Welcome to the 'I Feel Good' policy

aka

Digit Health Care Plus Policy

UIN: GODHLIP25037V042425
Policy Wordings

CONTENTS

Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Think of Digit as your running or gym buddy, keeping pace with you all the way. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-5956 or mail us at hello@godigit.com

A. PREAMBLE

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

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

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

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

B. DEFINITIONS

Digit Simplification: ***Who says it's hard to crack Insurance terms? At least at Digit, we don't! Simply put, below are some definitions. These are no ordinary definitions that you used to mug up at school. These are like magic spells / words that empower you to understand this policy better. Abra..ca..dabra!***

Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

I. STANDARD DEFINITIONS:

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
7. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Insurer to the extent Pre-authorization is approved.
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly means a Congenital anomaly which is in the visible and accessible parts of the body
10. **Co-Payment** means a cost sharing requirement under a Health Insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
    (Co-Payment will not be applicable to benefit Policies – Daily Hospital Cash Cover & Critical Illness Benefit, Cancer Benefit, Women cancer benefit cover, Long Hospitalization Cash Benefit, Daily Hospital Cash for Accompanying an Insured Child, Loss of Income, Health check up.)
11. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

12. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
    i. has qualified nursing staff under its employment;
    ii. has qualified medical practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
14. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital Cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured. Deductible specific to Section 1 A. Accidental Hospitalization and Section 1B. Accidental and illness Hospitalization will be applicable in aggregate or smart deduct (per claim deductible) as opted towards the hospitalization expenses incurred during policy period.
15. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
16. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
17. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.
18. **Emergency / Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
19. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
20. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
21. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
22. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        2. it needs ongoing or long-term control or relief of symptoms
        3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

4. it continues indefinitely
5. it recurs or is likely to recur

23. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
24. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
25. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
26. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
27. **Indemnity based health insurance section** means an insurance section that compensates an insured for the loss due to occurrence of an insured event as specified in the policy.
28. **Benefit based health insurance section** means an insurance section that pays fixed amount on the occurrence of an insured event as specified in the policy.
29. **Maternity expenses** means;
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
30. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
31. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
32. **Medical Practitioner/Dentist** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
    The registered practitioner should not be the insured or close member of the family.
33. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i)is required for the medical management of the illness or injury suffered by the insured;
    ii)must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii)must have been prescribed by a medical practitioner;
    iv)must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
34. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
35. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
36. **New-born Baby** means baby born during the Policy Period and is aged upto 90 days.
37. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
38. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
39. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
40. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
41. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

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

42. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
43. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
44. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
45. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
46. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
47. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
48. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
49. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
50. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

II. SPECIFIC DEFINITIONS

51. **Contribution**
    Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis.
52. **Hazardous Sports** means any sport, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.
53. **Life threatening health condition** shall mean a serious medical condition or symptom resulting from Injury or Illness, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore**.**
54. **Policy** means the Proposal, the Policy Schedule (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
55. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule and includes both the commencement date as well as the expiry date.
56. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
57. **Psychiatric Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.
58. **Related Hospitalization** means hospitalization arising out of same illness including its complications, for which a claim has already been availed during the same policy year.

59. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
60. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy.
    Unlimited Sum Insured option provided under the product refers to Sum Insured more than INR 3 crore without any limitation. Premium for Unlimited Sum Insured will be calculated by multiplying 1.15 to the premium of Sum Insured INR 3 crore.
61. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neurosurgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
62. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
63. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule Members who has concluded this Policy with Us.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

SECTION 1. HOSPITALIZATION COVER

Digit Simplification: Hospital stays can be exhausting, and we understand that. That's why we strive to make your days at the hospital as comfortable as possible. After all, you're there to recover. Our Hospitalization Cover is a ray of hope that aims to make your stay more comfortable, allowing you to focus solely on getting healthy!

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.

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'** restriction 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

Digit Simplification: Technology has sped up healthcare. Some treatments such as dialysis, cancer chemotherapy, etc. that are completed in less than 24 hour and do not require 24-hour hospitalization. Your policy covers such procedures too.

