CUSTOMER INFORMATION SHEET/KNOW YOUR POLICY

This document provides key information about your policy. You are also advised to go through your policy document.

Please Note: *This Customer Information Sheet provides information available under this Product. Kindly refer to the Policy Schedule to know exact details of coverage opted by You.*

SI No	Title	Description	Policy Clause Number
1	Name of Insurance Product/ Policy	**Digit Health Care Plus Policy** **(UIN: GODHLIP25037V042425)**	
2	Policy number	Please refer Your Policy Schedule	
3	Type of Insurance Product/ Policy	**Both Indemnity and Benefit Basis** **On Indemnity Basis:** **Section 1. Hospitalization Cover** **A. Accidental & Illness Hospitalization Cover** A1. Day Care Procedures A2. Pre-Hospitalization Expenses A3. Post-Hospitalization Expenses A4. Dental Treatment A5. Road Ambulance A6. Bariatric Surgery Cover A7. Psychiatric Illness Cover A8. Complimentary Health Check Up A9. Ayush Cover A10. Daily Cash For Choosing Shared Accommodation **B. Accidental Hospitalization Cover** B1. Day Care Procedures B2. Pre-Hospitalization Expenses B3. Post-Hospitalization Expenses B4. Dental Treatment B5. Road Ambulance **Section 3. Organ Donor** **Section 4. Emergency Air Ambulance** **Section 5. Home (Domiciliary) Hospitalization** **Section 6. Maternity & Newborn Baby Cover** **Section 7. Infertility Treatment Cover** **Section 9. Second Medical Opinion** **Section 10. Consumable Cover** **Section 12. Sum Insured Refill Benefit** **Section 18. Critical Illness Hospitalization Cover** **Section 20. Cancer Hospitalization Cover** **Section 23. Advance Heart Ambulance** **Section 24. Advance Care** **Section 25. Si Multiplier** **Section 26. Support Plus**	**I. Coverage**

		Section 27. Fast Track **Section 29. Smart Save** **Section 30. Wellness Benefit Program** **<u>On Benefit Basis</u>** **Section 1.B6. Daily Cash For Choosing Shared Accommodation** **Section 2. Post-Hospitalization Lumpsum Benefit** **Section 8. Out-Patient (Opd) Benefit** **Section 13. Daily Hospital Cash Cover** **Section 14. Daily Cash For Accompanying An Insured Child** **Section 15. Long Hospitalisation Cash Benefit** **Section 16. Loss Of Income Cover** **Section 17. Critical Illness Benefit Cover** **Section 19. Cancer Benefit Cover** **Section 21. Woman Cancer Benefit** **Section 22. Health Check-Up From Day 1** **<u>Renewal Benefit:</u>** **Section 11. Unused Sum Insured Benefit** **Section 28. Cumulative Bonus Protection Cover**	
4	Sum Insured (Basis) (Along with amount)	This product can be on “Individual Sum Insured” as well as on “Floater Sum Insured” basis. Please refer Your Policy Schedule to know the Sum Insured basis applicable to Your Policy. • **Individual Sum Insured**-Where each member has a separate sum insured under the policy), • **Floater Sum Insured**-Where all members under the policy have a single sum insured limit which may be utilised by any or all members. Sum Insured Amount available under Your policy will be as per amount mentioned in Your Policy Schedule.	NA
5	Policy Coverage (What am I covered for?) (Policy Clause Number/s)	**Please find the below detailed of all coverages available under the Product.** **Coverages available under Your Policy will be as mentioned in Your policy schedule.** **There are 30 Sections under this product. Detailed Coverages are listed below.** **<u>SECTION 1. HOSPITALIZATION COVER</u>** **A. 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 against this Section.	C.I. Section

			Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: 1.If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.*** 2.If You have opted for a specific '**Room type'** in your policy and the Room chosen at the time of hospitalization belongs to a higher room category then our liability will be restricted to the same proportion as the expenses of the admissible room type opted by you except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule		
			ICU	Intensive Care Unit		
			Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.		
			Medication	Drugs, medicines 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 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.

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 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.A. Accidental & Illness 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 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.A. Accidental & Illness Hospitalization Cover** of this Policy.

A4. 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. A. Accidental & Illness 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, provided that:

a) We have accepted a claim under **Section 1. A. Accidental & Illness Hospitalization Cover.**

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

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

A6. 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 against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.

e) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. *Example: Endocrine disorder*.
f) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
g) A prior approval should be taken from us before the Bariatric Surgery is performed.
h) Our maximum liability under this benefit is restricted to the Limit as opted by You and mentioned in Your Policy Schedule against this Cover.

Bariatric surgery for the following reasons is not covered:

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

A7. Psychiatric illness Cover

We will pay upto the Sum Insured as mentioned in your policy schedule for the Medical Expenses, related to Psychiatric Illness, provided that:

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

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

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

A8. <u>Complimentary Health Check Up</u>

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

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

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

A9. AYUSH COVER

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

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

a) 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).

A10. DAILY CASH FOR CHOOSING SHARED ACCOMMODATION

If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule.

Please note:

a. Your claim must be admissible under Section 1 Hospitalization Cover

b. Your hospitalization must exceed 48 hours unless specifically agreed by Us

c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days

d. Daily cash will be provided only for the days You were hospitalized in shared accommodation.

e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU.

f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule

B. 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 against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room base on the room type opted by you or subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: 1. If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.*** 2. If You have opted for a specific '**Room type'** in your policy and the Room chosen at the time of hospitalization belongs to a higher room category then our liability will be restricted to the same proportion as the expenses of the admissible room type opted by you except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule.
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, prescribed by a specialist or medical practitioner. This also includes

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

B1. Day Care Procedures

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.

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 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.B. Accidental 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 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. B. Accidental Hospitalization Cover** of this Policy.

B4. 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. B. Accidental 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 arising out of an Accident, provided that:

a) We have accepted a claim under **Section 1. B. Accidental Hospitalization Cover.**

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

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

B6. DAILY CASH FOR CHOOSING SHARED ACCOMMODATION

If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule.

