Digit Group Hospital Cash Policy

Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Especially with so many new illnesses sprouting every year, one needs to protect oneself against the financial & emotional burden of falling ill.
So, think of Digit as your fitness buddy, keeping pace with you on your way to good health. 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 / Certificate of Insurance. 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 / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule / Certificate of Insurance 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 / Certificate of Insurance 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** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one illness** means continuous period of illness and it includes relapse within forty-five days from the date of last consultation with the hospital where treatment has been taken.
3. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
5. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

   a) Internal Congenital Anomaly

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

   b) External Congenital Anomaly

   Congenital anomaly which is in the visible and accessible parts of the body.
6. **Day Care Centre means** any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
   i. has qualified nursing staff under its employment;
   ii. has qualified medical practitioner (s) in charge;
   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
7. **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 twenty-four hours because of technological advancement, and
   ii. which would have otherwise required a hospitalisation of more than twenty-four hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.
8. **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.
9. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
10. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
11. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received.

    The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
12. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and

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

i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
iii) has qualified medical practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

13. **Hospitalization/Hospitalized** 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.
14. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
    i. **Acute Condition** means a disease, illness or injury that is likely to response 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.
    ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
        a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/ or tests
        b. it needs ongoing or long-term control or relief of symptoms
        c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
        d. it continues indefinitely
        e. it recurs or is likely to recur
15. **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.
16. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
17. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
18. **Benefit based health insurance section** means an insurance section that pays fixed amount on the occurrence of an insured event as specified in the policy.
19. **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.
20. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
21. **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.
22. **Medical Practitioner** 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 the scope and jurisdiction of the licence.
    The registered practitioner should not be the insured or close member of the family.
23. **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.

24. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
25. **Newborn Baby** means baby born during the Policy Period and is aged upto 90 days.
26. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
27. **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.
28. **Pre-Existing Disease (PED)** Pre-existing disease means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) For which medical advice or treatment was recommended by, or received from, a physician , not more than 36 months prior to the date of commencement of the policy.
29. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insure.
30. **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.
31. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
32. **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.
33. **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. <u>Specific Definitions:</u>

34. **Contribution**
Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis.
35. **Credit Linked Policy** means a policy in which the policy period can be extended upto the underlying credit period not exceeding five years
36. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport/activity includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, 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.

37. **Policy** means these Policy wordings, the Policy Schedule/Certificate of Insurance and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.
38. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule / Certificate of Insurance and includes both the commencement date as well as the expiry date.
39. **Policy year**
    a. **For Annual Policy –** Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such policy period, as mentioned in the Policy Schedule / Certificate of Insurance.
    b. **For Long Term Policy-** Policy year means each period in multiples of twelve (12) months beginning from the date of commencement of the policy period and any subsequent additional months, not constituting a period of twelve months, will be considered as a complete policy year. Such policy will end on last day of the policy period, as mentioned in the Policy Schedule/Certificate of Insurance.

       Digit Explanation of Long-Term Policy: Say you bought a Group Hospital Cash policy with us for a period of 32 months with Policy Inception Date as 1st January 2020. This means that you are covered for three policy years:

       - ***1st January 2020 to 31st December 2020 (counted as one policy year)***
       - ***1st January 2021 to 31st December 2021 (counted as your second policy year).***
       - ***1st January 2022 to 31st August 2022 (counted as your third policy year)***

       You can exhaust your sum insured in each of these policy years
40. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule / Certificate of Insurance 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**.**
41. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
42. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited**.**
43. **You, Your, Yours, Yourself, Policyholder, Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

Digit Simplification: ***Staying is Hospital has expenditure beyond Hospital bill! This helps you cover that.***

All the Benefits available under this Policy are described below. The Benefits opted by You are specifically mentioned in the Policy Schedule/Certificate of Insurance.