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

Digit Simplification: There is so much to be taken care of before You get admitted to the hospital. Doctors may recommend various tests and medications, consultation of specialists, etc. We cover these expenses for the period mentioned in Your Policy Schedule.

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

Digit Simplification: There are certain expenses that are incurred after discharge relating to the said hospitalization such as follow-up treatments, medical consultations, diagnostic tests, medication, etc. Don't worry! These expenses are covered for the period mentioned in Your policy schedule.

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

Digit Simplification: You are covered if You meet with an accident and require a dental treatment. Unfortunately, any dental treatment arising from a pre-existing condition is not covered.

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

Digit Simplification: Get reimbursed for road ambulance expenses when there is a health emergency, and you need to be admitted to a hospital. The benefit of this cover is not included in case you plan Your hospitalisation in advance. (It's only available in case of emergency hospitalizations.)

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

Digit Simplification: Obesity may be the root cause of so many health issues. We understand this, and cover for Bariatric Surgery when it is medically necessary and advised by Your doctor. However, We DO NOT cover if hospitalisation for this treatment is undertaken for cosmetic reasons.

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

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

- History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
- Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.

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

d) This particular cover has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.

e) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. ***Example: Endocrine disorder***.

f) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.

g) A prior approval should be taken from us before the Bariatric Surgery is performed.

h) Our maximum liability under this benefit is restricted to the Limit as opted by You and mentioned in Your Policy Schedule against this Cover.

Bariatric surgery for the following reasons is not covered:

a) For Cosmetic/Aesthetic reasons.

b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity. ***Digit Simplification: This is in such cases, treatment of the cause that has caused the obesity, will be more beneficial than treating obesity itself.***

A7. Psychiatric illness Cover

Digit Simplification: We cover medical expenses for psychiatric illnesses if the first diagnosis and hospitalization occur during the policy period. Hospitalization under this benefit requires prior approval, except for emergencies.

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. Complimentary Health Check Up

Digit Simplification: Prevention is always better than cure! Get health check-up after policy renewal.

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

Digit Simplification: We'll cover Your in-patient medical expenses for treatments in Ayurveda, Unani, Siddha, or Homeopathy. This coverage is up to the sum insured specified in Your policy, as long as You select a registered AYUSH Hospital.

Please Note: This cover does not include outpatient medical expenses. Also, treatments that are non-curative, and not medically necessary, like preventive and rejuvenation therapies, are not covered.

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

Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!

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

Please note:

a. Your claim must be admissible under Section 1 Hospitalization Cover
b. Your hospitalization must exceed 48 hours unless specifically agreed by Us
c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days
d. Daily cash will be provided only for the days You were hospitalized in shared accommodation.
e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU.
f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule

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

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'** restriction 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

Digit Simplification: Technology has sped up healthcare. Some treatments such as dislocated shoulder etc. that are completed in less than 24 hour and do not require 24 hour hospitalization. Your policy covers such procedures too.

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

Digit Simplification: There is so much to be taken care of before You get admitted to the hospital bed. Doctors may recommend various tests and medications such as X-rays, CT scans, MRI scans, involving consultation fees for physicians, etc. We cover these expenses for the period mentioned in Your Policy Schedule.

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

Digit Simplification: There are certain expenses that are incurred after discharge relating to the said hospitalization such as follow-up treatments, medical consultations, diagnostic tests, medication, etc. Don't worry! These expenses are covered for the period mentioned in Your policy schedule.

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

Digit Simplification: You are covered if You meet with an accident and require a dental treatment. Unfortunately, any dental treatment arising from a pre-existing condition is not covered.

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

Digit Simplification: Get reimbursed for road ambulance expenses when there is an emergency arising out of an accident, and you need to be admitted to a hospital.

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.

This space needs Your special attention!

✗: Expenses incurred in reaching home after discharge are not covered.

✗: The benefit of this cover is not included in case you plan Your hospitalisation in advance. (It's only available in case of emergency hospitalizations.)

B6. DAILY CASH FOR CHOOSING SHARED ACCOMMODATION

Digit Simplification: Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!