Please note:

a. Your claim must be admissible under Section 1 Hospitalization Cover.

b. Your hospitalization must exceed 48 hours unless specifically agreed by Us.

c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days

d. Daily cash will be provided only for the days You were hospitalized in shared accommodation.

e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU.

f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule

SECTION 2. POST HOSPITALIZATION LUMPSUM BENEFIT

If You have opted for this Cover and You got discharged from the Hospital, then you will be eligible for onetime lumpsum which shall be a percentage of the claim amount approved under Section 1A. Accidental & Illness Hospitalisation Cover and/ or Section 1B Accidental Hospitalisation Cover towards post hospitalisation expenses after Your discharge from the Hospital. This percentage will be mentioned in Your Policy Schedule.

If the insured opts for this cover, then he/she will have an option to choose between reimbursement of post hospitalization related expenses available under Section 1.A.3- Post-Hospitalization Expenses/1. B.3- Post-Hospitalization Expenses or opt for a lump sum amount as provided under this section towards post hospitalization expenses. At the time of claim, if You choose Post Hospitalisation lumpsum benefit as provided

C.I. Section 2

		under this section, then You will not be able to reimburse the post hospitalization expenses as provided under Section 1. 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. A. Accidental & Illness Hospitalization Cover.** b) There are strict guidelines when it comes to organ transplantation, therefore the organ donor whose organ has been made available should be in accordance and in compliance with the Transplantation of Human Organs Act 1994 (as amended) and the organ is donated for Your use only. c) We will pay the donor's Pre and Post Hospitalization expenses. This is up to 5% of the claim amount approved in respect of harvesting expenses. d) We will not pay any other medical treatment for the donor consequent on the harvesting. e) This also has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with ORGAN DONOR Cover as a benefit since inception of the first policy. Provided that, We have accepted a claim under **Section 1. A. Accidental & Illness Hospitalization Cover.** This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 4. 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 against **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental 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 & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**	C.I. Section 3

		This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 5. 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, any kind of rehabilitation or therapy or counselling related to Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin. e) Subject to availability of the sum insured under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**	C.I. Section 4
		This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 6. MATERNITY BENEFIT & NEW BORN 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 against this Section, during the Policy Period provided that: a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply***). This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.	C.I. Section 5

		b) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies. c) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule applied to the increased part of the Sum Insured. d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit. If we had already accepted a claim for Maternity Expenses for your first living child under this benefit, then for the subsequent Maternity Expenses i.e. for the delivery of Your Second child, we shall pay up to the percentage of the Sum Insured opted under this Section and mentioned in Your Policy Schedule provided the Policy is renewed with Us continuously without break with Maternity Benefit & New Born Baby Cover benefit. We will pay for the hospitalization expenses during the Pre-natal and Post-natal period if you have specifically opted for covering Pre and Post natal expenses up to 100% of Section 6. Sum Insured subject to the availability of sum insured under this section. Subject to if you have specifically opt for this coverage of Pre -natal and Post – natal in your Policy Schedule. 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. **<u>B. New Born Baby Benefit</u>** Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 6. A Maternity Benefit Section** of the Policy, provided that We have accepted a claim under **Section 6. A. Maternity Benefit**, incurred towards: a) The medical treatment of the Insured Person's New Born Baby while the Insured Person is hospitalised as an inpatient for delivery. b) The New Born Baby's hospitalisation charges as a result of any medical complications, up to 90 Days from the date of delivery. c) Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India, up to 90 Days from the date	C.I. Section 6

		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. **SECTION 7. 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 as opted by you and mentioned in your Policy Schedule will apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with this cover, without a break, with 'Infertility Treatment Cover' as a benefit since inception of the first policy. b) Our maximum liability per Hospitalization shall be restricted to the amount as mentioned in Your Policy Schedule against this Section. c) The benefit is payable only once to an Insured Person during the Policy 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 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:	C.I. Section 7

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.		

C.I. Section 8

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.

SECTION 9. SECOND MEDICAL OPINION

If you opted for this cover, 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 or illness 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. This cover will be subject to availability of Sum Insured mentioned in Your Policy Schedule against **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** 3. You have the option to choose any One of Our Panel Medical Practitioners. 4. We will not provide more than one Opinion for the same Medical Condition within a Policy Period. 5. We have accepted a claim under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.** This Covers are Subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 10. CONSUMABLE COVER** If you have opted for this cover and if Your claim is approved under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover**, we will compensate for non-medical expenses incurred by You (You can check them under Annexure A below) during the Policy period directly related to Your medical or surgical treatment of illness/disease/injury. The compensation will be maximum upto a Sum Insured as mentioned in Policy Schedule against **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover**. Please note: i. Coverage will be limited to the actual expenses incurred during the Hospitalisation but not paid under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** as Non-Medical expenses. In the General Exclusions section, ‘Non-medical Expenses’ as exclusion no. 25 will not be applicable if you have opted for this section. **SECTION 11. UNUSED SUM INSURED BENEFIT** If you have opted for this cover, then at the time of renewal of the policy, sum insured under the renewed policy will be increased based on the unused base sum insured of the expiring policy, subject to the following: i. Maximum 100% of the unused Base Sum Insured will be carried forward at the time of renewal. ii. Maximum carried forward of unused Base Sum Insured, year on year, will be limited to 100% of Base Sum Insured of the expiring policy. iii. No cumulative bonus benefit will be provided under the product, if this cover is opted. iv. Applicable under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**	C.I. Section 9

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

C.I. Section 10

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

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

C.I. Section 11

SECTION 12. 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 & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** for that particular Policy Period, provided that:

a) The backup Sum Insured would be utilized if the cause of the Hospitalization is related or not related (as opted by you) to or arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy year for the same Insured Person .
b) In case of related Hospitalization cooling off period of 45 days will be applicable.
c) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
d) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**
e) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule against this Section during each Policy Period.
f) 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 13. DAILY HOSPITAL CASH COVER

