DIGIT LIFE HEALTHY GROUP POLICY

(Health Plus Life Combi Product from Go Digit General Insurance Ltd. and Go Digit Life Insurance Ltd.)
PROSPECTUS
UIN: GODHLGP24094V012324

Product Introduction

Go Digit General Insurance Limited and Go Digit Life Insurance Limited have joined hands together to offer "Digit Life Healthy Group Policy", a product having dual benefits of health insurance and life insurance in a single plan. This Policy will provide complete health care to you and your family. Also, this will provide financial protection by providing life insurance coverage to you.

Key Features of this Product

- Affordable Premium
- Cashless claims for health cover
- Save tax as per prevailing Income Tax rules.
- Easy Claims settlement process.

Points to Note:

- The product is jointly offered by "Go Digit General Insurance Ltd" and "Go Digit Life Insurance Ltd."
- You will purchase two policies, I. Digit Health Plus Policy (Revision) offered by Go Digit General Insurance Limited & II. Digit Life Group Term Life Insurance offered by Go Digit Life Insurance Limited as part of this combo solution.
- You will receive the policy benefits as applicable for all the two polices as per standard terms & conditions of the respective products.
- The risks under the components of the Combi Product are distinct. Go Digit Life Insurance Ltd shall assume/accept the risk only in relation to the life insurance component of the Combi Product and Go Digit General Insurance Ltd shall assume/accept the risk only in relation to the health insurance component of the Combi Product.
- The premium of the life insurance and health insurance components of the Combi Product are separate and have been separately identified and disclosed in the Combi Product policy document. The health insurance component of the Combi Product is entitled to be renewed at the option of the policyholder of Go Digit General Insurance Ltd.
- You shall pay the integrated premium for the Combi Product to either of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. The insurer receiving the consolidate premium shall further transfer the relevant share of the premium to the other insurer. You shall be entitled to the underlying benefits of both life and health insurance components of the Combi Product from the date and time of acceptance of the integrated premium by Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd.
- The Combi Product shall have a free look option, which shall be applied to the Combi Product as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.
- At any time during the validity of the Combi Product policy, you shall be entitled to continue with either part of the Combi Product policy, discontinuing the other.
- The liability to settle the claim vests with respective Insurers, i.e., for life insurance benefits, Go Digit Life Insurance Ltd and for health insurance benefits, Go Digit General Insurance Ltd.
- All policy servicing requests pertaining to the Combi Product shall be received by either of the Insurers. However, Go Digit General Insurance Ltd, as the Lead Insurer of the Combi Product, shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.
- All requests pertaining to the Combi Product impacting premium or policy terms of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be serviced by Go Digit Life Insurance Ltd for life products and by Go Digit General Insurance Ltd for health products, as the case may be.
- Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall fulfil servicing requests received by them in accordance with the IRDAI (Protection of Policyholders' Interests) Regulations, 2017, as amended from time to time. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective life insurance or health insurance components of the Combi Product. The claim process is available on the website of both Go Digit Life Insurance Ltd and Go Digit General Insurance Ltd.
- You may lodge a grievance with respect to either or both of the life insurance and health insurance components of the Combi Product at branches of either Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. Complaint belonging to any product shall be routed to the respective insurer viz. Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd, who shall then respond/address to the Customer directly. Complaints shall be forwarded by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd to each other for their respective Product. In the event you are not satisfied with the resolution offered, you may also approach the Insurance Ombudsman in your region. Please refer to the relevant grievance redressal mechanism section mentioned under each component of the Combi Product.

- The legal/quasi legal disputes, if any, are dealt by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd for their respective benefits. The legal disputes pertaining to life insurance benefits shall be dealt with by Go Digit Life Insurance Ltd and for health benefits all the legal disputes will be handled by Go Digit General Insurance Ltd.
- You are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.
- Two Covers – "Critical Illness benefit cover" and "Wellness Benefit Program" are available under both I. "Digit Health Plus Policy (Revision)" as well as under II. "Digit Life Group Term Life Insurance". However, you are allowed to opt these covers in either I or II. You cannot opt these covers under both.
- Withdrawal of tie up between the Insurers:
  Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up between them after obtaining the requisite approval from the IRDAI. Upon receipt of such approval from the IRDAI, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up with notice period of ninety (90) days, or such other period as may be prescribed by the IRDAI, from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.
  In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, with respect to health cover policy, the same will be subject to Migration guidelines.
  In the event of termination of this tie up, Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall mutually cooperate for providing customer support and policy servicing post termination of the tie up between Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. Further, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd, as the case may be, shall remain liable for its respective life insurance or health insurance components for all Combi Product policies in force at the time of termination of this tie up until their expiry.

I. DIGIT HEALTH PLUS POLICY (REVISION)

What is covered under Digit Health Plus Policy (Revision)?
The coverage under this policy is as mentioned below:

SECTION 1. HOSPITALIZATION COVER

A. Accidental Hospitalization Cover

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

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

A1. Day Care Procedures

If You suffer an Accidental Injury during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement, We will pay the Medical Expenses Incurred for such Day Care Procedures.
Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

A2. Pre-Hospitalization Expenses

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

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

A3. Post-Hospitalization Expenses

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

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

Instead, You may also choose to opt for a onetime lumpsum benefit, which shall be a percentage of the claim amount approved under **Section 1.A. Accidental Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule/Certificate of Insurance.
If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

A4. Dental Treatment
We will pay for the medical expenses incurred by You for any necessary Dental Treatment needed after an accident. A claim here is valid if the accident resulted in an admissible inpatient Hospitalization Claim under **Section 1. A. Accidental Hospitalization Cover.**

A5. Road Ambulance
We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency arising out of an Accident, provided that:
a) We have accepted a claim under **Section 1. A. Accidental Hospitalization Cover.**
b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

A6. Second Medical Opinion
We shall arrange and bear the cost for Second Opinion from our panel of Medical Practitioners. This is for times when there has been a major accidental injury that requires your hospitalisation in a tertiary care facility during the Policy Period, provided that:
1. We have received Your request to arrange for a Second Opinion.
2. You have the option to choose any One of Our Panel Medical Practitioners.
3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.
   All the above Covers are Subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

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

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

Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	peration Theatre Fees

B1. Day Care Procedures

If You suffer an Accidental Injury or Illness during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for stay less than 24 hrs because of technological advancement, We will pay the Medial Expenses Incurred for such Day Care Procedure.
Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

B2. Pre-Hospitalization Expenses

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

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

B3. Post-Hospitalization Expenses

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

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.
   Instead, You may also choose to opt for a onetime lumpsum which shall be a percentage of the claim amount approved under **Section 1.B. Accidental & Illness Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule/Certificate of Insurance.
   If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

B4. Dental Treatment

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

B5. Road Ambulance

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

a) We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover.**
b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

B6. Bariatric Surgery Cover

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

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

- Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.

c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
   - Gastric Bypass-
   - The Roux-en-Y Gastric Bypass
   - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
   - Sleeve Gastrectomy
   - Laparoscopic Gastric Banding

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

Bariatric surgery for the following reasons is not covered:

a) For Cosmetic/Aesthetic reasons.
b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity.