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

Please note:

a. Your claim must be admissible under Section 1 Hospitalization Cover.
b. Your hospitalization must exceed 48 hours unless specifically agreed by Us.
c. For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days
d. Daily cash will be provided only for the days You were hospitalized in shared accommodation.
e. Daily Cash will not be applicable in case Insured Person is admitted in the ICU.
f. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule

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

SECTION 2. POST HOSPITALIZATION LUMPSUM BENEFIT

Digit Simplification: One-time lumpsum amount will be given post discharge for your post hospitalization expenses.

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 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

Digit Simplification: Organ Donor expenses refer to the medical costs incurred for organ transplantation. This will also cover pre- and post-hospital care of the 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.

This space needs Your special attention!

✗: If the surgery required for the organ transplant is not covered in Your policy, then the organ donor expenses for the same treatment will not be payable.
☺: Organ donor expenses include expenses such as cost of surgery, room, nursing, medication, doctor's follow-ups, etc.

SECTION 4. EMERGENCY AIR AMBULANCE

Digit Simplification: There may be emergency, life-threatening health conditions that require immediate transportation to hospital. We understand this and reimburse You for expenses incurred for Your transportation to a hospital by airplane or helicopter.

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.**

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

This section needs Your special attention!

✗: You are not covered for the air ambulance charges in case of a planned hospitalisation and in case Your location has the necessary treatment available.

☺: This benefit applies within India, which can be valuable in situations where access to hospitals by road is challenging due to geographical or infrastructural limitations.

SECTION 5. HOME (DOMICILIARY) HOSPITALIZATION

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

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

a) The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
b) The patient takes treatment at home on account of non-availability of room in a Hospital, and
c) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period

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

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

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

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

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

b) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.

c) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule applied to the increased part of the Sum Insured.

d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.

Digit Simplification: Sticking with us has its advantages

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

If you have specifically opted for covering Pre and Post natal expenses, We will pay for the hospitalization expenses up to 100% of Section 6. Sum Insured during the Pre-natal and Post-natal period, subject to the availability of sum insured under this section.

We shall not pay for the following under this Section:

a) Expenses for the harvesting and storage of stem cells when carried out as a preventive measure against possible future illness.

b) Medical Expenses for Ectopic Pregnancy will be covered under **Section 1. B. In-patient Accidental & Medical Treatment** and not under the Maternity Benefit.

c) Pre-natal and Post-natal Medical Expenses are not covered unless leading to Your Hospitalization.

B. New Born Baby Benefit

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

Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 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 of delivery. However, once the New Born Baby is added as an Insured Person under the Policy, We will pay the Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India until the New Born Baby attains 5 Years of age, provided that the Policy is continuously renewed with Us

without break and with **Maternity Benefit and New Born Baby Cover** as a benefit since inception of the first policy.

d) If the Policy Expires before 90 days from the date of delivery, the New Born Baby will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of any additional premium.

e) After 90 Days from the date of delivery, the New Born Baby will be covered under the existing Policy only if it is Endorsed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of the Pro-Rata Additional Premium, for the balance period.

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

SECTION 7. INFERTILITY TREATMENT COVER

Digit Simplification: We make your road to parenthood easier.

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

Make sure the following conditions are met:

a) A waiting period as opted by You and mentioned in your Policy Schedule will apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with this cover, without a break, with 'Infertility Treatment Cover' as a benefit since inception of the first policy.

b) Our maximum liability per Hospitalization shall be restricted to the amount as mentioned in Your Policy Schedule against this Section.

c) The benefit is payable only once to an Insured Person during the Policy Period.

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

SECTION 8. OUT-PATIENT (OPD) BENEFIT

Digit Simplification: Expenses like doctor's consultation fees, dental treatment, diagnostic tests, etc… when You are not hospitalized are covered under this!

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

- Basis 1: Co-payment of 25% in the First Year of this Section being Opted, 10% on First Renewal. From the Second Renewal, there will be no Co-payment, provided the Policy is renewed with Us continuously without a break with this benefit.
- Basis 2: Nil Co-payment

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any Illness.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner
Out-Patient Dental Treatment	Out-patient dental treatment for the immediate relief of dental Pain; taken by You from a dentist, provided that We will pay only for X-rays, Extractions, Amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.