A) Accidental & Illness Hospitalization Cover

C.I. Section 12

		If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this will be mentioned in your Policy Schedule against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident or illness for a maximum number of days as mentioned in Your Policy Schedule against this Section. If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule against this Section. Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule against this Section. B) **<u>Accidental Hospitalization Cover</u>** If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident for a maximum number of days as mentioned in Your Policy Schedule against this Section. If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule against this Section. Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule against this Section. **<u>SECTION 14. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD</u>** If You opted for this cover, and if the Insured Person hospitalized is a child aged 14 years or less, then we will pay you a Daily Cash for an accompanying adult for every completion of 24 hours at the hospital. The daily cash amount is mentioned in your Policy Schedule. Please note: a. The claim must be admissible under Section 1 Hospitalization Cover b. Hospitalization must exceed 48 hours unless specifically agreed otherwise by us c. For each policy period, there is a maximum number of days this can be paid, please check your policy schedule for the exact days d. Daily cash will be provided only if an adult aged 18 years or more is accompanying the Insured Child during the said hospitalization e. We have accepted a claim under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**	C.I. Section 13

		SECTION 15. LONG HOSPITALIZATION CASH BENEFIT If You have opted for this cover, and You are Hospitalized for a minimum number of consecutive days as Opted by You and mentioned in the Policy Schedule against this Section, We will give you a lump sum amount as mentioned in the Policy Schedule. Provided that: a) We have accepted a claim under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental 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.	C.I. Section 14
		SECTION 16. LOSS OF INCOME COVER If you have opted for this cover and are continuously hospitalized for certain number of days, mentioned in your policy schedule, you will receive a pre-set amount for every block of specified number of days, again mentioned in your policy schedule. Please note: a. Your claim should be admissible under **Section 1- Hospitalization Cover** b. For each policy period, there is a maximum number of times this can be paid as mentioned in your policy schedule.	C.I. Section 15
		SECTION 17. CRITICAL ILLNESS BENEFIT COVER If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule against this Section, in case You are diagnosed as suffering from 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.	C.I. Section 16

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:

C.I. Section 17

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

This section needs Your special attention!

✕: If You are not able to survive for a minimum period of 30 days from the date of diagnosis of Critical Illness then unfortunately You won't receive any benefit under this section.

😊: Once You claim for a critical illness, We want You to fully focus on Your recovery and receiving the best care possible. That's why, instead of the Sum-insured amount, We give You a lump sum amount which can be utilized for Your treatment.

SECTION 18. 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 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 base on the room type opted by you or subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: 1. If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.*** 2. If You have opted for a specific '**Room type'** in your policy and the Room chosen at the time of hospitalization belongs to a higher room category then our liability will	C.I. Section 18

	be restricted to the same proportion as the expenses of the admissible room type opted by you except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

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

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

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

Critical Illness Definitions Applicable to Section 17 & Section 18 Above:

I. Standard Definitions:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

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

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

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

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

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

   vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

		i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) ii. New characteristic electrocardiogram changes iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. II. The following are excluded: i. Other acute Coronary Syndromes ii. Any type of angina pectoris iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure. **3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES** I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded. **4. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION** I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment. II. The NYHA Classification of Cardiac Impairment are as follows: i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms. ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest. III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded. **5. OPEN CHEST CABG** I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The	

diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

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

6. END STAGE LUNG FAILURE

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

7. END STAGE LIVER FAILURE

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

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

8. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   e. Other stem-cell transplants
   f. Where only Islets of Langerhans are transplanted

10. BENIGN BRAIN TUMOR

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

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

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

11. COMA OF SPECIFIED SEVERITY

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

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

12. MAJOR HEAD TRAUMA

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

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

III. The Activities of Daily Living are:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an

upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

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

13. PERMANENT PARALYSIS OF LIMBS

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

14. STROKE RESULTING IN PERMANENT SYMPTOMS

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

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

15. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
i. investigations including typical MRI findings which unequivocally confirm the diagnosis to
ii. be multiple sclerosis and
iii. there must be current clinical impairment of motor or sensory function, which must

iv. have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

II. Specific Definitions:

17. SURGERY TO AORTA

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

18. APALLIC SYNDROME

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

19. LOSS OF INDEPENDENT EXISTENCE

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

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

20. APLASTIC ANAEMIA

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

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

		The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present: - Absolute Neutrophil count of 500 per cubic millimetre or less; - Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and - Platelet count of 20,000 per cubic millimetre or less. Subject to terms, conditions, limitations and exclusions mentioned in the Policy. **SECTION 19. CANCER BENEFIT COVER** If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule against this Section, in case You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life. Provided that, a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us. b) You survive for a minimum period of at least 30 days from the date of diagnosis of such Cancer for Specified Severity, unless this condition is specifically waived by Us c) No Claim under this option shall be admissible if the Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted. d) Cover under this Section shall cease upon payment of the compensation on the happening of a Cancer for Specified Severity and no further payment will be made for any consequent disease or any dependent disease. **For this Cover, “CANCER OF SPECIFIED SEVERITY” means:** I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. II. The following are excluded – i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3. ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond; iii. Malignant melanoma that has not caused invasion	C.I. Section 19

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 20. 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 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 base on the room type opted by you or subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover. Note: 1.If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room

C.I. Section 20

	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.* 2.If You have opted for a specific '**Room type'** in your policy and the Room chosen at the time of hospitalization belongs to a higher room category then our liability will be restricted to the same proportion as the expenses of the admissible room type opted by you except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

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, 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 21. WOMAN CANCER BENEFIT** In case You are a woman and have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule against this Section, in case You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life. Provided that, a) Under this cover only to cancers specific to women, then coverage under this section will be limited only to the diagnosis of Cancers as mentioned in Your Policy Schedule/Certificate of Insurance b) 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. c) 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 d) 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. e) 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	C.I. Section 21

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 22. HEALTH CHECKUP COVER FROM DAY ONE

If You have opted for this cover, we will pay for the expenses incurred towards cost of health check-up which will be available from Day 1 of the Policy, subject to details mentioned in the Policy Schedule, subject to following conditions:

a. This cover should be opted at the time of inception of the policy, unless specifically waived by Us.
b. List of medical tests available under various options is mentioned in Annexure 1 of this document. List of medical tests covered will be as per option opted by You and mentioned in the Policy Schedule
c. The benefit provided under this cover will be applied only once during each Policy Year and any unutilized benefit will not be carried forward to subsequent Policy Year.
d. These services should be provided subject to the availability of lab / diagnostic centre at the time of appointment.
e. In case of Family Floater policy, Health Check-up will be subject to details mentioned in the Policy Schedule.
f. On opting this section, point no. 4 "Investigation and Evaluation Code- Excl04" as mentioned under "D – Exclusions" of policy shall be deleted to the extent of coverage provided under this section.