SECTION 1. ACCIDENTAL HOSPITALIZATION CASH ALLOWANCE COVER

This Cover protects You in case of Your Hospitalization as an inpatient due to an Accidental Injury during the Policy Period, We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

A. **Sum Insured Basis Option:**

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis We will pay You a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accidental bodily injury for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance 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 an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis We will pay You a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out of accidental bodily injury for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 2. ACCIDENTAL & ILLNESS HOSPITALIZATION CASH ALLOWANCE COVER

This Cover protects You in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury or Illness during the Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

A. **Sum Insured Basis Option:**

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance 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 an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis We agree to pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 3. CRITICAL ILLNESS HOSPITALIZATION CASH ALLOWANCE COVER

This cover protects You in case of Your Hospitalization as an inpatient due to a Critical Illnesses or undergoing related Surgical Procedures during the Policy Period, as per the **Plan Opted by You** and mentioned in Your Policy Schedule/Certificate of Insurance. We will pay You as per the **Sum Insured Basis Opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that,

a) This Critical illness or Covered Surgical Procedure has happened to You for the first time in Your life.
b) The diagnosis of the Critical Illness or Covered Surgical Procedure and hospitalization should have happed after the **Critical Illness Initial Waiting Period mentioned in Your Policy Schedule/Certificate of Insurance against this section**.
c) No Claim under this option shall be admissible if the Critical Illness or the Surgical Procedure is a result of any pre-existing condition/disease.

A. **Sum Insured Basis Option:**

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of the Critical Illnesses or Surgical Procedures mentioned in Your Plan, for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance 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 an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out arising out of the Critical Illnesses or Surgical Procedures mentioned in Your Plan, for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- In case of **Individual Sum Insured basis**, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on **Floater Sum Insured basis**.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

Plan wise Covered Critical Illnesses

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

29	Others	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

C. Critical Illness Definitions:

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 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

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN DAMAGE or TRANSPLANT / 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:**
   i. Other stem-cell transplants
   ii. Where only Islets of Langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be

progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

12. BENIGN BRAIN TUMOR

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

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

III. The following conditions are excluded:

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

13. END STAGE LUNG FAILURE

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

14. 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.**

15. MAJOR HEAD TRAUMA

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

II. The Accidental Head injury must result in an inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent”

shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The following are excluded:

i. Spinal cord injury;

16. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

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.

II. <u>SPECIFIC DEFINITIONS:</u>

17. SURGERY TO AORTA

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

18. ABDOMINAL AORTA ANEURYSM

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

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

b. Congenital conditions are excluded

19. CARDIOMYOPATHY

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

The following conditions are excluded:

• Cardiomyopathy secondary to alcohol or drug abuse.
• All other forms of heart disease, heart enlargement and myocarditis.

20. PULMONARY ARTERY GRAFT SURGERY:

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

21. APALLIC SYNDROME

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

22. PARKINSON'S DISEASE

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist

acceptable to Us.

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

a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living (either with or without the use of mechanical equipment, special devices or other aids and Adaptations in use for disabled persons) for a continuous period of at least 6 months.

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

23. MUSCULAR DYSTROPHY

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

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities Of daily living (either with or without the use of mechanical equipment, special devices Or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.

24. PROGRESSIVE SUPRANUCLEAR PALSY:

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

25. CREUTZFELDT-JAKOB DISEASE (CJD)

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

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

26. BACTERIAL MENINGITIS

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

This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

27. ALZHEIMER'S DISEASE

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

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be

supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

28. ENCEPHALITIS

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

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

Exclusions:

• Encephalitis in the presence of HIV infection is excluded.

29. LOSS OF INDEPENDENT EXISTENCE

I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living .

30. SYSTEMIC LUPUS ERYTHEMATOUS

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

The WHO lupus classification is as follows:

a. Class I: Minimal change – Negative, normal urine.
b. Class II: Mesangial – Moderate proteinuria, active sediment.
c. Class III: Focal Segmental – Proteinuria, active sediment.
d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE`S SYNDROME

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

32. FULMINANT HEPATITIS

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
c. Rapid deterioration of liver function tests;
d. Deepening jaundice; and
e. Hepatic encephalopathy.