Hearing Aids	One pair of hearing aids (Excluding Batteries), provided that: ▪ These have been prescribed by an ENT specialist or Network Medical Practitioner. ▪ You have continuously renewed the Policy with Us without break for a period of 36 months with **Out-Patient (OPD) Benefit** as a benefit, since inception of the first policy.
Psychiatric Illness	Specialist Consultation, assessment, treatment and medication for Psychiatric Disorders.

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

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

SECTION 9. SECOND MEDICAL OPINION

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

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

SECTION 10. CONSUMABLE COVER

Digit Simplification: During Your hospitalization, there are many other medical aids & expenditures such as crepe bandages, belts, etc., which needs your pocket's attention... This cover takes care of these expenses that are otherwise excluded from the policy.

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 in this Policy Wordings) 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.

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

SECTION 11. UNUSED SUM INSURED BENEFIT

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

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.**

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

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

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

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

SECTION 12. SUM INSURED REFILL BENEFIT

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

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

a) The refiled 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, unless this condition is specifically waived by Us and mentioned in Your Policy Schedule.
b) In case of related Hospitalization cooling off period of 45 days will be applicable.
Digit Simplification: Time gap between two related hospitalizations should be minimum 45 days.
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

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

A) Accidental & Illness Hospitalization Cover

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

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

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

B) Accidental Hospitalization Cover

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

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

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

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

SECTION 14. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD

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

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

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

SECTION 15. LONG HOSPITALIZATION CASH BENEFIT

Digit Simplification: You'll get a lump sum amount mentioned in your policy schedule and if You're in the hospital for a specific number of days, as chosen in Your policy. This payment only happens once per person during the policy period.

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.

SECTION 16. LOSS OF INCOME COVER

Digit Simplification: You will receive a pre-set amount specified, if you are continuously hospitalized for certain number of days.

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 completed block of specified number of days, again mentioned in your policy schedule.

Please note:

a. Your claim should be admissible under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover**
b. For each policy period, there is a maximum number of times this can be paid as mentioned in your policy schedule.

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

SECTION 17. CRITICAL ILLNESS BENEFIT COVER

Digit Simplification: God forbid if You get diagnosed with a serious illness such as cancer or brain tumour for the first time, this coverage will provide You with a lump sum amount to help pay Your treatment expenses.

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 from the date of inception of first policy with us..
c) You survive for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us
d) The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease
e) Once a claim has been Paid under Critical Illness and / or Surgical Procedure, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.

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

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity
2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

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, We give You a lump sum amount which can be utilized for Your treatment.

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

SECTION 18. CRITICAL ILLNESS HOSPITALIZATION COVER

Digit Simplification: In times like these, You'll be getting all reasonable and Customary Charges that are Medically Necessary and Incurred, in case You are hospitalised because of critical illness.

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 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'** restriction 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

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:

Digit Simplification: What all is covered and what is not. Meaning of each Critical Illness in black and white for You!

I. Standard Definitions:

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

2. **MYOCARDIAL INFARCTION**

   (First Heart Attack of specific severity)
   - I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
     - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
     - ii. New characteristic electrocardiogram changes
     - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
   - II. The following are excluded:
     - i. Other acute Coronary Syndromes
     - ii. Any type of angina pectoris
     - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES**
   - I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a

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

4. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

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

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

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

5. OPEN CHEST CABG

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

II. The following are excluded:

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

6. END STAGE LUNG FAILURE

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

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
d. Dyspnoea at rest.

7. END STAGE LIVER FAILURE

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

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

8. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

II. The following are excluded:

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.

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

SECTION 19. CANCER BENEFIT COVER

Digit Simplification: The big C requires another C: Cover

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

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

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

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

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

SECTION 20. CANCER HOSPITALIZATION COVER

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

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

Provided that,

a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity and hospitalized within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule 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 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'** restriction 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.

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

SECTION 21. WOMAN CANCER BENEFIT

Digit Simplification: Cancer can affect women during any phase of life, When women have shouldered equal responsibilities, it is necessary to ensure protection and complete cover for cancer treatment.