Please note:

- The health check-up needs to be booked through Digit App only, unless specifically waived by Us.
- This benefit will be available through our network service provider and on cashless basis, unless specifically waived by Us.

SECTION 23. ADVANCE HEART AMBULANCE

If You have opted for this cover, We will pay for the expenses incurred on Your road transportation by an Advanced heart Ambulance to a hospital following an emergency arising out of Your cardiac arrest, provided that:

a. We have accepted a claim under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**
b. The benefit provided under this cover will be over and above the Road Ambulance Cover provided under the policy. The maximum liability under this cover per Policy Year is restricted to the amount as mentioned in Your Policy Schedule against this cover.
c. For this cover, Advanced Heart Ambulance shall mean special ambulances equipped with specialized equipment for patients with cardiac issues, such as defibrillators, cardiac monitors, and ventilators. These ambulances are staffed with specialized medical professionals who can provide immediate care to patients with cardiac emergencies.

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

C.I. Section 22

SECTION 24. ADVANCE CARE

If You have opted for this cover, our maximum liability in respect of the following procedures or new age treatments will be up to 100% of the sum insured as opted under Section 1.A. Accidental & Illness Hospitalization Cover and/or Section 1.B. Accidental Hospitalization Cover of the policy:

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

On opting this section, Point no 37 as mentioned under "D- Exclusions" of this policy (***which restricts maximum liability in respect of new age treatments and procedures upto 50% of Sum Insured***) shall be deleted.

C.I. Section 23

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

SECTION 25. SI MULTIPLIER

If You have opted for this cover, We will provide enhanced Sum Insured under the Policy which will be equivalent to base Sum Insured provided under the policy multiplied by opted number of times (SI multiplier). This enhanced Sum Insured will be available from day 1 of the policy for admissible claims during the Policy Year under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** of this Policy, subject to following conditions:

i. The benefit provided under this cover will be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to subsequent Policy Year.
ii. The enhanced Sum Insured can be utilized for multiple claims within the Policy Year, unless specifically restricted and mention in Policy schedule.
iii. The enhanced Sum Insured can only be used for hospitalization in India only, unless specifically agreed by Us.
iv. In case of family floater policy, the enhanced Sum Insured will be available on floater basis for all Insured Persons covered under the Policy.
v. SI multiplier will be applicable to the base Sum Insured of the Policy and will not be applicable on cumulative bonus available under the Policy. It will not be applicable on Cumulative bonus booster or Sum insured multiplier or refill benefit.

C.I. Section 24

For Example:

- *Mr. A has taken Digit Health Care Plus Policy with base Sum Insured as INR 5 lakh.*
- *SI multiplier opted by him is 2 times of the base Sum Insured.*
- *In this case, available coverage Sum Insured under the policy from day 1 will be equivalent to INR 10 lakhs (2 times of the base Sum Insured ie. INR 5 lakh).*

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

SECTION 26. SUPPORT PLUS

If You have opted for this cover, We will reimburse the expenses incurred for food and lodging by Your accompanying adult, for each day You are hospitalized in Intensive Care Unit (ICU) at the hospital during the Policy Period, provided that:

a) We have accepted a claim under Section 1. Hospitalization Cover.
b) The hospital in which You are hospitalized is minimum 15 km away from Your residence.
c) Benefit under this cover will be available only for the particular days You are hospitalized in ICU.
d) Per day maximum amount payable, maximum number of days this cover will be available and total amount payable under this cover during the Policy Year will be as mentioned in the Policy Schedule.

C.I. Section 25

		e) Claim under this cover will be provided subject to submission of valid bills or proof of expenses incurred by Your accompanying adult (aged 18 years or more). This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 27. FASTRACK** If You opted for this cover, We will indemnify medical expenses incurred for hospitalization of the Insured Person(s) admissible under the **Section 1.A. Accidental & Illness Hospitalization Cover** for the below listed diseases/illnesses/conditions after expiry of 30 days from the first Policy Start date, provided that: i. the diseases/illnesses/conditions has been declared by the Insured Person and accepted by Us, or ii. the diseases/illnesses/conditions has been detected during Pre-policy medical examination and have been accepted by Us. **iii.** Exclusions Pre-Existing Diseases (Code- Excl01) shall not apply to the extent coverage is provided in this section, if this section has been opted by the You. **List of diseases/illnesses/conditions covered under this section** 1. Asthma 2. Chronic Obsutructive Pulmonary Disease (COPD) 3. Diabetes 4. Hypertension 5. Hyperlipidaemia 6. Obesity 7. Bilateral Cataract 8. Bilateral Knee Replacement 9. Bilateral Hip Replacement 10. Thyroid **Specific Definitions to Section 27:** 1. **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath. 2. **Chronic obstructive pulmonary disease (COPD)** is an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs. This limited airflow is known as obstruction. 3. **Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences. 4. **Hypertension** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.	C.I. Section 26

		5. **Hyperlipidaemia** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease. 6. **Obesity** where Obesity means abnormal or excessive fat accumulation that presents risk to the health (Body Mass Index i.e. BMI is less than or equal to 39.99. This BMI limit will be modified in case of co-morbidities.) 7. **Bilateral cataract** refers to Partial or complete opacity of the crystalline lens of both eyes that decreases visual acuity and eventually results in blindness. 8. **Bilateral Knee Replacement** means both knees have this procedure simultaneously or when both knees are replaced during the same surgical procedure. 9. **Bilateral Hip Replacement** refers to when both hip joints are replaced with artificial joints during a single surgery. The procedure is used for people with pain or loss of function in both hips caused by arthritis, childhood hip disorders, or other bone diseases that affect the hips. 10. **Thyroid** disease refers to a range of medical conditions that affect the thyroid gland, which is responsible for producing hormones that regulate metabolism, energy levels and overall bodily functions. Common types of thyroid includes: Hypothyroidism, Hyperthyroidism, Goiter, thyroiditis etc. This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy. **SECTION 28. Cumulative Bonus Protection Cover** If you have opted for this cover and you make any claim in the expiring policy*, your cumulative bonus will never reduce. The following two scenarios are possible: • It will remain same on renewal in case total claim amount is more than the cumulative bonus protection cover amount chosen by you or • It will increase on renewal (like how it is when there is no claim made) in case the total claim amount is less than the cumulative bonus protection cover amount chosen by you *Claim made under the **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** and/or **Section 18. Critical Illness Hospitalization Cover** and/or **Section 20. Cancer Hospitalization Cover** Please note, there is an upper limit to the Cumulative Bonus you can earn, it will be mentioned in your Policy Schedule. Also, Point no 2 and 3 as provided under "Cumulative Bonus" stands deleted in case you have opted this cover. This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.	C.I. Section 27