B7. Psychiatric illness Cover

We will pay up to the Limit mentioned in Your Policy Schedule / Certificate of Insurance against this Cover for the Medical Expenses, related to Psychiatric Illness which includes, though not limited to, dementia, depression, bipolar disorder, schizophrenia, Anxiety disorders and obsessive-compulsive disorders, provided that:

a) The first diagnosis and Hospitalization, as an inpatient, was during the Policy Period.
b) This also has a waiting period. Waiting period shall be as per the '"**Specific Waiting Period**'" Section stated in Your Schedule / Certificate of Insurance against this Cover which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Psychiatric as a benefit since inception of the first policy.
c) Hospitalization under this benefit shall be subject to prior approval from Us, except in cases of emergencies.

B8. Complimentary Health Check Up

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

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

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

B9. Second Medical Opinion

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

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

SECTION 2. INFERTILITY TREATMENT COVER

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

a) A waiting period of 48 months will apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with this cover, without a break, with 'Infertility Treatment Cover' as a benefit since inception of the first policy.
b) Our maximum liability per Hospitalization shall be restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
c) The benefit is payable only once to an Insured Person during the Policy Tenure.
This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 3. ORGAN DONOR

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

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

SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER (Mandatory In-Built cover in Section-1 Hospitalization Cover)

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

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

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

Specific Conditions applicable to this cover:

Claim will be payable under this section only if AYUSH Hospitals and AYUSH Day Care Centres have obtained pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

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

SECTION 5. EMERGENCY AIR AMBULANCE

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

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

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

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

SECTION 6. LONG HOSPITALIZATION CASH BENEFIT

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

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

b) The benefit is payable only once to an Insured Person during the Policy Period.
For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER

A. Maternity Benefit

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

a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply***). This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule / Certificate of Insurance shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
b) If you are porting an existing policy under Portability Guidelines, from some other General or Health insurance company or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.
c) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
d) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance applied to the increased part of the Sum Insured.
e) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.
If we had already accepted a claim for Maternity Expenses for your first living child under this benefit, then for the subsequent Maternity Expenses i.e. for the delivery of Your Second child, we shall pay up to the percentage of the Sum Insured opted under this Section and mentioned in Your Policy Schedule / Certificate of Insurance provided the Policy is renewed with Us continuously without break with Maternity Benefit & New Born Baby Cover benefit.

We shall not pay for the following under this Section:

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

B. Newborn Baby Benefit

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

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

SECTION 8. OUT-PATIENT (OPD) BENEFIT

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

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

Basis 2: Nil Co-payment
What all is covered under this:

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

This cover excludes expenses incurred towards Spectacles, Contact Lenses and Physiotherapy, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.
This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION

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

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

SECTION 10. SUM INSURED REFILL BENEFIT

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

a) The refilled Sum Insured would be triggered only if the cause of the Hospitalization is not related to /arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy period for the same Insured Person, unless this condition is specifically waived by us and mentioned in Your Policy Schedule / Certificate of Insurance
b) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
c) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**

d) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule / Certificate of Insurance against this Section during each Policy Period.
e) In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.
This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 11. DAILY HOSPITAL CASH COVER

Accidental Hospitalization Cover

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

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

Accidental & Illness Hospitalization Cover

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

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

SECTION 12. CRITICAL ILLNESS BENEFIT COVER

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

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

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

12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER

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

Provided that,

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

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

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

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity
2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension

6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

SECTION 14. CANCER BENEFIT COVER

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

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

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

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

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

SECTION 15. CANCER HOSPITALIZATION COVER

If You have opted for this Cover and You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life during the Policy Period , We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You

in respect of an admissible hospitalization claim for Cancer for Specified Severity up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Provided that,

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

b) No Claim under this option shall be admissible if Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.

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

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

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

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

SECTION 16. WELLNESS BENEFIT PROGRAM

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

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

1. **Doctor on Call**
2. **Wellness Coach**

3. **Lab Services (Home Collection)**
4. **Pharmacy (Home Delivery)**
5. **Vital/Physical Activity Monitoring Services**
6. **Reminder Notifications**
7. **Medical Wallet**
8. **Report Aggregation**
9. **Home Care Services**
10. **Ambulance Arrangement Services**
11. **Pick-up and Drop Services for Consultation**
12. **Prioritizing Appointments**

Terms and Conditions applicable to Wellness Benefit Program

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

What are the conditions applicable under Digit Health Care Plus Policy?

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

i. If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
ii. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy

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

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

3. Withdrawal of Product

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

4. 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.

5. Cancellation

A. Cancellation by You

You may cancel your policy at any time during the term, by giving 7 days notice to us in writing. We shall

1. Refund proportionate premium for unexpired policy period, if the term of policy is upto one year and there is no claim (s) made during the policy period.
2. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

B. Cancellation by Company

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

C. In case of Death of Insured Person

1. 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, 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.

2. 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 proportionate premium for unexpired policy period, subject to the terms and conditions of the Policy. Difference between proportionate premium for unexpired policy period 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.

What are the exclusions under Digit Health Care Plus Policy?

We shall not be liable to make any claim payment under this Policy directly or indirectly 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. STANDARD EXCLUSIONS

1. Pre-Existing Diseases - Code- Excl01

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

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

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage
f. List of specific diseases/procedures
   i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
   ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
   iii. Cataract, Glaucoma and Disorder of retina

iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
vii. Hernia of all sites,
viii. Chronic Kidney disease and failure,
ix. Varicose veins of lower extremities,
x. 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,
xi. 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),
xii. Internal Congenital Anomaly. This specific waiting period will not be applicable to New Born Baby/infants.
xiii. Psychiatric illness
xiv. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease.
xv. **Joint Replacement, Bariatric Surgery and Organ Transplant**

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

3. 30-day waiting period/ Initial Waiting Period - Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

4. Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

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

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

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

6. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. Cosmetic or plastic Surgery: Code- Excl08

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

9. Hazardous or Adventure sports: Code- Excl09

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

However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional

10. Breach of law: Code- Excl10

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

11. Excluded Providers: Code- Excl11

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

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

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

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

15. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters

16. Unproven Treatments: Code- Excl16

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

17. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

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

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

18. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
This exclusion stands deleted to the extent of the coverage provided under **SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER**, if opted by You.

II. <u>SPECIFIC EXCLUSIONS</u>

19. Artificial Life Maintenance

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

20. Suicide and Self-Injury

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

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

21. Circumcision, Aesthetic reasons

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

22. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geography

Any treatment received outside India is not covered under this Policy.

24. Defence Operation

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

25. Non-Medical Expenses

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

26. Insufficient Document

We have tried to reduce the number of documents you need to share. 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.

27. Preventive Treatment

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

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

28. 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.

29. 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.

30. Sleep Disorders and Sleep Problems

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

31. 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.