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) This section only covers cancers specific to women. Coverage under this section will be limited only to the diagnosis of Cancers as mentioned in Your Policy Schedule.
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 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 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;

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

SECTION 22. HEALTH CHECKUP COVER FROM DAY ONE

Digit Simplification: We pay for your health check-up expenses from Day 1 of the Policy up to the amount mentioned in your Policy .

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.

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

SECTION 23. ADVANCE HEART AMBULANCE

Digit Simplification: An emergency does not come announced! With this section, you will be covered for expenses incurred on your road transportation by an Advanced Heart Ambulance due to an emergency arising out of Your cardiac arrest.
An Advanced Heart Ambulance means special ambulances equipped with specialized equipment for patients with cardiac issues, such as defibrillators, cardiac monitors, and ventilators.

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. Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**
b. Sum Insured for this cover will be part of Section 1 Sum Insured. 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.

SECTION 24. ADVANCE CARE

Digit Simplification: In this new era there many modern treatments and procedures for which we are covering you. By opting this section, You can enhance cost of covering modern treatment from upto 50% of Sum Insured to upto 100% of Sum Insured.
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.

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

SECTION 25. SI MULTIPLIER

Digit Simplification: In this cover, you get a boosted sum insured which kicks in from Day 1 of your policy period. We will increase your Sum Insured by your chosen multiplier.
Must-knows: 👀
☑ It is eligible for claims only under Section 1.A. Accidental & Illness Hospitalization Cover and/or Section 1.B. Accidental Hospitalization Cover.
Will be applied only once during each policy year.

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.

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

Digit Simplification: We understand the importance of having support during challenging times. With this cover, we've got you covered for food and lodging expenses for your accompanying adult while you're hospitalized in the ICU.
Must-knows:
The hospital in which you are hospitalized must be at least 15 km away from your residence.

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.
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

Digit Simplification: This cover will indemnify medical expenses incurred for hospitalization of some pre-existing illness like Asthma, Diabetes, Hypertension etc. as mentioned in the coverage below.

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.
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

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

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.

SECTION 29. SMART SAVE

Digit Simplification: If opted this, SI capping will be applied on specific aliment listed mentioned in coverage. You will be eligible for certain percentage of discount as mentioned in your policy schedule.

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.

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

SECTION 30. WELLNESS BENEFIT PROGRAM

Digit Simplification: If opted this section you will be entitled for the benefits for taking care of your health/fitness and maintaining healthy lifestyle, available under Our Wellness Benefit Program as mentioned in the Policy Schedule.

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.

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 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

Digit Simplification: "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'.

"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

Digit Simplification: If You've had a healthy year with no claims under the Hospitalization Cover in Your expiring policy, You'll be eligible for a Cumulative Bonus when renewing Your policy, depending on Your chosen Cumulative Bonus. There is an upper limit to the bonus, mentioned in Your policy.
If You make a claim during a policy year, Your bonus decreases when you renew,

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

Digit Simplification: 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.

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.

For Example:

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

D. EXCLUSIONS

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

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

I. STANDARD EXCLUSIONS

1. Pre-Existing Diseases - Code- Excl01

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

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

e. 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.
f. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
g. 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.
h. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
i. 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
j. List of specific diseases/procedures

i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
iii. Cataract, Glaucoma and Disorder of retina
iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
vii. Hernia of all sites,
viii. Varicose veins of lower extremities,
ix. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,
x. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),
xi. Internal Congenital Anomaly. This specific waiting period will not be applicable to New Born Baby/infants.
xii. Psychiatric illness and Disorders listed below:

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

xiii. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease
xiv. **Joint Replacement, Bariatric Surgery and Organ Transplant**

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

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

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

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

4. Investigation & Evaluation- Code- Excl04

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

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

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

except to the extent covered under **SECTION 5. HOME (DOMICILIARY) HOSPITALIZATION** if opted by You.