SECTION 29– SMART SAVE

If you have opted for this cover, then it is hereby agreed and declared that Sum Insured capping will be applied on specific aliment listed below, which will be as mentioned in your policy schedule.

S.no.	Ailments
1.	Eye Diseases / Cataract
2.	Knee Replacement - per knee
3.	Angiography
4.	Angioplasty
5.	All types of Hernia
6.	CABG
7.	Hysterectomy
8.	Kidney / Bladder Stone
9.	Oral Chemotherapy
10.	Hip Replacement

Special conditions of Section 29. Smart Save

If you opt for this section, Sum Insured capping will be applied on the respective ailments and instead you will be eligible for discount in premium.

C.I. Section 28

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

SECTION 30. WELLNESS BENEFIT PROGRAM

If You have opted for this section, You will be entitled for the below listed benefits available under Our Wellness Benefit Program as mentioned in the Policy Schedule. Through this Program, We intend to incentivize to 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 17 services under Wellness Benefit Program. Services applicable for Your Policy are as shown in Your Policy Schedule. Only services mentioned in your Policy Schedule are available for You.

1. Doctor on Call

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

C.I. Section 29

2. Wellness Coach

In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide You 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 Your 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 You. **4. Pharmacy (Home Delivery)** Upon Your request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner 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 You. **5. Vital/Physical Activity Monitoring Services** Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s), orDigital 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 Your vitals as reported by the device. It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You. **6. Reminder Notifications** Upon Your request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You. **7. Medical Wallet** Upon Your request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You. **8. Report Aggregation** Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical	C.I. Section 30

records/reports/information or data shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.

9. Home Care Services

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

10. Ambulance Arrangement Services

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

11. Pick-up and Drop Services for Consultation

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

12. Prioritizing Appointments

Upon Your request, We will facilitate, through Our Empanelled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary 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 You. These may include the following but not limited to :-

- Doctors' services
- Nursing services
- Dietitian services

13. Mental wellbeing - Upon Your 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 You.

14. **Physiotherapy -** Upon Your 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 You.

15. **Childcare/Children's activities** - Upon Your 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 You.

16. **Out-Patient (OPD) Services** - Upon Your 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 You.

17. **Fitness** – Upon your 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 You.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by You shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. You need 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 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.

NO CLAIM BONUS BENEFIT

"No Claim Bonus benefit" means any benefit received by the Policyholder either through Cumulative bonus (in the form of Increase in Sum Insured at renewal) or through No Claim Discount (in the form of Discount on renewal premium), as opted, if there is no claim in the expiring policy. Please note that You can choose **either of** 'Cumulative bonus' or 'No Claim Discount'.

A. Cumulative Bonus

If You've been safe and healthy and have had No Claims made under the **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** and/or **Section 18. Critical Illness Hospitalization Cover** and/or **Section 20. Cancer Hospitalization Cover** in the expiring Policy Period, You would be eligible for Cumulative Bonus at the time of renewal as mentioned in Your Policy Schedule, provided that:

1. There is an upper limit to the Cumulative Bonus You can earn. In any Policy period, the accrued Cumulative Bonus (including any carried forward Cumulative Bonuses from the previous policy) shall not exceed the limit mentioned in Your Policy Schedule.
2. For a Floater Policy, the Cumulative Bonus shall be available only on Floater Basis. It shall accrue only if no claim has been made for any of the Insured Members during the expiring Policy Period.
3. In the event of a claim in the expiring policy period, the Cumulative Bonus will reduce in the same way as it was accrued in the policy at the time of renewal.
4. If You discontinue the Policy or fail to renew the Policy within the Grace Period of 30 days from the due date of renewal, the entire Cumulative Bonus will be lost.
5. The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with Us.
6. The Cumulative Bonus will be Calculated on the Sum Insured as opted by You under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** and/or **Section 18. Critical Illness Hospitalization Cover** and/or **Section 20. Cancer Hospitalization Cover**.

B. No Claim Discount

If You had no claim in the expiring policy, then You will be eligible to receive a discount in the premium, at the time of renewal of Your policy.

Provided that:

i. No Claim Discount will be provided if no claim is made under the sections **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover** and/or **Section 18. Critical Illness Hospitalization Cover** and/or **Section 20. Cancer Hospitalization Cover**. This discount will be

provided only to the extent of premium applicable for the sections where Sum Insured is increased by Cumulative Bonus under the Policy.

For e.g., If You have opted for "Cumulative Bonus" (in the form of Increase in Sum Insured at renewal for Hospitalization Section) and no claim is made under Section 1. Hospitalization Cover of the health product in expiring policy, then You will be entitled to Increase in Sum Insured of Hospitalization Section only.

Similarly, if You have opted for "No Claim Discount" (in the form of Discount on renewal premium for Hospitalization Section) and no claim is made under Hospitalization Section of the base health product in expiring policy, then You will be entitled to discount on applicable premium of Hospitalization Section.

ii. No Claim discount will accrue for each claim free policy period, subject to a maximum limit on No Claim Bonus Benefit. In the event of a claim in the expiring policy, No Claim Discount will reduce in the same way as it was accrued in the policy at the time of renewal.