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

33. Unjustified **or Unwarranted Hospitalization**

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

34. War and hazardous substances

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

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

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

35. 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.

36. Substance abuse and Addictions

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

SPECIFIC ONES (CAN'T BE WAIVED)

37. Eye Sight & Optical Services

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

38. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

39. Specific Treatments

We will not pay for expenses related to administration of medications or procedures including but not limited to expense related:

a. Hyaluronic acid, Remicade or similar medications
b. Intra-articular/intra thecal or cortico-steroid injections,.
c. Predictive Genome testing

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

40. Dental Treatment

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

41. Organ Donor

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

42. Weight loss Surgery

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

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

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

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty

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

Policy Term:
This being a Group Policy, Policy term will be 12 months.

Group Details:
1. Policy to be offered to members of the Group who are Indian Citizens or Foreign Nationals residing in India.
2. Group Size should be of minimum 7 members

Age at Entry:

Type	Entry Age	Minimum	Maximum
Hospitalization Cover & Daily Hospital Cash Cover	Proposer	18yrs	No Limit
	Child	91days	No Limit
	Adult Insured	18yrs	No Limit
Critical Illness Cover	Proposer	18yrs	No Limit
	Child	181days	NA
	Adult Insured	18yrs	No Limit

II. DIGIT LIFE GROUP TERM LIFE INSURANCE

Key Features of the Plan

- Can be offered to both Employer-Employee and Non-Employer-Employee or Affinity groups.
- Provides a high degree of customization and flexibility to create a tailormade solution.
  - Option to choose death benefit as lumpsum or regular income or combination of both basis members' financial needs.
  - Inbuilt optional benefits for protection against **Accidental Death, Critical Illness, Total & Permanent Disability and Terminal Illness**, based on the option chosen.
  - Option to extend insurance coverage to member's spouse.
  - Option to change the members' Sum assured during the coverage term.
  - Single Pay, One Year Renewable Term, Regular Premium pay options
  - Option to pay the premium as per preferred premium payment frequency (Single, monthly, quarterly, half-yearly, or annually)
- Super Simple services with our **Corporate Portal** where any changes like addition or deletion of members at any time during the policy year can be done easily.
- **Hassle Free Implementation - No medical check-up** is required for the cover up to the free cover limit.
- Up to 3 year premium rate guarantee with regular pay option
- Availability of Profit-sharing option to master policyholder
- **Wellness benefits** to insured members
- Offers Cover for policies issued in lieu of Employees' Deposit Linked Insurance Scheme.

An individual member will get the choice to opt from the various options made available by the master policyholder under the policy with respect to applicable benefit options, coverage term, premium payment term, premium payment frequency, sum assured, other applicable options, if any, subject to terms and conditions of the master policy, scheme rules and prevailing underwriting policy of Company.

How this Policy Benefits Master policyholder and Members?

Benefits to Master policyholder	Benefits to Member
• Financial Protection to family of all members under one policy • Provides high coverage amount at low costs • Highly customizable solution providing additional comprehensive benefit options to suit member needs • Hassle free implementation. • Can serve as employee retention tool • Tax Benefit on Premium paid by Employer as per prevailing tax laws • Group Term Life Insurance coverage for future service gratuity liability	• Peace of Mind with family being financially protected in case of unfortunate event with member • Protection against other Death, Disease and Disability • Convenience of no medical tests till free cover limits • Premium paid by individual member (if any) qualifies for tax deduction as per prevailing tax laws • Death Benefits received by the beneficiary is exempt from tax as per prevailing tax laws.

Eligibility Conditions

Entry Age (as per last birthday)	Minimum - 14 years Maximum - 80 years		
Maturity Age (as per last birthday)	Minimum - 14 years Maximum - 80 years		
Group Size	Minimum - 5 members Maximum - No limit		
Minimum Sum Assured (SA)	Lumpsum Sum Assured per person - ₹5,000 Income Benefit per person - ₹100/month (provided sum total of income payable is not less than ₹5,000)		
Maximum Sum Assured (SA)	Death Benefit	No Limit (subject to prevailing underwriting policy of the Company)	
	Optional Benefits	Additional Accidental Death Benefit Additional Accidental Total & Permanent Disability Benefit, Additional or Accelerated Critical Illness Benefit, Accelerated Terminal Illness Benefit	No Limit (subject to prevailing underwriting policy of the Company)

	Accelerated Benefits shall not exceed lumpsum sum assured chosen under death benefit
Policy Term	Master policy will continue indefinitely until terminated. At member level, the coverage term will be as per Premium Payment Option chosen › For Single Premium Option – One month to Three Years (in multiples of months) › For Regular Premium Option – Two or Three years › One Year Renewable Term - One year
Premium Payment Term	› For Single Premium Option – Single Pay › For Regular Premium option – Two or Three years › One Year Renewable Term – One year
Premium Payment Frequency	Yearly, Half-Yearly, Quarterly, Monthly for One Year Renewable Term and Regular Pay Single Pay for Single Premium option

***Please Note** : For Group Term Life policies in lieu of EDLI, the eligibility conditions will be as per Employees' Deposit Linked Insurance (Amendment) Scheme, 2018, as amended from time to time.*

What is covered under Digit Life Group Term Life Insurance?

The coverage under this policy is as mentioned below:

A. Death Benefit

This is the compulsory benefit and in case of unfortunate demise of the member during the coverage term, Death Benefit is payable to the nominee.

Death Benefit Payout Options

Master policyholder can choose to offer the members any one or combination of the any of the following four death benefit payout options subject to acceptance by the Company:

a. Lumpsum Sum Assured: Under this option (if chosen), a lumpsum amount will be paid following the death of insured member.
b. Regular Income till the retirement age of insured member: Under this option (if chosen), regular income will be paid following date of member's death till his / her retirement age.
c. Regular Income linked to the age of members' child/children: Under this option (if chosen), regular income will be paid following date of member's death till his or her child / children attain a certain age, as chosen (not exceeding 25 years as on last birthday)
d. Regular Income for a specified period: Under this option (if chosen), regular income will be paid for chosen number of years (not exceeding 40 years) following date of member's death.

Regular Income chosen can be level or increasing with income increasing at specified simple rate of up to 10% per annum. Any one of annual, half-yearly, quarterly or monthly mode can be chosen to receive the regular income payouts.

In case of any of the regular income options mentioned above, for presentation purpose, sum assured shall be defined as the total income payable in the next 12 months following the death of insured member.

Members of the same master policy can have different lumpsum sum assured amount and regular income amount. The lumpsum sum assured or regular annual income or combination of these two benefits, as chosen for each individual member will be specified on coverage inception date or the coverage renewal date, if applicable. Any changes in the lumpsum sum assured or regular income during the coverage term will be as per the master policyholder's request and Company's acceptance.

On payment of Death Benefit, insurance coverage for the insured member under this plan will immediately and automatically terminate.