6. Obesity/ Weight Control: Code- Excl06

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

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

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

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

8. Cosmetic or plastic Surgery: Code- Excl08

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

9. Hazardous or Adventure sports: Code- Excl09

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

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

10. Breach of law: Code- Excl10

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

11. Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case

of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
For updated list of excluded hospitals, kindly refer the link:
https://www.godigit.com/health-insurance/non-preferred-hospitals

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

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

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

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

16. Unproven Treatments: Code- Excl16
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. Sterility and Infertility: Code- Excl17
Expenses related to sterility and infertility. This includes:
i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

This exclusion stands deleted to extent of the coverage provided under **SECTION 7. INFERTILITY TREATMENT COVER**, if opted by You.

18. Maternity: Code Excl18
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion stands deleted to the extent of the coverage provided under **SECTION 6. MATERNITY BENEFIT & NEWBORN BABY COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS

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

20. Suicide and Self-Injury
We do not cover treatment arising from or contributed or aggravated or accelerated by any of the following:
a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
b. Intentional self-injury
c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

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

22. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geographical Limits

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

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

24. Defence Operation

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

25. Non-Medical Expenses

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

26. Insufficient Document

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

27. Preventive Treatment

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

a. For an active vaccination for dog or animal bite;
b. To the extent covered under **SECTION 6. MATERNITY BENEFIT & NEW BORN BABY COVER** if opted by You.

28. Spectacles, Hearing aids & other Expenses

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

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

30. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover.**

31. War and hazardous substances

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

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

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

32. Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

33. Substance abuse and Addictions by the Insured

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

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

III. SPECIFIC ONES (CAN'T BE WAIVED)

34. Ear, Eyesight & Optical Services

a) We do not cover treatment for:
   1. Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery

b) We do not cover Femto Laser Procedure and multifocal lenses.

c) Our Maximum Liability in respect of Cochlear Implant Procedure will be restricted to 50% of the Sum Insured opted under **Section 1.A. Accidental & Illness Hospitalization Cover** and/or **Section 1.B. Accidental Hospitalization Cover**

35. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

36. Specific Treatments

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

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

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

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

38. Dental Treatment

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

39. Organ Donor

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

40. Weight loss Surgery

We do not cover treatment that is directly or indirectly related to:
Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue, unless You have specifically opted for **SECTION 1.A. Accidental & Illness Hospitalization Cover which covers Bariatric Surgery.**

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES

CONDITIONS PRECEDENT TO THE CONTRACT

Digit Simplification: There are some more conditions you should be aware of that we considered before we issued you the policy.

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

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

2. Condition Precedent to admission of Liability

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

3. Nomination

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

CONDITION APPLICABLE DURING THE CONTRACT

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

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

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

i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
ii. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period .
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy

5. Withdrawal of Policy

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

6. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on 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.

7. Cancellation

A. Cancellation by You

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

a) Refund proportionate premium for unexpired policy period, if the term of policy is upto one year and there is no claim (s) made during the policy period.

b) Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

B. Cancellation by Company

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

C. In Case of Death of Insured Person

i. Individual Policy

In case, no claim has been made, and termination takes place on account of death of the insured person, We shall refund proportionate premium for unexpired policy period. There will be no change in premium for other family members covered under the policy for the remaining duration of the policy.

ii. Family Floater Policy

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

8. 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.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

9. Multiple Policies

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

ii. Indemnity based Insurance Sections:
A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

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

10. Fraud

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

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

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

a) The suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) The active concealment of a fact by the insured person having knowledge or belief of the fact;
c) Any other act fitted to deceive; and
d) Any such act or omission as the law specially declares to be fraudulent.

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

11. Claim Settlement (provision for Penal Interest)

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.

12. Complete Discharge

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

CONDITIONS FOR RENEWAL OF THE CONTRACT

13. Renewal

i. The policy shall ordinarily be renewable provided the product is not withdrawn except on grounds of established fraud or non-disclosure or misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience.
vii. No fresh underwriting unless there is an increase in sum insured .
viii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected and shall be applicable for both Indemnity based and Benefit based sections.

14. Portability

In case of Indemnity based Insurance sections:

a. A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.
b. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.

c. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
d. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

15. Migration

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.
The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

16. Customer Grievance Redressal Policy:

In case of any grievance the insured person may contact the company through
Website: https://www.godigit.com
Toll Free: 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@godigit.com
For updated details of grievance officer, kindly refer the link:
https://www.godigit.com/claim/grievance-redressal-procedure
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017
Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://irdai.gov.in/igms1

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

II. SPECIFIC TERMS AND CLAUSES

CONDITIONS PRECEDENT TO THE CONTRACT

Digit Simplification: There are some more conditions you should be aware of that we considered before we issued you the policy.