For example:

a. No Claim Bonus Benefit is provided only on Section 1. Hospitalisation Section of the Policy
b. Sum Insured for Hospitalisation Cover = INR 10,00,000
c. Premium for Hospitalisation Section = INR 10,000
d. Maximum Limit on No Claim Bonus Benefit = 5 times (Maximum Discount 5%)
e. No Claim Discount per claim free Policy Period = 1% on Hospitalisation Section Premium

Policy Year	Claim in Hospitalisation Section in Previous Policy	Incremental Discount on Premium	Accrued Discount for the policy period	Discount on Hospitalisation Section Premium (in INR)	Premium after discount on Hospitalisation Section (in INR)
1	-	0	0	0	10000
2	No	1%	1%	100	9900
3	No	1%	2%	200	9800
4	No	1%	3%	300	9700
5	Yes	-1%	2%	200	9800
6	No	1%	3%	300	9700
7	No	1%	4%	400	9600
8	No	1%	5%	500	9500
9	No	1%	5%	500	9500
10	Yes	-1%	4%	400	9600

iii. For a Floater Policy, No Claim Discount shall be available only on Floater Basis. It shall accrue only if no claim has been made for any of the Insured Members during the expiring Policy Period.

iv. If You have reached the maximum limit of accruing No Claim Bonus benefit (either through Cumulative bonus or through no claim discount), the accrued benefit will stop increasing and will remain constant subject to no claim in the policies.

v. If You discontinue the Policy or fail to renew the Policy within the Grace Period of 30 days from the due date of renewal, the entire No Claim Discount will be lost.

vi. If You already have accrued Cumulative Bonus / No Claim Bonus benefit under Your Policy and You have opted for this cover/ switched to another No Claim bonus benefit option:

a. Your accrued Cumulative Bonus / No Claim Bonus benefit will not lapse.

b. In case You have made any claim during the policy period, Your No Claim Bonus Benefit will reduce in the same way as it was accrued.

<u>For Example:</u>

a. No Claim Bonus Benefit is provided only on Hospitalisation Section of the Policy

b. Sum Insured for Hospitalisation Cover = INR 5,00,000

c. Premium for Hospitalisation Section = INR 5,000

d. Cumulative Bonus = 10% each claim free policy period, subject to maximum of 50% (Maximum 5 No Claim Bonus Benefit points)

e. Maximum Limit on No Claim Bonus Benefit = 5 times

f. No Claim Discount per claim free Policy Period = 1% on Hospitalisation Section Premium

Policy Year	Claim made in expiring Policy	Incremental No Claim Bonus Benefit	No Claim Bonus benefit points accrued	No Claim Bonus Benefit Type Opted	Accrued CB	Accrued No Claim Discount	Effective SI	Effective Premium
1	-	0	0		0	0.0%	5,00,000	5,000
2	No	1	1	CB	50,000	0.0%	5,50,000	5,000
3	No	1	2	CB	1,00,000	0.0%	6,00,000	5,000
4	No	1	3	CB	1,50,000	0.0%	6,50,000	5,000
5	No	1	4	Discount	1,50,000	1.0%	6,50,000	4,950
6	No	1	5	Discount	1,50,000	2.0%	6,50,000	4,900
7	No	1	5	Discount	1,50,000	2.0%	6,50,000	4,900
8	Yes	-1	4		1,50,000	1.0%	6,50,000	4,950
9	Yes	-1	3		1,50,000	0.0%	6,50,000	5,000

		10	Yes	-1	2		1,00,000	0.0%	6,00,000	5,000	
		11	Yes	-1	1		50,000	0.0%	5,50,000	5,000	
		12	No	1	2	CB	1,00,000	0.0%	6,00,000	5,000	

6	Exclusions (what the policy does not cover)	<u>**There are 3 types of exclusions:**</u> **I. <u>STANDARD EXCLUSIONS (Please refer below for brief headers, for detail exclusions, please refer to the policy wordings)</u>** **1. Pre-Existing Diseases - Code- Excl01** **2. Specified disease/procedure waiting period- Code- Excl02** **3. 30-day waiting period/ Initial Waiting Period- Code- Excl03** **4. Investigation & Evaluation- Code- Excl04** **5. Rest Cure, rehabilitation and respite care- Code- Excl05** **6. Obesity/ Weight Control: Code- Excl06** **7. Change-of-Gender treatments: Code- Excl07** **8. Cosmetic or plastic Surgery: Code- Excl08** **9. Hazardous or Adventure sports: Code- Excl09** **10. Breach of law: Code- Excl10** **11. Excluded Providers: Code- Excl11** **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** **16. Unproven Treatments: Code- Excl16** **17. Sterility and Infertility: Code- Excl17** **18. Maternity: Code Excl18** **II.<u>SPECIFIC EXCLUSIONS ((Please refer below for brief headers, for detail exclusions, please refer to the policy wordings)</u>** **19. Artificial Life Maintenance** **20. Suicide and Self-Injury** **21. Circumcision, Aesthetic reasons** **22. External Congenital Anomaly** **23. Geographical Limits** **24. Defence Operation** **25. Non-Medical Expenses** **26. Insufficient Document** **27. Preventive Treatment** **28. Spectacles, Hearing aids & other Expenses** **29. Stem Cell Transplant**: **30. Unjustified or Unwarranted Hospitalization** **31. War and hazardous substances**	D.I Standard Exclusion D.II Specific Exclusion

<table>
<tr><td></td><td></td><td>
32. Legal Liability
33. Substance abuse and Addictions by the Insured

<u>III. SPECIFIC ONES (CAN'T BE WAIVED)</u>
34. Ear, Eyesight & Optical Services
35. Prosthetics and other devices
36. Specific Treatments
37. Our Maximum Liability in respect of the following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured opted under Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover:
A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

<u>IV. SPECIFIC ONES (CAN BE WAIVED IN LIEU OF ADDITIONAL PREMIUM)</u>
38. Dental Treatment
39. Organ Donor
40. Weight loss Surgery

<u>V. Any other specific exclusions mentioned in the policy schedule.</u>
</td><td>D.III Specific Ones (Can't Be Waived)