B. Inbuilt Optional Benefits –

The master policyholder can choose one or more of the following in-built optional benefits before master policy commencement date or policy renewal date (if applicable) subject to Company's acceptance and members can choose from such available options under the master policy, subject to prevailing underwriting policy of the Company and terms and conditions of this master policy. Premium will vary depending upon the inbuilt optional benefit/(s) chosen. Only lumpsum sum assured shall be available for inbuilt optional benefits. Option to choose income benefit is available in case of death benefit only.

i. Additional Accidental Death Benefit (ADB)

In case of accidental death of insured member, in addition to Death Benefit, an amount equal to the ADB Sum Assured will be paid in lumpsum and on such payment, insurance coverage for the insured member under this plan will terminate.
A claim under this Benefit Option shall be admitted provided that the death:

a) is caused by injury resulting from an accident,
b) occurs solely and directly due to the Injury, and independent of any other causes,
c) occurs within 180 days of the occurrence of accident and
d) is not a result from any of the causes listed in the exclusions for additional Accidental Death Benefit specified in general policy provisions.

In case, the accident occurs while the insured member's additional ADB insurance coverage is in-force, but the accidental death occurs after the end of the member coverage term and within 180 days of the accident, additional ADB sum assured applicable at the time of such accident shall be payable.

This benefit will be paid in following conditions as well:

a. **Disappearance**: If the insured member's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the member coverage term, where it is reasonable to believe that such insured Member has died as a result of an accidental injury.
b. **Drowning:** If the insured member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the member coverage term, where it is reasonable to believe that such insured member has died as a result of drowning.

For both (a) and (b) above, benefit will be paid, when the claimant provides a legally binding indemnity bond or any other document as required by the Company which guarantees, that, if at any time, after the payment of the additional Accidental Death Benefit, it is discovered that the insured member is still alive, all payments shall be repaid in full to the Company.

Definitions and exclusions with respect to Additional ADB are provided in General Policy Provisions.

ii. Additional Accidental Total And Permanent Disability (ATPD) Benefit

Accidental Total and Permanent Disability refers to a disability, which

a. Is caused by bodily injury resulting from an accident; and
b. Occurs solely and directly due to the said bodily injury and shall be independent ofany other cause; and
c. Occurs within 180 days of the occurrence of such accident; and
d. Results in (i) Total and irrecoverable loss of sight of both eyes, or; (ii) Physical separation or loss of use of both hands or feet, or; (iii) Physical separation or loss of use of one hand and one foot, or; (iv) loss of sight of one eye and Physical separation or loss of use of hand or foot; (v) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Member from engaging in any employment or occupation of any description whatsoever.

The above is exclusive of and without prejudice to the other causes of total and permanentdisability.
Where,
Physical separation shall mean physical severance of the hand at or above the wrist orphysical severance of the foot at or above the ankle.

The date of the accident should be after the date of inception of insurance coverage and before the termination/ expiry of the insured member's insurance coverage.

In case, the accident occurs while the insured member's additional ATPD benefit coverage is in force, but the ATPD occurs after the end of the member coverage term and within 180 days of the accident, additional ATPD sum assured applicable at the time of such accident will be payable.

This is an additional benefit and on occurrence of accidental total & permanent disability (ATPD), an amount equal to the ATPD sum assured will be payable in lump sum. On payment of the additional ATPD sum assured, additional ATPD benefit for the member will terminate (in case it was chosen by the member), however the member's insurance coverage will continue for death benefit and all the other inbuilt optional benefits, if chosen, for the remaining member coverage term.

Definitions and exclusions with respect to additional ATPD benefit are provided in General Policy Provisions.

iii. Critical Illness Benefit (CI Benefit)

On occurrence of one of the covered Critical Illness Conditions with respect to the insured member, subject to survival period of 30 days and waiting period of 90 days, an amount equal to the CI sum assured shall be payable in lumpsum.
There are following three variants offered under this benefit and any one of them can be chosen by member before inception of insurance coverage.

Variant 1 – 14 Critical Illnesses
Variant 2 – 20 Critical Illnesses
Variant 3 – 34 Critiical Illnesses
The Critical Illnesses offered under three variants are as given in the table below:

Sr.No.	Category	Critical Illness	Plan A	Plan B	Plan C
1	**Cancer**	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 Transplant**	End Stage Lung Failure	Covered	Covered	Covered
11		End Stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered
14	**Nervous System**	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered
17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered
22		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

The CI benefit can be either chosen as additional benefit to the death benefit or as an accelerated benefit.

If CI Benefit is chosen as Additional CI Benefit - On admission of a claim under the additional CI benefit, the member's Insurance

Coverage under the master policy will continue in respect of death benefit and all other in-built optional benefits (if any) except additional CI benefit for the remaining of the member coverage term.

If CI Benefit is chosen as Accelerated CI Benefit – Accelerated Benefit means payment of this benefit shall not be in addition to lumpsum death benefit chosen and it only facilitates an earlier payment of lumpsum death benefit on prior occurrence of critical illness. Accelerated CI Benefit can be opted for when lumpsum sum assured under death benefit is chosen (either standalone or in combination with any of the regular income benefit options) and shall not exceed lumpsum Sum Assured under Death Benefit. On admission of claim under the accelerated CI Benefit:

- **Where the CI Sum Assured is equal to the applicable lumpsum sum assured under Death Benefit and income benefit option is not chosen under death benefit additionally**, the member's insurance coverage for all the benefits will terminate immediately upon diagnosis of Critical Illness and payment of CI Benefit. However, if in such case, income benefit option is also chosen additionally, on payment of such accelerated CI benefit, insurance coverage for accelerated CI benefit and lumpsum sum assured under death benefit will terminate, whereas the member's insurance coverage will continue with respect to the income benefit option under death benefit and other inbuilt optional benefits, if any.

- **Where the CI Sum Assured is less than the applicable lumpsum sum assured under Death Benefit**, on payment of the CI Sum Assured, the applicable lumpsum sum assured under the Death Benefit will be reduced to the extent of the CI sum assured paid, and such change will be effective from the date of the payment of the accelerated CI benefit. Such member's insurance coverage for other applicable inbuilt optional benefits (if any) shall continue for rest of member coverage term.

The claim for Critical illness Benefit shall be accepted only if Critical Illness condition has happened to insured member for the first time in life and is not a consequence of or arising out of any pre-existing condition/disease

Once a claim has been accepted under CI benefit, insurance coverage for the insured member under this policy with respect to CI benefit shall cease and no further payment will be made for any consequent Critical Illness condition or any dependent Critical Illness/Illnesses.

