissible under Section 1 Hospitalization Cover
b. Hospitalization must exceed 48 hours unless specifically agreed otherwise by us

c. For each policy period, there is a maximum number of days this can be paid, please check your policy schedule for the exact days
d. Daily cash will be provided only if an adult aged 18 years or more is accompanying the Insured Child during the said hospitalization

3) Loss of Income Cover

Digit Simplification: ***The losses of being hospitalized sometimes is beyond the hospitalization expenses as it disrupts your flow of income. This cover helps there!***

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If you have this cover and are continuously hospitalized for certain number of days, mentioned in your policy schedule, you will receive a pre-set amount for every block of specified number of days, again mentioned in your policy schedule.

Please note:

a. Your claim should be admissible under Section 1- Hospitalization Cover
b. For each policy period, there is a maximum number of times this can be paid as mentioned in your policy schedule.

4) Cumulative Bonus Protection Cover

Digit Simplification: ***Cumulative bonus is a bonus for all the claim free years and it deserves to be protected. With this cover, it will never reduce even in face of a claim.***

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

If you have opted for this cover and you make any claim in the expiring policy*, your cumulative bonus will never reduce. The following two scenarios are possible:

- It will remain same on renewal in case total claim amount is more than the cumulative bonus protection cover amount chosen by you or
- It will increase on renewal (like how it is when there is no claim made) in case the total claim amount is less than the cumulative bonus protection cover amount chosen by you

*Claim made under the **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover**

Please note, there is an upper limit to the Cumulative Bonus you can earn, it will be mentioned in your Policy Schedule. Also, Point no 2 and 3 as provided under “Cumulative Bonus” stands deleted in case you have opted this cover.

5) Unused Sum Insured Benefit

Digit Simplification: ***Your sum insured is yours! If you don’t use it, it will be added to your renewing policy as an increased sum insured.***

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If you have opted for this cover, then at the time of renewal of the policy, sum insured under the renewed policy will be increased based on the unused base sum insured of the expiring policy, subject to the following:

i. Maximum 100% of the unused Base Sum Insured will be carried forward at the time of renewal.
ii. Maximum carried forward of unused Base Sum Insured, year on year, will be limited to 100% of Base Sum Insured of the expiring policy.
iii. No cumulative bonus benefit will be provided under the product, if this cover is opted.

For this cover, unused base sum insured will mean total sum insured minus any claim amount under the policy during the policy period.

For Example: Mr. X has a policy with sum insured of Rs. 5,00,000.

a. During the policy period, he claimed for Rs. 1,00,000. His unused base sum insured in this case will be Rs. 4,00,000 (Rs. 5,00,000- 1,00,000). Maximum Sum Insured which can be carried forward to the renewed policy is 100% of the unused Base Sum Insured of the expiring policy i.e., Rs. 4,00,000. So, in case he renews the policy with same Sum Insured, he will be eligible for claims upto Rs. 9,00,000 after the renewal of the policy.
b. Next Year, he claimed for Rs. 3,00,000. His unused base sum insured in this case will be Rs. 6,00,000 (Rs. 9,00,000- 3,00,000). Maximum Sum Insured which can be carried forward to the renewed policy is 100% of the unused Base Sum Insured subject to maximum of 100% of base sum insured of expiring policy i.e. Rs. 5,00,000. His total sum insured at the time of renewal shall be 5,00,000 (base sum insured) + 5,00,000 (Unused sum insured) = 10,00,000

6) Network Hospital Co-payment

***Digit Simplification:* If you choose a network hospital and choose reimbursement claim method, there will be a co-payment, share of claim paid by you.**

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

If you have opted for this cover and are hospitalized* in any of the network hospital, and if you choose the claim on reimbursement basis, then you shall bear a co-payment of a specified percentage as opted by you and mentioned in Policy Schedule on each and every claim.

*(under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

Specific Conditions applicable to this cover:

i. This co-payment will be applicable on admissible claim amount and will be over and above any other co-payment applicable in the policy.
ii. Co-payment will not be applicable on capped ailments.
iii. Co-payment will not be applicable for treatment taken on cashless basis.
iv. For complete list of Network Hospitals, kindly refer Company's Website.

III. 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.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover** in the expiring Policy Period, You would be eligible for Cumulative Bonus at the time of renewal as mentioned in Your Policy Schedule, provided that:

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

6. The Cumulative Bonus will be Calculated on the Sum Insured as opted by You under **Section 1. A. Accidental Hospitalization Cover** and/or **Section 1. B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover**.

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

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:***

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

I. STANDARD EXCLUSIONS

1. Pre-Existing Diseases - Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with insurer.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of number of months, as specified in the Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure waiting period- Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage
f. List of specific diseases/procedures
   i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
   ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
   iii. Cataract, Glaucoma and Disorder of retina
   iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
   v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
   vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
   vii. Hernia of all sites,
   viii. Varicose veins of lower extremities,
   ix. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,

x. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),

xi. Internal Congenital Anomaly. This specific waiting period will not be applicable to New Born Baby/infants.

xii. Psychiatric illness and Disorders listed below:

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

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

xiv. **Joint Replacement, Bariatric Surgery and Organ Transplant**

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

3. 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 reduced to number of days as opted by you and mentioned in your policy schedule.

4. 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

5. Rest Cure, rehabilitation and respite care- Code- Excl05

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

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

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

except to the extent covered under **SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION** if opted by You.

6. Obesity/ Weight Control: Code- Excl06

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

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

ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

7. **Change-of-Gender treatments: Code- Excl07**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. **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.

9. **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

10. **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.

11. **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.