D.IV Specific Ones (Can Be Waived in lieu of additional premium)</td></tr>
<tr><td>7</td><td>Waiting period
• Time period during which specified diseases/treatments are not covered.
• It is counted</td><td>
(<u>Waiting Periods</u> as applicable to Your policy will be mentioned in your policy schedule)

<u>Initial Waiting Period</u>
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
</td><td>D.I.
3.30-day waiting period / Initial Waiting Period- Code- Excl03</td></tr>
</table>

	from the beginning of the policy coverage.	insured subsequently. However, such waiting Period can be reduced to number of days as opted by you and mentioned in your policy schedule. **<u>Specific Waiting Periods</u>** **Specified disease/procedure waiting period** a. Expenses related to the treatment of the listed Conditions, surgeries /treatments shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident. b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply. d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion. e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage. f. List of specific diseases/procedures i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident) ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse. iii. Cataract, Glaucoma and Disorder of retina iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula. vii. Hernia of all sites, viii. Varicose veins of lower extremities, ix. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa, x. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling,	**D.I.** 2. Specified disease/ procedure waiting period- Code- Excl02

Mass or Lump including breast lumps (each of any kind unless malignant),

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

xii. Psychiatric illness and Disorders listed below:

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

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

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

Pre-Existing Diseases

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.

D.I.
1. Pre-Existing Diseases - Code-Excl01

Following are the waiting period options available under this product. Waiting Period applicable to Your policy will be as mentioned in Your Policy Schedule.

Description	Waiting Period Options
Initial Waiting Period Option	No Initial Waiting Period, 2 days, 7 days, 15 days, 30 days
Pre-existing Disease Waiting Period Options	No Pre-existing Disease Waiting Period,3 months,6 months, 1 Year, 2 Years, 3 Years,

Specific Waiting period	No Specific Waiting Period, 3 months,6 months,1 Year, 2 years
Section 6. Maternity and New Born Baby Cover	No Waiting Period, 6 Months, 9 Months, 1 Year, 2 Years, 3 Years, 4 Years
Section 17. Critical Illness Benefit Cover	No Waiting Period, 30 days, 60 days, 90 days
Section 19. Cancer Benefit Cover	No Waiting Period, 30 days, 60 days, 90 days

8 Financial limits of coverage

I.Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit).

Sub – Limit, Co-payment and Deductible as applicable to Your policy will be mentioned in your policy schedule.

Details of Section Wise Sub-Limits available under the product are mentioned below:

Section Details	**Sub Limits (Options)**
SECTION 1-HOSPITALIZATION COVER	
A. Accidental & Illness Hospitalization Cover	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 1.A Sum Insured)
A1. Day Care Procedures	NA
A2. Pre-Hospitalization Expenses	NA
A3. Post-Hospitalization Expenses	NA
A4. Dental Treatment	NA
A5. Road Ambulance	1% of Section 1.A Sum Insured Max up to the INR 5000
A6. Bariatric Surgery Cover	5%/10%/20% / 100% of Section 1.A Sum Insured
A7. Psychiatric Illness Cover	NA
A8. Complimentary Health Check Up	Up to 0.25%/0.5% of the Sum Insured (excluding any cumulative bonus) Subject to maximum of INR 5,000 Per Policy
A9. Ayush Cover	NA
A10. Daily Cash for Choosing Shared Accommodation	NA
B. Accidental Hospitalization Cover	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 1.B Sum Insured)
B1. Day Care Procedures	NA
B2. Pre-Hospitalization Expenses	NA
B3. Post-Hospitalization Expenses	NA
B4. Dental Treatment	NA
B5. Road Ambulance	1% of Section 1.B Sum Insured Max up to the INR 5000
B6. Daily Cash for Choosing Shared Accommodation	
SECTION 2. POST-HOSPITALIZATION LUMPSUM BENEFIT	One-time lumpsum benefit of (1% /1.5% / 2% / 3% or 5%) of the approved amount claimed under Section 1A./1B. as opted.
SECTION 3. ORGAN DONOR	NA. However donor's Pre and Post Hospitalization expenses up to 5% of the admissible harvesting expenses
SECTION 4. EMERGENCY AIR AMBULANCE	NA
SECTION 5. HOME (DOMICILIARY) HOSPITALIZATION	NA
SECTION 6. MATERNITY BENEFIT & NEW BORN BABY COVER	NA
SECTION 7. INFERTILITY TREATMENT COVER	NA
SECTION 8. OUT-PATIENT (OPD) BENEFIT	NA

SECTION 9. SECOND MEDICAL OPINION	NA
SECTION 10. CONSUMABLE COVER	Inbuilt Sum Insured under Section 1 (1%/2%/5%/10%/15%/ 100% of approved claim amount)
SECTION 11. UNUSED SUM INSURED BENEFIT	NA
SECTION 12. SUM INSURED REFILL BENEFIT	NA
SECTION 13. DAILY HOSPITAL CASH COVER	NA
SECTION 14. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD	NA
SECTION 15. LONG HOSPITALIZATION CASH BENEFIT	NA
SECTION 16. LOSS OF INCOME COVER	NA
SECTION 17. CRITICAL ILLNESS BENEFIT COVER	NA
SECTION 18. CRITICAL ILLNESS HOSPITALIZATION COVER	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 18 Sum Insured)
SECTION 19. CANCER BENEFIT COVER	NA
SECTION 20. CANCER HOSPITALIZATION COVER	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 20 Sum Insured)
SECTION 21. WOMAN CANCER BENEFIT	NA
SECTION 22. HEALTH CHECK-UP FROM DAY 1	NA
SECTION 23. ADVANCE HEART AMBULANCE	NA
SECTION 24. ADVANCE CARE	NA
SECTION 25. SI MULTIPLIER	NA
SECTION 26. SUPPORT PLUS	NA
SECTION 27. FAST TRACK	NA
SECTION 28. CUMULATIVE BONUS PROTECTION COVER	NA
SECTION 29. SMART SAVE	NA
SECTION 30. WELLNESS BENEFIT PROGRAM	NA

Note: We also have a Sub Limit of 5% of Sum Insured Opted under Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover on expenses related to administration of below medications or procedures:

a. Hyaluronic acid, Remicade or similar medications
b. Intra-articular/intra thecal or cortico-steroid injections, Immunotherapy/hormonal therapy.