Definitions and exclusions with respect to critical illness benefit are provided in General Policy Provisions.

iv. Accelerated Terminal Illness (TI) Benefit

Terminal Illness means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners, chosen by the Company and specializing in treatment of such illness, certify that the illness is expected to lead to death of the member within 6 months of the date of diagnosis of the Terminal Illness.
The Terminal Illness must be diagnosed and confirmed by Medical Practitioners. The Company reserve the right for an independent assessment by two different medical practitioners other than the medical practitioner whose diagnosis has been provided by the insured member.
Terminal Illness is an accelerated benefit which means payment of this benefit will not be in addition to lumpsum death benefit chosen and it only facilitates an earlier payment of lumpsum death benefit on prior occurrence of terminal illness. Accelerated TI benefit can be opted for when lumpsum death benefit is chosen (either as standalone or in combination with any of the regular income benefit options). On diagnosis of a Terminal Illness, an amount equal to the TI Sum Assured will be paid. This benefit is payable only once during the lifetime of a member and shall not exceed lumpsum sum assured under death benefit.

Where the TI Sum Assured is equal to the applicable lumpsum Sum Assured under Death Benefit and income benefit option is not chosen under death benefit additionally, the insurance coverage for all the benefits, including inbuilt optional benefits (if any) in respect of the insured member will terminate immediately upon diagnosis of Terminal Illness and payment of accelerated TI Benefit. However, if in such case, income benefit option is also chosen additionally, on payment of such accelerated TI benefit, the member's insurance coverage will continue with respect to only income benefit option under death benefit.

Where the TI Sum Assured is less than the applicable lumpsum Sum Assured under Death Benefit, on payment of the TI Sum Assured, the applicable lumpsum death benefit will be reduced to the extent of the TI Sum Assured paid and this change shall be effective from the date of payment of accelerated TI Benefit. On payment of the accelerated TI Benefit, the member's insurance coverage in respect of inbuilt optional benefits (if any) under this master policy will immediately and automatically terminate.

C. Other Add-On Benefits available under the plan

i. Spouse Cover

- This option is provided to extend insurance coverage to the spouse of members in the group.
- Insurance cover to members' spouse will be provided subject to the submission of the evidence of insurability and evidence of health as per prevailing underwriting policy and terms and conditions of this plan and upon payment of an additional premium.

ii. Voluntary Insurance Coverage

The member has an option to choose for voluntary Insurance Coverage, subject to following conditions:

- Maximum sum assured allowed will be as per Company's prevailing underwriting policy.
- A written request is submitted along with the evidence of insurability and health to the Company as per our prevailing underwriting policy and on payment of an additional Premium.
- The premium rate applicable for sum assured under this Voluntary Insurance Coverage shall be independently derived based on the expected risk profile and take-up rates.

Some of the coverages where this option could be utilized, including but not limited to cover the following:

- Coverage towards Credit card outstanding
- Coverage for Funeral expenses
- Coverage for Child education

iii. Profit sharing

This plan also offers a profit-sharing option wherein in case of favourable claims experience, the master policyholder would be refunded back a part of the premium depending on the formula mutually agreed between master policyholder and the Company for the same.

iv. Renewal Rate Guarantee

The master policyholder by choosing a regular pay option can ensure that the premium paid by them remains the same during the chosen policy term.

v. Risk Sharing and Risk Capping

To address the ever-evolving needs of the group customers who have partial risk appetite at their own or through suitable insurance arrangement and requires insurance for the risks beyond their appetite and up to a maximum limit subject to board approved underwriting policy, this product offers the following options at master policy and member level as well.

Options at Member Level:

Proportional sharing: The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits for each Member where the Insurance Coverage / claim liability for Us will be limited to the opted percentage of Benefits / claims for each Member.

Excess level sharing: The Master Policyholder can choose the option to insure the Benefits above certain threshold level for each applicable Member where the Insurance Coverage / claim liability for Us will be the amount of Benefits / claims in excess of the opted threshold limit for each applicable Member.

Options at Master Policy Level:

Proportional sharing: The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits capped to maximum limit at Master Policy level, applicable for the entire group where the Insurance Coverage / claim liability for Us towards the group will be limited to the opted percentage of Benefits / claims at the concerned group level.

Excess level sharing: The Master Policyholder can choose the option to insure the Benefits above certain threshold level capped to maximum limit at Master Policy level, where the Insurance Coverage / claim liability for Us will be the amount in excess of the opted threshold limit at the concerned group level.

If any of the options at Master Policy level is chosen, any Benefit payable will further be subject to the arrangement agreed at Master Policy level.

Please Note *- The option to choose spouse cover and voluntary insurance coverage will not be available for policies issued in lieu of EDLI.*

D. Survival / Maturity Benefit

There is no survival / maturity benefit under this plan

E. Wellness benefit

We provide wellness benefits to the insured members which intends to incentivize the insured member for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.

The applicability of the wellness benefit program and its features may be amended from time to time as per the prevailing underwriting policy of Go Digit Life Insurance Limited. The list of benefits under this program and terms and conditions applicable to it are provided in Annexure I.

F. Benefit in case of Surrender

In case of surrender of the master policy by the master policyholder, the members shall have an option to continue the insurance coverage till the end of their respective member coverage term, such insurance coverage will continue with the same terms and

conditions as the original insurance coverage and Company/ intermediary, if any, shall continue to be responsible to serve such members till their insurance coverage is terminated. Unexpired risk premium value (surrender value) for such members opting to continue the insurance coverage shall not be paid out.

Following Unexpired Risk Premium Value will be payable on Surrender:

Single Pay	In case of surrender of the master policy or member's insurance coverage where premiums are paid by member, an amount equal to 60% of the single premium adjusted for the unexpired duration of the policy term or member coverage term of the discontinuing members, as applicable, would be payable. In case of surrender by members for schemes where premiums are paid by the master policyholder, an amount equal to the single premium adjusted for the unexpired duration of the coverage term of the discontinuing member would be payable to the master policyholder.
One Year Renewable Term	In case of surrender of the master policy, an amount equal to the instalment premium for the unexpired coverage term of the discontinuing members, less appropriate deduction for expenses, stamp duty paid, commission and taxes and levies as applicable shall be payable. In case of surrender by members for schemes where premiums are paid by the master policyholder, an amount equal to the instalment premium for the unexpired duration of the member coverage term for which the instalment premium was applicable, in respect of the discontinuing members, shall be payable to the master policyholder, who typically adjusts it against any premiums payable.
Regular Pay	In case of surrender of the master policy or member's insurance coverage where premiums are paid by member, an amount equal to 60% of the instalment premium adjusted for the unexpired duration of the policy term or member coverage term, as the case may be, for which the instalment premium was applicable in respect to discontinuing members shall be payable. In case of surrender by members, for schemes where premiums are paid by the master policyholder, an amount equal to the instalment premium adjusted for the unexpired duration of member coverage term for which the instalment premium was applicable in respect of the discontinuing members, shall be payable to the master policyholder, who typically adjusts it against any premiums payable.

General Policy Provisions / Definitions / Exclusions:

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.

Grace Period

In the event where the master policyholder or insured Member (as applicable) fails to pay the due Premium on the instalment premium due date, a grace period will be allowed to pay the due Premium while continuing the applicable insurance coverage and other benefits under it. After the expiry of the grace period without receipt of the due premium in full, the insurance coverage and benefits under the master policy or for the respective insured member(s) will lapse. A grace period of 15 days in respect of monthly frequency and 30 days in other applicable frequencies from the instalment premium due date will be provided for one year renewable term and regular pay policies for paying overdue premium to the Company without any penalty/late fee during which time the benefits under the Master policy/Insurance Coverage of insured member will be considered to be continuing without any interruption as per the terms of the master policy.