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

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

14. 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**

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

16. **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.

17. **Sterility and Infertility: Code- Excl17**
Expenses related to sterility and infertility. This includes:
i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

This exclusion stands deleted to extent of the coverage provided under **SECTION 2. INFERTILITY TREATMENT COVER**, if opted by You.

18. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion stands deleted to the extent of the coverage provided under **SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS

19. 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.

20. Suicide and Self-Injury

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

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

21. Circumcision, Aesthetic reasons

a. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
b. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
c. Aesthetic Surgeries of any description.

22. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geographical Limits

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

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

24. Defence Operation

We will not pay any claim under this Policy, whilst You are Involved in naval, military, air force operation

25. Non-Medical Expenses

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet),

cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please refer Annexure A provided in the policy document or visit our website for complete list of non-medical items)

26. Insufficient Document

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

27. Preventive Treatment

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

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

28. Spectacles, Hearing aids & other Expenses

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

29. Stem Cell Transplant: Any stem cell transplant other than for Bone Marrow Transplant

30. Unjustified or Unwarranted Hospitalization

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

31. War and hazardous substances

We do not cover treatment directly or indirectly arising from or required as a consequence of:
War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government or any acts of terrorism.
Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.

32. 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.

33. Substance abuse and Addictions by the Insured

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

SPECIFIC ONES (CAN'T BE WAIVED)

34. Ear, Eyesight & Optical Services

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

35. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

36. Specific Treatments

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

37. Our Maximum Liability in respect of the following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured opted under **Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover**:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

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

38. Dental Treatment

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

39. Non-Allopathic Treatment

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

40. Organ Donor

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

41. Weight loss Surgery

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

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

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 tale 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. Special Conditions Applicable for Policies issued with premium Payment on Instalment 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)

i. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
ii. 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.
iii. 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 .
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy

5. 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.

6. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the Policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

7. 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.

8. Cancellation

A. Cancellation by You

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

Short Period Scale

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

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

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

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

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

10.Multiple Policies

i. 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.
ii. 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.
iii. 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.
iv. 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.
v. The contribution clause shall not be applicable where the cover/ benefit offered:
   - is fixed in nature i.e. Critical Illness Benefit Cover, Cancer Benefit Cover and Daily Hospital Cash Benefit Cover,
   - does not have any relation to the treatment costs;
vi. If You are covered under multiple policies providing Critical Illness Benefit, Cancer Benefit and Daily Hospital Cash Benefits, We shall make the claim payments independent of payments received under other similar polices in respect of the covered event.

11.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 supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

12.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.

13.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.

CONDITIONS FOR RENEWAL OF THE CONTRACT

14.Renewal

i. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience.

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 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 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: **Error! Hyperlink reference not valid.**
Toll Free: 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can now 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 Centres 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.Zone wise Classification

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

Zone A Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan),
Zone B Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.
Zone C Rest of India apart from Zone A and Zone B cities are classified as Zone C.

Zone opted by you is mentioned in your Policy Schedule.

Note:

1. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.
2. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% Co-pay would be applicable on admissible claim amount.
3. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.
4. Zone based Co-pay as mentioned above will not be applicable in case of accidental injury.

19.Alterations to the Policy

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

20.Non-Disclosure or Misrepresentation:

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

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form either physically or electronically or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall
be:

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

21.Insured Person

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

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

22.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.

23.Claims Notification and Procedure

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

A. Cashless Claim Process:

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

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
   c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
   d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
   e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
   f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
   g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

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

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. 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.

Sr. No	List of Documents / Information	Hospitalization Claim	Out-Patient (OPD) Claim	Critical Illness/Cancer Claim	Daily Hospital Cash Claim
1	Duly Filled and Signed Claim form	√	√	√	√
2	Discharge Summary	√	×	×	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	×	√	×
4	Original Hospital Main Bill	√	×	×	×
5	Original Hospital Bill Break Up	√	×	×	×
6	Original Pharmacy Bills	√	√	×	×
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	×	×
8	Consultation Papers	√	√	√	×
9	Investigation Reports	√	√	√	×
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	×	×
11	MLC/FIR Report (If applicable)	√	×	√	×
12	Original Invoice/Sticker (If applicable)	√	×	×	×
13	Post Mortem Report (If applicable)	√	×	×	×
14	Disability Certificate (If applicable)	√	×	√	×
15	Attending Physician Certificate (If applicable)	√	×	√	×
16	Ante-natal Record (If applicable)	√	×	×	×
17	Birth discharge Summary (If applicable)	√	×	×	×
18	Death Certificate (If applicable)	√	×	√	×
19	*KYC (Photo ID card) (If applicable)	√	√	√	√
20	Bank Details with Cancelled Cheque	√	√	√	√

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

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

CONDITIONS FOR RENEWAL OF THE CONTRACT

24.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 health condition of the insured members & claim history of the policy.
c. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

25.Continuity Benefits

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

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period, wait period of Specific Diseases pre-existing disease etc) which are applicable under this Policy;
ii. Any other wait period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

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 upto 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.	ARMSLING *(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 upto 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 FRESHNERS *(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	HOUSE KEEPING 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	GAUSE 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, HARMONICSCALPEL, 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	TORNIQUET *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 - A. Accidental Hospitalization Cover And/Or B. Accidental & Illness Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(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 *(Except to the extent covered under SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER if opted & For dog or animal bite)*
15	ALCOHOL SWABES *(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

Sr. 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.	Novarapid
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.	Sofnet
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.	Tamil Nadu, Tamil Nadu Puducherry Town and

	Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	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, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@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, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad,

		Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	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