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

33. PNEUMONECTOMY

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

The following conditions are excluded:

- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision

34. APLASTIC ANAEMIA

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

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

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

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

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

SECTION 4. COMPANION BENEFIT COVER

We will pay towards the expenses incurred on one of Your attendants, accompanying You at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the **Sum Insured Basis Opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted;
2. Insured Person's attendant should be his/her spouse, siblings, Children above age of 18 years, parents or parents in law.

A. **Sum Insured Basis Option:**

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation arising out of accidental bodily injury and/or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury and/or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- In case of **Individual Sum Insured basis**, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on **Floater Sum Insured basis**.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the **time excess as opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 5. PARENT ACCOMODATION

We will pay towards expenses incurred on accommodation of parents at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted;
2. The Insured Person hospitalized is a Child aged 16 Years or below, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.

A. **Sum Insured Basis Option:**

You would have chosen one among the following **two 'Basis' of payment**. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on Floater Sum Insured basis.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the **time excess as opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 6. DAY CARE PROCEDURE BENEFIT

We will pay the Sum Insured Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You require to undergo a Day Care Procedure as an inpatient for less than 24 hours in a Hospital or Day Care Centre during the Policy Period as a result of Accidental bodily Injury and/or Illness during the Policy Period.

A. **Conditions Applicable**

- We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.
- This benefit is applicable on an Individual Sum Insured basis irrespective of type of Policy (Individual/Floater).
- This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 7. MATERNITY BENEFIT

This Cover protects You in case of Your Hospitalization as an inpatient under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy during this Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

a. The treatment is taken as an In-patient in a Hospital
b. "Maternity Benefit Waiting Period" as mentioned in the Policy Schedule/Certificate of Insurance against this Section is applicable

A. **Sum Insured Basis Option:**

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

Basis 1 - Per Day Benefit

If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B. **Conditions Applicable to both Basis 1 & 2:**

- Permanent "**Exclusion No. 19 Reproductive Medicine & Other Maternity Expenses**" of the Policy Wordings stands partially deleted to the extent of the Coverage provided under this Section.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.
- This benefit is applicable on an Individual Sum Insured basis irrespective of type of Policy (Individual/Floater).
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

D. Exclusions

WAITING PERIOD- EXCLUSION

Digit Simplification: Some covers have a defined period in which you cannot make claims. This makes sure that someone who just got detected with the disease doesn't buy the policy to cover the charges 😉 Read on:

We are not liable to pay for any claims arising out of any Hospitalization which begins during waiting periods except if Your Hospitalization is as a result of accidental bodily injury.

I. STANDARD DEFINITIONS:

1. Pre-existing Disease Waiting Period – 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 continuous coverage after the date of inception of the first policy with insurer. These number of months as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. ***Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Pre-existing Disease, will be applied to this increased part of Sum Insured.***

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

d. Coverage under the policy after the expiry of number of months, as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specific Illness Waiting Periods – Code – Excl02

a. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of number of months of continuous coverage after the date of inception of the first policy with us. These number of months as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance. 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. ***Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Pre-existing Disease, will be applied to this increased part of Sum Insured.***

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:
   a. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
   b. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
   c. Cataract, Glaucoma and Disorder of retina
   d. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
   e. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
   f. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
   g. Hernia of all sites,

h. Varicose veins of lower extremities,
i. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,
j. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),
k. Internal Congenital Anomaly,
l. Psychiatric illness and Disorders listed below:

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

m. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease.
n. Joint replacement unless due to Accident.

II. SPECIFIC DEFINITIONS:

3. Initial Waiting Period

a. Expenses related to the treatment of any illness within number of days as mentioned in Your Policy Schedule / Certificate of Insurance 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.