If any of the insured event occurs during the grace period, applicable benefit shall be payable subject to receipt of unpaid due premium for the master policy, where premium is paid by master policyholder. However, in policies, where premium is paid by the member, the applicable benefit shall be payable subject to deduction of unpaid due premium for such member. In case, the premium which was due with respect of any insured member, is collected by the master policyholder within grace period but is not remitted to the Company for some reason, then the insurance coverage for such member will continue even on expiry of grace period, provided such member has the receipt of payment of such premium to the master policyholder within grace period. The Company reserves the right to recover such premium from the master policyholder.

Free Look Period:

At Master policy Level

In case the master policyholder does not agree with the terms and conditions of the master policy, the master policyholder has the option to request for cancellation of the master policy by returning the original master policy document along with a written

request stating the reasons for objection to the Company within 15 days (30 days in case the policy is sourced through electronic mode or distance marketing mode) from the date of receipt of master policy document. Upon the receipt of such a cancellation request, the Company will cancel the master policy and refund the premiums received after deducting proportionate risk premium for the period of insurance coverage and expenses incurred on medical examination, if any and applicable stamp duty. All insured members' coverage will cease post the request for free look cancellation by the master policyholder.

At Member Level

If the insured member does not agree with the terms and conditions specified in Certificate of Insurance, he/she has the option of returning the Certificate of Insurance to the company stating the reasons thereof, within 15 days (30 days in case the Policy is sourced through electronic mode or distance marketing mode) from the date of receipt of the Certificate of Insurance. Upon receipt of the free look cancellation request and original Certificate of Insurance, we shall refund the premium received in respect of insured member, subject to deduction of the proportionate risk premium for the period of insurance coverage, expenses incurred on medical examination, if any and applicable stamp duty for that insured member. The coverage for the insured member will cease post the request for such free look cancellation.

For Administrative purposes, all free-look requests should be registered by the Master policyholder on behalf of the Insured.

Lapsation

If the due premium is not paid within grace period, the insurance coverage and other applicable benefits will be lapsed till the policy or member's coverage, as applicable, is revived/reinstated. No benefit shall be paid during lapsed status.

Paid-up Benefit No paid-up benefits are available under this policy.

Revival: The Company will consider requests to revive lapsed policies or the member's insurance coverage, as applicable from the date of first unpaid premium, provided such requests are received within the original policy or member coverage term. Any agreement to revive the lapsed policy/ member's insurance coverage would be subject to Company's prevailing underwriting policy.

The Company shall collect all the premiums due and other charges or late fee if any, as per the terms and conditions of the Policy, to revive the lapsed policy or member's coverage term, as applicable.

The late fees shall be calculated at such interest rate as may be prevailing at the time of the payment. The revival interest rate compounding annually, will be set using prevailing interest rates. The prevailing interest rates will be derived from yields of the 30 years G-Sec security. Any change in the interest rate used will be in accordance with the formula below:.

Annualized Yield on reference government bond + 100 basis points, rounded up to the nearest 25 basis points.

The revival interest rate for the financial year 2023-24 is 8.25% p.a.

The revival interest rate will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the rate shall be effective from 25th February and 25th August each year.

Any change on basis of determination of interest rate for revival can be done only after prior approval of the Authority.

Reinstatement: If the due premium is not received by the end of the grace period, the policy will lapse. The lapsed policy could be reinstated, and the insurance coverage will recommence from the date of reinstatement and the premium will be collected accordingly. The Company shall not collect any unpaid premiums on reinstatement, nor shall be liable to pay the claims occurring during the period for which the policy is in lapsed status. In certain circumstances, the Company may also change certain terms of the policy including the pricing. Such reinstatement shall be as per the prevailing underwriting policy of the Company.

Policy Loan This policy does not offer loan facility.

Premium payment

In case insurance coverage under any of the inbuilt optional benefits ceases before the completion of member coverage term, though member coverage continues for death benefit or other applicable inbuilt optional benefits, no further premium shall be payable for the remaining premium payment term, if any, for inbuilt optional benefit(s) which are terminated.

Premium Payment Frequency

- The premium may be paid monthly, quarterly, half-yearly or annually in advance for one-year renewable term and regular pay policy.
- For non-annual premium payment frequency, instalment premiums are calculated by applying the loading factor as given below on annual premium:

Premium frequency	Loading factor
Monthly	4%
Quarterly	3%

Half-yearly	2%

Policy changes/alterations:

Addition of members

- New members can join the policy during the year at any well-defined date. Premiums shall be collected in advance for insurance coverage being provided to such members.
- The master policyholder should inform or intimate the Company with the list of new joiners preferably within 45 days from the date of new joiners becoming eligible to be admitted under this master policy.
- Members joining the scheme during policy year or policy term will be charged the premium proportionate to the duration the member is covered during the policy year or policy term, as applicable. Any applicable levies, taxes, duties or surcharges will also be charged.
- The effective date of coverage for the new joiners shall be the date of joining of the member or the date of intimation whichever is earlier. The Company shall communicate its decision on addition of Member based on its then prevailing underwriting policy. In case of inadequate Premium, the insurance coverage will begin from the date of receipt of the full Premium.
- Where appropriate, Company may permit at scheme level for individual scheme members to be covered for chosen coverage term from their scheme joining date.
- Company will have right to discontinue addition of new Members by giving a notice of 30 days to master policyholder of this effect.

Deletion of Members

- In case a member leaves the scheme during the member coverage term (due to reasons other than death), where master policyholder has paid the premium, the Company will refund the pro- rata premium to the master policyholder. The master policyholder should inform the Company of deletions for members leaving the scheme. The risk will cease from the date of leaving.
- The insurance coverage of the member paying premium for his/her coverage, if he/she leaves the scheme, will continue as per original terms and conditions of the master policy, unless such member informs the Company about discontinuance of the insurance coverage.

Sum Assured Reset

- The lumpsum Sum Assured or income benefit amount under Death Benefit for each insured member can be increased or decreased during the policy term, subject to prevailing underwriting policy. The pro-rated excess premium will be payable by or payable to the master policyholder, as the case may be.

Change of Policy Renewal date:

- The master policyholder has the option to modify the policy renewal date at any time during the policy term. Premium applicable from the modified policy renewal date will be calculated based on the latest data provided, adjusting for the Premium for the unexpired period up to the original policy renewal date on a pro-rata basis.