1. Zone wise Classification

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

Zone A - Delhi & NCR, Greater Hyderabad Area, Mumbai and Greater Mumbai region (including Thane and Navi Mumbai), Gujarat
Zone B Chennai, Bengaluru, Kolkata, Pune
Zone C Rest of India
Zone opted by you is mentioned in your Policy Schedule.

Note:

1. If You have availed choice of Zone A at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B or C, no Co-pay would be applicable on admissible claim amount.
2. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.
3. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone C, no Co-pay would be applicable on admissible claim amount.
4. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.
5. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% co-payment will be applicable. on admissible claim amount.
6. Zone based Co-pay as mentioned above will not be applicable in case of accidental injury.

2. Alterations to the Policy

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

3. Non-Disclosure or Misrepresentation:

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

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

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

4. Insured Person

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

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

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

5. Arbitration

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

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.

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

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

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

CONDITIONS FOR RENEWAL OF THE CONTRACT

7. Sum Insured Enhancement

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

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

c. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

8. Continuity Benefits

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

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period, wait period of Specific Diseases pre-existing disease etc) which are applicable under this Policy;

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

Annexure 1

List of Health Checkup packages available under Section 22. Health Check Up Cover from Day One

Package 1	Package 2	Package 3	Package 4	Package 5	Package 6
Vital Care	**Smart Health**	**Comfort Lite**	**Comfort Pro**	**Elite Care**	**Luxe Plus**
Complete Blood Count (CBC)	Complete Blood Count (CBC) including ESR	Complete Blood Count (CBC) including ESR	Complete Blood Count (CBC) including ESR	Complete Blood Count (CBC) including ESR	Complete Blood Count (CBC) including ESR
Basophils- Absolute Count	Basophils- Absolute Count	Basophils- Absolute Count	Basophils- Absolute Count	Basophils- Absolute Count	Basophils- Absolute Count
Eosinophils- Absolute Count	Eosinophils- Absolute Count	Eosinophils- Absolute Count	Eosinophils- Absolute Count	Eosinophils- Absolute Count	Eosinophils- Absolute Count
Lymphocytes- Absolute Count	Lymphocytes- Absolute Count	Lymphocytes- Absolute Count	Lymphocytes- Absolute Count	Lymphocytes- Absolute Count	Lymphocytes- Absolute Count
Monocytes- Absolute Count	Monocytes- Absolute Count	Monocytes- Absolute Count	Monocytes- Absolute Count	Monocytes- Absolute Count	Monocytes- Absolute Count
Neutrophils Count	Neutrophils Count	Neutrophils Count	Neutrophils Count	Neutrophils Count	Neutrophils Count
Basophils	Basophils	Basophils	Basophils	Basophils	Basophils