4. Maternity Benefit Waiting Period

Maternity Benefit in this Policy shall not be covered until the number of months of continuous coverage as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, have elapsed since inception of the first Policy with Us.
However:

a. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then Maternity Benefit Waiting Period would be reduced by the number of Your continuous preceding years of coverage under the previous health insurance Policy.
Example, if a Maternity Benefit has a waiting period of 2 years and one year is already completed according to Your last policy, then when You renew with us as per the Portability Guidelines, the Waiting Period will not be 2 years, it will only be 1 Year.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Maternity Benefit, will be applied to this increased part of Sum Insured.

GENERAL EXCLUSIONS

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

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

I. SPECIFIC EXCLUSIONS (CAN'T BE WAIVED)

1. **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.

2. **Breach of Law with Criminal Intent, Suicide and Self-Injury**
   Any claim as a result of the following:
   a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
   b. Intentional self-injury
   c. Participation in any illegal or unlawful or criminal act
   d. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

3. **Behavioural and Neurodevelopment Disorders**
   Medical Expenses related to Behavioural and Neurodevelopment delays and disorders such as:
   a. Disorders of adult personality including gender related problems, gender change
   b. Learning disability including but not limited to speech and language including stammering, dyslexia, Attention Deficit Hyperactive Disorder;
   c. Neurodevelopmental disorders including but not limited to cerebral palsy, autism spectrum disorder.

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

5. **Dental Treatmen**t
   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.

6. **External Congenital Anomaly**
   Screening, Counselling or treatment related to external Congenital Anomaly.

7. **Ear, Eyesight & Optical Services**
   We do not cover any claims in respect of treatment for 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.

8. **Geographical Limits**
   Claims related to Hospital Cash under this Policy, will be paid only if the Hospitalization is done within India, unless specifically agreed other wise and mentioned in Your Policy Schedule/Certificate of Insurance.
   Our liability will be to make any Payment under this Policy will be in Indian Rupees Only.

9. **Hazardous Activities / Defence Operation**
   We will not pay any claim under this Policy, whilst You are:
   a. Involved in any **Hazardous Activity**.
   b. Involved in naval, military, air force operation

10. **Home Care Nursing**
    Any claim in respect of Convalescence/ recovery, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.

11. **Insufficient Document**

We have tried to reduce the number of documents you need to share. In case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us, We shall be liable to pay claims based on documents submitted to us.

12. 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.

13. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment.

14. Organ Donor

The Expenses incurred by You on organ donation.

15. Out-Patient (OPD) Treatment

Any claim in respect of Out-Patient (OPD) Treatment will be not be covered

16. 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 it is post dog or animal bite and treated as an in-patient.

17. Professional Sports

We will not pay any claim under this Policy, whilst You are under training or taking part in sport as a professional for which You are paid or funded by sponsorship or grant.

However, You would be covered if you participate in a non-professional capacity for any recreational sport which is **NOT** a **Hazardous Activity** and You are under the supervision of a trained professional.

18. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

19. Reproductive Medicine & Other Maternity Expenses

Any assessment or treatment method for:

a. Birth Control

Any type of contraception, sterilization, abortions, voluntary termination of pregnancy (except under **SECTION 7. MATERNITY BENEFIT** for Medical Termination of Pregnancy (MTP) as governed by MTP Act 1971) or family planning.

b. Infertility

We shall not be liable to make any payment in respect of expenses incurred towards Infertility/Subfertility including but not limited to IVF, IUI, ZIFT, ICSI Procedures and similar methods of assisted conception.

c. Sexual disorder and Erectile Dysfunction

Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.

d. Any claim related to pregnancy, complications arising from pregnancy or medical termination of pregnancy unless You have specifically opted for **SECTION 7. MATERNITY BENEFIT.**

20. Sexually Transmitted Infections & Disease

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

21. Sleep Disorders and Sleep Problems

We do not cover treatment related to sleep disorders and sleep problems, such as snoring,
insomnia or sleep apnoea (when breathing stops temporarily during sleep) including but not limited to expense related to purchase of CPAP, BIPAP or similar instruments.