II. Co-payment (It is a specified amount /percentage of the admissible claim amount to be paid by policyhold

Details of Section Wise Deductible and Co-payment available under the product are mentioned below:

Name of the Benefit	**Deductible allowed**	**If Yes, range of Deductible**		**Co-Pay allowed**	**If yes, range of Co-Pay**	
		Min	**Max**		**Min**	**Max**
SECTION 1-HOSPITALIZATION COVER	Yes					
A. Accidental & Illness Hospitalization Cover	Yes	50,000	25 Lakhs	Yes	0 %	50%
B. Accidental Hospitalization	Yes	50,0 00	25 Lakhs	Yes	0 %	50%
SECTION 2. POST-	No	-	-	No	-	-

er/insured).

III. Deductible (It is a specified amount:
- upto which an insurance company will not pay any claim, and
- which will be deducted from total claim amount (if claim amount is more than the specified amount)

IV. Any other limit (as applicable)

HOSPITALIZATION LUMPSUM BENEFIT						
SECTION 3. ORGAN DONOR	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 4. EMERGENCY AIR AMBULANCE	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 5. HOME (DOMICILIARY) HOSPITALIZATION	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 6. MATERNITY BENEFIT & NEW BORN BABY COVER	No	-	-	No	-	-
SECTION 7. INFERTILITY TREATMENT COVER	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 8. OUT-PATIENT (OPD) BENEFIT	No	-	-	No	-	-
SECTION 9. SECOND MEDICAL OPINION	No	-	-	Yes	0%	50%
SECTION 10. CONSUMABLE COVER	No	-	-	Yes	0%	50%
SECTION 11. UNUSED SUM INSURED BENEFIT	No	-	-	No	-	-
SECTION 12. SUM INSURED REFILL BENEFIT	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 13. DAILY HOSPITAL CASH COVER	Yes	50,000	25 Lakhs	No	-	-
SECTION 14. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD	No	-	-	No	-	-
SECTION 15. LONG HOSPITALISATION CASH BENEFIT	No	-	-	No	-	-
SECTION 16. LOSS OF INCOME COVER	No	-	-	No	-	-
SECTION 17. CRITICAL ILLNESS BENEFIT COVER	No	-	-	No	-	-
SECTION 18. CRITICAL ILLNESS HOSPITALIZATION COVER	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 19. CANCER BENEFIT COVER	No	-	-	No	-	-
SECTION 20. CANCER HOSPITALIZATION COVER	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 21. WOMAN CANCER BENEFIT	No	-	-	No	-	-
SECTION 22. HEALTH CHECK-UP FROM DAY 1	No	-	-	No	-	-
SECTION 23. ADVANCE HEART AMBULANCE	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 24. ADVANCE CARE	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 25. SI MULTIPLIER	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 26. SUPPORT PLUS	Yes	50,000	25 Lakhs	Yes	0%	50%
SECTION 27. FAST TRACK	Yes	50,000	25 Lakhs	Yes	0%	50%

SECTION 28. CUMULATIVE BONUS PROTECTION COVER	No	-	-	No	-	-
SECTION 29. SMART SAVE	No	-	-	No	-	-
SECTION 30. WELLNESS BENEFIT PROGRAM	No	-	-	No	-	-

For Geographical Limits Outside India: Co-payment Options are 0%, 5%, 10%, 15% and 20%.

9	Claims/Claims Procedure		E.II.6

Claims Notification and Procedure

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

A. Cashless Claim Process:

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

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

B. Reimbursement Claim Process:

		Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that: 1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission. 2. For Reimbursement Claim You shall follow the below Procedure: a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document. b. In case the claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment. "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due. c. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule or Your Legal representative holding a valid succession certificate.	E.II.23

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

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

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other

		person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1, B.1 and B.2.a may be considered where the reason for delay is proved to our satisfaction. * **Network Hospitals details:** https://www.godigit.com/health-insurance/digit-cashless-network-hospitals-list **Helpline no.** - 1800-258- 4242 **Hospitals which are blacklisted or from where no claims will be accepted by insurer:** List of Non-Preferred Hospital https://www.godigit.com/health-insurance/digit-cashless-network-hospitals-list/non-preferred-hospitals **Downloading/getting claim form:** https://www.godigit.com/health-insurance/file-a-claim	
10	Policy Servicing	**Call Centre Details of the Insurer** Toll Free: 1800-258- 4242 Email: healthclaims@godigit.com Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com Website: https://www.godigit.com **Details of Company Officials:** NA With intent to provide better and fast service to our customers, our claims process is paperless. You may get in touch with the above email id and call centre number we assist you in case of any Policy Servicing issues.	E.I.1
11	Grievances/ Complaints	**Customer Grievance Redressal Policy** In case of any grievance the insured person may contact the company through Website: https://www.godigit.com Toll Free: 1-800-258- 4242 Email: hello@godigit.com Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com Insured person may also approach the grievance cell at any of the company's branches with the details of grievance If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@godigit.com For updated details of grievance officer, kindly refer the link: Click Here https://www.godigit.com/claim/grievance-redressal-procedure If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of	E.I.16

		grievance as per Insurance Ombudsman Rules 2017 Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://irdai.gov.in/igms1 The contact details of the Insurance Ombudsman Centers are mentioned in the Policy Wordings.	
11	Things you need to know	**Free Look Period** The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of thirty(30)from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; The request received for cancellation of the policy during free look period shall be processed and the premium shall be refunded within 7 days of receipt of such request. **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.** **Policy Renewal** Except on grounds of fraud, moral hazard or misrepresentation or non-cooperation, renewal of your policy shall not be denied, provided the policy is not withdrawn. **Portability** In case of Indemnity based insurance sections a. A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred. b. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.	E.I.8 E.I.14

digit INSURANCE

		c. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer. d. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy **<u>Migration</u>** In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy. The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months. **<u>Change in Sum Insured:</u>** Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured. **<u>Moratorium Period</u>** 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 grounds of non-disclosure, 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.	E.I.15 E.II.7 E.I.6
12	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. Please Disclose any change in Material Information during the policy period. Material Information for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to tale informed decision in the context of underwriting the risk.	