In case of Lender-Borrower Schemes

Where the master policy is issued under Lender-Borrower category and master policyholder is one of the following entities:

i. RBI regulated Scheduled Commercial Banks (including Co-operative Banks);
ii. NBFCs having Certificate of Registration from RBI;
iii. National Housing Bank (NHB) regulated Housing Finance Companies
iv. National Minority Development Finance Corporation (NMDFC) and its State channelizing agencies
v. Small Finance Banks regulated by RBI
vi. Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
vii. Microfinance companies registered under section 8 of the Companies Act, 2013
viii. Any other category as approved by the Authority., in accordance with IRDAI guidelines as amended from time to time,

the insured member may give Us a written authorization in the form specified by Us to make payment towards Insured member's outstanding loan balance amount to the Master policyholder from lumpsum Death Benefit and certain inbuilt optional Benefits (if any) payable on happening of respective insured events

during member coverage term under this master policy. This written authorization may be given to Us at the stage of member's addition to the master policy or at a later date. On receipt of such written authorization from the member we will pay an amount to the extent of outstanding loan to the master policyholder from the lumpsum Death Benefit and from Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit (if any of these inbuilt optional benefits are chosen by the member) on occurrence of respective insured events, while member's insurance coverage is in-force and on providing documents as mentioned in scheme rules. The remainder of the lumpsum Death Benefit, Additional ADB, Accelerated Terminal Illness Benefit,

Accelerated Critical Illness Benefit, if any shall be payable to the claimant other than the master policyholder. We shall, under no circumstance, pay any amount more than the outstanding loan to the master policyholder. In case, benefits other than those mentioned above in this para, are chosen by the member, 100% of such benefits shall be paid directly to the claimant other than the master policyholder. Where no such authorization is received by us from the insured member or the master policyholder does not fall under the above-mentioned regulated entities, we will pay the entire lumpsum death benefit and Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any, directly to the claimant other than the master policyholder.

Benefit on Foreclosure of loan

In case of lender-borrower schemes, in the event where the insured member(s) makes a prepayment for closure of the loan to the master policyholder or where the lender borrower relationship between an insured member and the master policyholder comes to an end prior to coverage end date (other than due to death of Member), the insurance coverage provided to the insured member shall continue till the occurrence of covered insured event/s or end of the coverage term, whichever is earlier, as per sum assured specified in the Certificate of Insurance, subject to the master policy being in-force. The insured member has the option to terminate his/her insurance coverage at the time of foreclosure of loan by applying for surrender and receive the unexpired risk premium value.

Free Cover Limit represents the amount of sum assured granted on life of the member without any need for individual underwriting for assessment of risk on account of various benefits offered under Digit Life Group Term Life Insurance. Sum Assured in excess of free cover limit may be accepted subject to evidence of insurability satisfactory to the Company. Such free cover limit shall be determined by the prevailing underwriting policy of the Company and subject to amendment from time to time.

Actively at Work

Subject to prevailing underwriting policy, Company may require that the members covered under the Employer-Employee Scheme are not absent from work for more than 7 days immediately prior to commencement of insurance coverage.

Suicide Exclusion (in case of base death benefit)

- In case of schemes, where the insurance coverage is compulsory, suicide exclusion will not be applicable.
- In case of other schemes, under which members are covered on a voluntary basis and where the suicide exclusion clause is applicable, if the member commits suicide, whether sane or insane, within 12 (Twelve) months of continuous coverage from the date of inception of risk cover or from date of revival or date of reinstatement, as applicable, the nominee or beneficiary shall be entitled to get at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided such member's insurance coverage is in force.

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 its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family.

All medical professionals referred to in Digit Life Group Term Life Insurance, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, specialist in respiratory medicine shall be registered Medical Practitioners.

Definitions and Exclusions - Additional Accidental Death Benefit and Additional Accidental Total & Permanent Disability Benefit (ATPD Benefit)

"Accident" is defined as "A sudden, unforeseen and involuntary event, caused by external, visible and violent means.

Accidental Death The Accident shall result in Bodily Injury or injuries to the Insured member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the death of the Insured member. Such a death is defined as "Accidental Death". The date of the Accident should be after the insurance cover start date and before the termination/ expiry of the Insured member's insurance coverage.

Injury means accidental physical bodily harm excluding illness or disease, solely and directly caused by an external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

The date of the Accident should be after the effective date of Coverage and before the termination/ expiry of the insured member's insurance coverage.

Exclusions to additional Accidental Death Benefit (ADB) and additional Accidental Total and Permanent Disability (ATPD) Benefit

No ADB benefit will be payable on death of the insured member or no ATPD benefit will be payable on occurrence of total and permanent disability to the insured member which happens directly or indirectly as a result of any of the following:

1. Infection: Death or ATPD caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, suicide / attempted suicide while sane or insane.
3. Insured member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.

4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

Critical Illness Benefit – Definitions and Exclusions

Waiting Period means a period of 90 days beginning from the date of start of insured member's coverage or from the date of its revival or date of its reinstatement . No amount shall be payable in case of occurrence of covered Critical Illness Condition within the Waiting Period. Waiting Period shall not be applicable for the Insured Member(s) whose insurance coverage is renewed with the Company before due date or Grace Period, if any, provided who have already completed their Waiting Period fully. In cases where the Waiting Period is only partially exhausted at the time of renewal, the balance Waiting Period shall be applicable on the renewed coverage.

Waiting period shall not be applicable in case critical illness condition manifests due to an accident.
Survival Period means the period of 30 days from the date of the first diagnosis of covered Critical Illness Condition that the insured Member has to survive to be eligible for receiving Critical Illness Sum Assured (if opted) under the Master policy.

Critical Illness (CI) Condition means the first diagnosis of any of the covered Critical Illnesses or undergoing any surgery explained and defined below:

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 –

- 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.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

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

   II. The following are excluded:
      - Other acute Coronary Syndromes

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

3. **OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES**

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

II. Catheter based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded.

4. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION**

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

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

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

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

5. **OPEN CHEST CABG**

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

II. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

6. **END STAGE LUNG FAILURE**

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

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
- Dyspnoea at rest.

7. **END STAGE LIVER FAILURE**

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

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

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

8. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS**

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

9. **MAJOR ORGAN /BONE MARROW TRANSPLANT**

I. The actual undergoing of a transplant of:

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

- Other stem-cell transplants
- Where only Islets of Langerhans are transplanted

10. **BENIGN BRAIN TUMOR**

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the

skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

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

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

11. COMA OF SPECIFIED SEVERITY

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

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

12. MAJOR HEAD TRAUMA

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

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

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

IV. The following are excluded:
- Spinal cord injury;

13. PERMANENT PARALYSIS OF LIMBS

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

14. STROKE RESULTING IN PERMANENT SYMPTOMS

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

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

15. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological

impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

16. **MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS**

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE are excluded.

Specific Definitions:

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**

I. 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.
- 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.
- Congenital conditions are excluded

19. **CARDIOMYOPATHY**

I. 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.

II. 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:**

I. 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**

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

II. The diagnosis must be supported by all of the following conditions:
- the disease cannot be controlled with medication;
- signs of progressive impairment; and
- 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.