22. 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.

23. Specific Treatments

i. Admission primarily for administration of monoclonal antibodies or Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid.

ii. Treatment for Age Related Macular Degeneration (ARMD), Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy will not be covered unless it forms a part of in-patient treatment in case of hospitalisation.

24. Substance abuse and Addictions by the Insured

1. Expenses incurred for the treatment of any Illness or accidental Injury caused due to:
   a) Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured unless associated with Psychiatric Illness.
   b) Withdrawal and de-addiction treatment taken by the Insured.

2. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

25. Unjustified or Unwarranted Hospitalization

Admission solely at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization

26. Unproven or Experimental treatment

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

a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.

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

27. Vitamins/ Nutritional Supplements

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

28. War and hazardous substances

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

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

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

c. Any acts of terrorism unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance

29. Weight loss Surgery

We do not cover any claims related to:

i. Weight management services and treatment, vitamins and tonics related to weight reduction programs including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;

ii. Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue.

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES:

CONDITIONS PRECEDENT TO THE CONTRACT

1. Disclosure of Information

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

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.

2. Condition Precedent to admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for 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. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

CONDITION APPLICABLE DURING THE CONTRACT

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

4. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

5. **Withdrawal of Product**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Group Manager/ Insured Person about the same 90 days prior to expiry of the policy.

ii. Group Manager / lnsured 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 waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

6. Migration:

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

7. 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the Policy Schedule/Certificate of Insurance, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

8. Special Conditions Applicable For Policies Issued With Premium Payment On Instalment Basis

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

1. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
2. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by US.
3. The Benefit of “Waiting Periods” shall continue in the event of default payment being received within the Grace Period.
4. No interest will be charged If the instalment premium is not paid on due date.
5. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled and a fresh policy would be issued with fresh waiting periods.
6. In case of any admissible claim in a Policy year:

a. If the claim amount is equivalent or higher than the balance of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.
b. If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.

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

a) <u>Important Note (ECS Or NACH Mode):</u>

1. Installment can also be paid through ECS or NACH mode. In cases where monthly installment is allowed by NACH or ECS mandate, three (3) installments need to be paid at the inception of the Policy, unless this condition is specifically amended by Us.
2. We shall inform You in case of any change either in the terms and conditions of the Policy Contract or in the Premium Rate and afresh ECS authorization needs to be submitted by You.
3. You can withdraw from the ECS mode of payment at least fifteen days prior to the due date of instalment premium payable as per the ECS/NACH mandate form submitted by You, by submitting written communication to Us as well as Your Bank.

CONDITIONS FOR RENEWAL OF THE CONTRACT

9. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on any grounds of non-disclosure and/or misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

10. CUSTOMER GRIEVANCE REDRESSAL POLICY

In case of any grievance the insured person may contact the company through
Website: https://www.godigit.com
Toll Free: 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can 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:
https://www.godigit.com/claim/grievance-redressal-procedure

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 as amended from time to time.

The policyholder or the claimant also has the option to register the complaint on-line at IRDAI's Bima Bharosa by visiting https://bimabharosa.irdai.gov.in/

Insurance Ombudsman - 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. The contact details of the Insurance Ombudsman offices have been provided in Annexure – A

II. SPECIFIC TERMS AND CLAUSES:

CONDITIONS PRECEDENT TO THE CONTRACT

11. Policy Period

The Policy can be issued for tenure of 1 year, 2 years, 3 years, 4 years and 5 years on Per Day Benefit or Fixed Lumpsum Benefit Sum Insured basis. Long Term policies (of more than 1-year tenure) can only be issued in case of loan/ credit linked policies, subject to maximum of loan period.

12. Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance 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.

13. Role of Group Administrator/ Policyholder

i. The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic

intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.

ii. In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.

iii. In case of such policies, claims of the individual employees may be processed through the employer.

iv. In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.

v. In case of such policies, the Group Administrator may facilitate the claims process for the members.