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

23. **MUSCULAR DYSTROPHY**

I. 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:
- Family history of muscular dystrophy;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;

- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

II. 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. Activities of daily living means:

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

24. **PROGRESSIVE SUPRANUCLEAR PALSY:**

I. 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)**

I. 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.

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

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

26. **BACTERIAL MENINGITIS**

I. 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.

II. This diagnosis must be confirmed by:

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

27. **ALZHEIMER'S DISEASE**

I. 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.

II. 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.

III. The following conditions are however not covered:

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

28. **ENCEPHALITIS**

I. 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)

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

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**

I. 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:

II. The WHO lupus classification is as follows:

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

31. **GOODPASTURE`S SYNDROME**

I. 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**

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

II. This diagnosis must be supported by all of the following:

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

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

33. **PNEUMONECTOMY**

I. 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.

II. 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:

- Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

II. 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.

Critical Illness – General Exclusions

The Critical illness condition should have been diagnosed for the first time in life.

Claim for Critical Illness Benefit will be accepted subject to Survival Period of 30 days and Waiting Period of 90 days. Waiting period shall not be applicable if critical illness condition manifests due to an accident.

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit will be payable if any of the above listed Critical Illness Conditions occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily, due to one of the following:

1. Congenital Condition: Any external congenital condition or related illness is not covered. In case any Internal congenital condition or related illness is known and was/is being treated, is disclosed at proposal stage and accepted, claims will be processed as per Policy terms and conditions.
2. Any covered condition or its signs or symptoms having occurred within the Waiting Period.
3. Drug Abuse: Insured member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
4. Pre-existing Disease: means any condition, ailment, Injury or disease:
   - that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
   - for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival or its Reinstatement.
5. Self-inflicted Injury: Intentional self-inflicted injury by the Insured member.
6. Suicide: If the Critical Illness was contracted due to attempted suicide.
7. Criminal Acts: Insured member involvement in criminal activities with criminal intent.
8. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / violent acts.
9. Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
10. Biological, chemical or radioactive contamination.
11. Aviation: Participation by the Insured member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
12. Hazardous sports and pastimes: Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
13. Any treatment of the donor for the replacement of an organ.
14. Unreasonable failure to seek or follow medical advice or treatment by a medical practitioner leading to occurrence of the insured event or member delaying medical treatment in order to circumvent the waiting period or other conditions and restrictions applying to this policy.

Nomination Provisions: The nomination shall be subject to Section 39 of the Insurance Act, 1938, as amended from time to time.

Assignment Provisions: Assignment shall be as per the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time.

Section 41: Prohibition of Rebate: Under the provisions of Section 41 of the Insurance Act, 1938 as amended from time to time

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:
2. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

Section 45 of the Insurance Act, 1938 as amended from time to time

Fraud, misstatement and forfeiture would be dealt with in accordance with provisions of Sec 45 of the Insurance Act 1938 as amended from time to time. For provisions of this Section, please contact the Insurance Company or refer to the policy contract of this product.

Beware of Spurious/Fraud Phone Calls: IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.

Annexure I – Wellness Benefit Program

Below listed benefits will be made available under Wellness Benefit Program

1. Doctor on Call

Upon Insured member's request, we will facilitate an appointment, through our empanelled Service Provider, with a Medical Practitioner who can help Insured member by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service or a video call service.

2. Wellness Coach

In order to educate, empower and engage Insured member to become more aware of his/her health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide him/her information on wellness coaching including but not limited to the areas as provided below:

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

3. Lab Services and Imaging (For Diagnostic Services)

Upon Insured member's request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc or imaging for further testing and analysis. The cost of these tests and reports will have to be borne by the Insured member.

4. Pharmacy (Home Delivery)

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner and nutritional supplement from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy. The cost of the medication will have to be borne by the Insured member.

5. Vital/Physical Activity Monitoring Services

Upon member's request, We will facilitate, through Our Empanelled Service Provider, the integration of his/her Health Device(s), or Digital Wearables or trackers such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, heart rate monitors, pulse oximeters, non-invasive wearable blood-sugar sensors, Smart Watches etc. to an online database that will track and asses his/her vitals as reported by the device. It can provide periodic updates and reports of Insured member's health status. The cost of the device will have to be borne by the Insured member.

6. Reminder Notifications

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

7. Medical Wallet

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

8. Report Aggregation

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of his/her health status as per the medical records/reports/information or data shared by him/her. It will highlight his/her wellbeing or any areas of concern or deterioration in his/her health, allowing him/her to take necessary calls about his/her health.

9. Home Care Services

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for him/her in case he/she are in need of services , including but not limited to the following:

a) Home Care Nursing
b) Patient Assistant
c) Physiotherapy
d) Yoga Trainer

e) Psychologist
f) Palliative Care
g) Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.
h) Doctor Visit
i) Elderly care and senior living assistance related to their health condition

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

10. Ambulance Arrangement Services

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, ambulance services for his/her transportation subject to availability of ambulance in the area where such service needs to be arranged. The cost of the transportation will have to be borne by the insured member.

11. Pick up and drop services for consultation

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

12. Prioritizing Appointments

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, prioritization of his/her appointment, based on the urgency, with the Network Providers offering the necessary consultation/treatment/diagnostics/packages/memberships/risk assessment/procedures subject to availability of the service(s).The cost of the Consultancy/Diagnostic will have to be borne by the Insured member. These may include the following but not limited to :-

- Doctors' services
- Nursing services
- Dietitian services

13. Mental wellbeing

Upon Insured member's request, We will facilitate, through Our empanelled Service Provider, self- assessments, therapy sessions, activities and educational/awareness blogs, videos and webinars. The cost of these sessions will have to be borne by the Insured member.

14. Physiotherapy

Upon Insured member's request, We will facilitate, through Our empanelled Service Provider, consultation and treatment sessions/packages, pain management sessions, ergonomics sessions. The cost of these services will have to be borne by the Insured member.

15. Childcare/Children's activities

Upon Insured member's request, We will facilitate, through Our empanelled Service Provider, recreational/developmental activities for children of different age groups. The cost of these services will have to be borne by the Insured member.

16. Out-Patient (OPD) Services

Upon Insured member's request, We will facilitate, through Our empanelled Service Provider, outpatient care services like doctor consultation, pharmacy and diagnostics, both online and onsite. The cost of these services will have to be borne by the Insured member.

17. Fitness

Upon Insured member's request, we will facilitate, through our empanelled service provider, access to membership or classes of fitness activities like but not limited to sports, yoga, Zumba, Pilates, dance, fitness coach services at gymnasiums, health studios, fitness centres, sports centres and playgrounds. The cost of these services will have to be borne by the Insured member.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by the Insured member shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. Insured member needs to pay directly to the Service Provider/Medical Experts/Centres for the services availed.
3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured member may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured member.

4. We or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured member may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured member's visit or consultation to an Independent Medical Practitioner. The Insured member is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

Go Digit General Insurance Limited, IRDAI Reg No. 158, Corporate Identification Number L66010PN2016PLC167410, Reg. Office Address Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office Address- Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

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