14.Assignment (If Opted) – It Is Hereby Declared and Agreed That:

a. from the Policy Start Date, the claim amount payable by Us to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of a person or an Institution or a company as named in the Policy Schedule/ Certificate of Insurance;

b. upon any claim amount becoming payable under this Policy the same shall be paid by Us to assignee as named in Policy Schedule/ Certificate of Insurance, without any reference/ notice to the Insured;

c. the receipt of such claim amount by the assignee as named in the Policy Schedule/ Certificate of Insurance and the Insured shall completely discharge Us from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

15.Electronic Transactions

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

16.No Constructive Notice

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

CONDITION APPLICABLE DURING THE CONTRACT

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

17.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 Group Manager/ Insured Member.

18.Cancellation

A. Cancellation by You

1. You can choose to cancel the policy, giving us a 7 days' notice period by recorded delivery.
2. Below Cancellation Scales will be applicable depending on the Policy Tenure & Period On Risk.
3. The refund of premium under the Credit Linked Policies shall be as under:
   a. In the event of full prepayment of the Loan by the Insured, We shall refund a portion of the premium subject to the terms and conditions of the Policy as per the rates mentioned in the below table.

b. In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy.

4. No refunds of premium shall be made where any claim has been admitted by the Company or has been lodged with the Company.

Cancellation Scale

Period in Risk	Premium Refund based on Policy Term				
	Less than 18 months	More than 18 months but less than 30 months	More than 30 months but less than 42 months	More than 42 months but less than 54 months	More than 54 months but less than equal to 60 months
Within 3 months	60.0%	60%	60%	60%	60%
Exceeding 3 months but less than 6 months	50.0%	55%	55%	55%	55%
Exceeding 6 months but less than 9 months	40.0%	45%	50%	50%	50%
Exceeding 9 months but less than 12 months	25.0%	40%	45%	50%	50%
Exceeding 12 months but less than 15 months	15.0%	35%	40%	45%	45%
Exceeding 15 months but less than 18 months	5.0%	25%	35%	40%	45%
Exceeding 18 months but less than 21 months	NA	20%	30%	35%	40%
Exceeding 21 months but less than 24 months	NA	15%	25%	35%	35%
Exceeding 24 months but less than 27 months	NA	5%	20%	30%	35%
Exceeding 27 months but less than 30 months	NA	0%	20%	25%	30%
Exceeding 30 months but less than 33 months	NA	NA	15%	25%	25%
Exceeding 33 months but less than 36 months	NA	NA	10%	20%	25%
Exceeding 36 months but less than 39 months	NA	NA	5%	15%	20%
Exceeding 39 months but less than 42 months	NA	NA	0%	15%	20%
Exceeding 42 months but less than 45 months	NA	NA	NA	10%	15%
Exceeding 45 months but less than 48 months	NA	NA	NA	5%	10%
Exceeding 48 months but less than 51 months	NA	NA	NA	5%	10%
Exceeding 51 months but less than 54 months	NA	NA	NA	0%	5%
Exceeding 54 months but less than 57 months	NA	NA	NA	NA	0%
Exceeding 57 months	NA	NA	NA	NA	0%

B. CANCELLATION BY US

C. 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 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

D. 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 19.A, 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 19.A, 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.

19.Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Assignee, as the case may be, for any benefit under the Policy shall in all cases be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

20.Special Conditions Relating To Group Policy

All group policies are subject to the following conditions:

a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
b. New names can be added to the existing group policies by charging premium as agreed between Group Manager and Us.
c. For deletion of names from Group Policies during the Policy Period, refund of premium can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received.

21.Notice & Communication

Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule/Certificate of Insurance.

The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the Policy Schedule/Certificate of Insurance.

22. Law And Jurisdiction

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

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

23. Arbitration

(i) If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being

otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

(ii) It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

(iii) It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

24. Claims Notification and Procedure

In the event of any 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:

I. Reimbursement Claim Process:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. Within 15 Days from the date of discharge, You should submit all original documents pertaining to the hospitalization as mentioned is the List of Claim Documents.
   b. On receipt of intimation from You regarding a claim under the Policy, We are entitled to investigate and obtain information on the alleged injury or illness requiring hospitalization, if required,
   c. All Claims shall be settled/repudiated within 15 days from submission of claim, subject to the Policy Terms and Conditions. In case of any delay in payment for all approved claims beyond 15 days from submission of claim.
   d. In case the claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment.
   e. In case of Your Death, We shall reimburse the claim amount to Your Assignee / Nominee as named in Your Policy Schedule / Certificate of Insurance or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information
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	Copy of Hospital Main Bill
8	Investigation Reports & Consultation Papers
9	Positive Diagnostic Report for the Critical Illness and/or Surgical procedures as per the plan opted and stated in the Policy Schedule / Certificate of Insurance
10	Attending Physician Certificate (If applicable)
11	Document to Confirm Relationship with the Patient for Companion Benefit / Parent Benefit
14	Death Certificate (If applicable)
15	*KYC (Photo ID card) (If applicable)
16	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 1 and 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.

25.Multiple Policies

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.

a. Benefit based Insurance Sections:
   On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

CONDITIONS FOR RENEWAL OF THE CONTRACT

26.Portability

In case of Indemnity based Insurance sections:

a. A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.
b. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.
c. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
d. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy

27.Renewal

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
v. No loading shall apply on renewals based on individual claims experience.
vi. No fresh underwriting unless there is an increase in sum insured.
vii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected and shall be applicable for both Indemnity based and Benefit based sections.

Annexure - A

Address and contact number of Council For Insurance Ombudsman

Sl. No.	Office of Insurance Ombudsman	Address	Email	Landline NOs.
1	AHMEDABAD	Jeevan Prakash 6th floor Near S.V. College Relief Road Tilak Marg Ahmedabad- 380 001. Gujarat	E-mail: oio.ahmedabad@cioins.co.in	079-25501201, 079-25501202
2	BENGALURU	Jeevan Soudha Building, PID No.57-27-N-19, Ground Floor. No. 19/19 24th Main Rd. 1st Phase J.P. Nagar Bengaluru- 560 078.	Email: oio.bengaluru@cioins.co.in	080-26652048, 080-2665 2049
3	BHOPAL	UC of India Zonal Office Blda. 1st Floor, South Wing, Jeevan Shikha, Opp. Gayatri Mandir 60-B Hoshangabad Road Bhopal-462 011	Email: oio.bhopal@cioins.ca.in	0755-2769201, 0755-2769202, 0755-2769203, 0755-2769200
4	BHUBANESWAR	62 Forest Park, Bhubaneswar PIN -751 009.	Email: oio.bhubaneswar@cioins.co.in	0674-2596455, 0674-2596429, 0674-2596003, 0674-2596461
5	CHANDIGARH	Jeevan Deep, Ground Floor LIC of India Bldg, SCO 20-27 Sector 17-A. Chandigarh -160017	E-mail: oio.chandigarh@cioins.co.in	0172-2706468, 0172-2773101, 0172-2990938, 0172-2706196, 0172-2707468, 0172-2772101, 0172-2990942
6	CHENNAI	Fatima Akhtar Court, 4th fir 453 (old 312), Anna Salai Tevnampet. Chennai 600018	E-mail: oio.chennai@cioins.co.in	044-24333668, 044-24333678
7	DELHI	2/2 A 1st Floor. Universal Ins. Buildina. Asaf Ali Road New Delhi- 110002.	Email : oio.delhi@cioins.co.in	011-46013992
8	GUWAHATI	Jeevan Nivesh Bldg. 5th Floor Near Pan Bazar S.S. Road Guwahati-781001	E-mail: oio.auwahati@cioins.co.in	0361-2631307, 0361-2632204 0361-2732937, 0361-2632205
9	HYDERABAD	6-2-46 1st Floor Moin Court Lane Opp. Hyundai Showroom A. C. Guards. Lakdi-ka-pool, Hyderabad 500004	E-mail: oio.hvderabad@cioins.co.in	040-23376991, 040-23312122 040-23376S99, 040-23328709
10	JAIPUR	Jeevan Nidhi II, Ground Floor Bhawani Singh Road Ambedkar Circle Jaipur - 302005.	E-mail: oio.jaipur@cioins.co.in	0141-2740363
11	KOCHI	10th Floor LIC Bldg, Jeevan Prakash OPP Maharai College Ground M.G. Road, Ernakulam Kochi- 682011	E-mail: oio.ernakulam@cioins.co.in	0484-2358759, 0484-2358734, 0484-23S8336
12	KOLKATA	7th Floor of Hindustan Building (Annex). 4 CR Avenue Kolkata-700072	E-mail: oio.kolkata@cioins.co.in	033-22124339, 033-22124341
13	LUCKNOW	Jeevan Bhavan Phase II, 6th Floor Nawal Kishore Road, Hazratgani, Lucknow- 226001,	E-mail: oio.lucknow@cioins.co.in	0522-4002082
14	MUMBAI	3rd Floor, Jeevan Seva Annexe, S.V.Road Santacruz West Mumbai-400 054.	E-mail: oio.mumbai@cioins.co.in	022-69038800, 022-69038827 /8829, 022-69038831/8832
15	NOIDA	Bhagwan Sahai Palace 4th fir, Main Road Nava Bans Sector 15 Noida-201301	E-mail: oio.noida@cioins.co.in	0120- 2514252, 0120-2514253, 0120-4027589
16	PATNA	2nd Floor Lalit Bhawan Bailey Road. Patna- 800001	E-mail: oio.patna@cioins.co.in	061-22547067, 061-22547068
17	PUNE	3rd Floor Jeevan Darshan -LIC of India Bldg N.C. Kelkar Road Narayan Peth Pune- 411030.	Email: oio.pune@cioins.co.in	020-24471175
18	THANE	2nd Floor Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West), Thane - 400604	Email: oio.thane@cioins.co.in	022-20812868, 022-20812869

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
For updated details of Ombudsman details, request to please check Council of Insurance Ombudsmen website available on https://www.cioins.co.in/Ombudsman

Digit Group Hospital Cash Benefit Policy

Various Options under each Section

Section Description	No of Days Option based on Sum Insured Basis		Daily Cash Allowance / Fixed Cash Allowance (INR) Options	Time Excess Options	Other Options
	No of Days Options available for Per Day Benefit	No of Days Options available for Fixed Lump Sum Benefit			
Section 1. Accidental Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	**ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**
Section 2. Accidental & Illness Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	**ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**

Section 3. Critical Illness Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation*	**Plan Options: Plan A / Plan B / Plan C** **ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**
Section 4. Companion Benefit Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-
Section 5. Parent Accommodation	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-

Section 6. Day Care Procedure Benefit	Not Applicable	Not Applicable	INR 50 to INR 50,000	Not Applicable	-
Section 7. Maternity Benefit	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-

Waiting Period Options

Sr. No	Particulars	Applicable To Sections	Number of Days/Months/Years Options
1.	**Initial Waiting Period**	Section 2, 4, 5, and 6	0 Day / 7 Days / 15 Days / 30 Days
2.	**Critical Illness Initial Waiting Period**	Section 3	0 Day / 30 Days / 60 Days / 90 Days
3.	**Pre-existing Disease Waiting Period**	Section 2, 4, 5, 6 and 7	0 Year / 1 Year / 2 Years / 3 Years
4.	**Specific Illness Waiting Period**	Section 2, 4, 5, and 6	0 Year / 1 Year / 2 Years
5.	**Maternity Benefit Waiting Period**	Section 7	0 Month / 9 Months / 1 Year / 2 Years