Eosinophils	Eosinophils	Eosinophils	Eosinophils	Eosinophils	Eosinophils
Haemoglobin	Haemoglobin	Haemoglobin	Haemoglobin	Haemoglobin	Haemoglobin
Total Leucocytes Count	Total Leucocytes Count	Total Leucocytes Count	Total Leucocytes Count	Total Leucocytes Count	Total Leucocytes Count
Lymphocyte Percentage	Lymphocyte Percentage	Lymphocyte Percentage	Lymphocyte Percentage	Lymphocyte Percentage	Lymphocyte Percentage
MCH	MCH	MCH	MCH	MCH	MCH
MCHC	MCHC	MCHC	MCHC	MCHC	MCHC
MCV	MCV	MCV	MCV	MCV	MCV
Monocytes	Monocytes	Monocytes	Monocytes	Monocytes	Monocytes
Neutrophils	Neutrophils	Neutrophils	Neutrophils	Neutrophils	Neutrophils
Nucleated Red Blood Cells	Nucleated Red Blood Cells	Nucleated Red Blood Cells	Nucleated Red Blood Cells	Nucleated Red Blood Cells	Nucleated Red Blood Cells
Nucleated Red Blood Cells %	Nucleated Red Blood Cells %	Nucleated Red Blood Cells %	Nucleated Red Blood Cells %	Nucleated Red Blood Cells %	Nucleated Red Blood Cells %
Hematocrit (PCV)	Hematocrit (PCV)	Hematocrit (PCV)	Hematocrit (PCV)	Hematocrit (PCV)	Hematocrit (PCV)
Platelet Count	Platelet Count	Platelet Count	Platelet Count	Platelet Count	Platelet Count
Total RBC	Total RBC	Total RBC	Total RBC	Total RBC	Total RBC
RDW-CV	RDW-CV	RDW-CV	RDW-CV	RDW-CV	RDW-CV
RDW-SD	RDW-SD	RDW-SD	RDW-SD	RDW-SD	RDW-SD
FBS (Random Blood Sugar)	ESR	ESR	ESR	ESR	ESR
Total Cholesterol	Glycosylated Haemoglobin (HbA1 c)	Glycosylated Haemoglobin (HbA1 c)	Glycosylated Haemoglobin (HbA1 c)	Glycosylated Haemoglobin (HbA1 c)	Glycosylated Haemoglobin (HbA1 c)
Low Density Lipoprotein (LDL)	Average Blood Glucose	Average Blood Glucose	Average Blood Glucose	Average Blood Glucose	Average Blood Glucose
Routine Urine Analysis	Lipid Profile	Lipid Profile	Lipid Profile	Lipid Profile	Lipid Profile
	Total Cholesterol	Total Cholesterol	Total Cholesterol	Total Cholesterol	Total Cholesterol
	High Density Lipoprotein (HDL)	High Density Lipoprotein (HDL)	High Density Lipoprotein (HDL)	High Density Lipoprotein (HDL)	High Density Lipoprotein (HDL)
	Low Density Lipoprotein (LDL)	Low Density Lipoprotein (LDL)	Low Density Lipoprotein (LDL)	Low Density Lipoprotein (LDL)	Low Density Lipoprotein (LDL)
	Triglycerides	Triglycerides	Triglycerides	Triglycerides	Triglycerides
	Very Low-Density Lipoprotein (VLDL)	Very Low-Density Lipoprotein (VLDL)	Very Low-Density Lipoprotein (VLDL)	Very Low-Density Lipoprotein (VLDL)	Very Low-Density Lipoprotein (VLDL)
	Liver function test (LFT)	Liver function test (LFT)	Liver function test (LFT)	Liver function test (LFT)	Liver function test (LFT)
	Bilirubin (Total)	Bilirubin (Total)	Bilirubin (Total)	Bilirubin (Total)	Bilirubin (Total)

	Bilirubin (Direct)	Bilirubin (Direct)	Bilirubin (Direct)	Bilirubin (Direct)	Bilirubin (Direct)
	Bilirubin (Indirect)	Bilirubin (Indirect)	Bilirubin (Indirect)	Bilirubin (Indirect)	Bilirubin (Indirect)
	SGOT / Aspartate Aminotransferase (AST)	SGOT / Aspartate Aminotransferase (AST)	SGOT / Aspartate Aminotransferase (AST)	SGOT / Aspartate Aminotransferase (AST)	SGOT / Aspartate Aminotransferase (AST)
	SGPT / Alanine Aminotransferase (ALT)	SGPT / Alanine Aminotransferase (ALT)	SGPT / Alanine Aminotransferase (ALT)	SGPT / Alanine Aminotransferase (ALT)	SGPT / Alanine Aminotransferase (ALT)
	Alkaline Phosphatase (Total)	Alkaline Phosphatase (Total)	Alkaline Phosphatase (Total)	Alkaline Phosphatase (Total)	Alkaline Phosphatase (Total)
	Albumin	Albumin	Albumin	Albumin	Albumin
	Globulin	Globulin	Globulin	Globulin	Globulin
	Serum Albumin/ Globulin Ratio	Serum Albumin/ Globulin Ratio	Serum Albumin/ Globulin Ratio	Serum Albumin/ Globulin Ratio	Serum Albumin/ Globulin Ratio
	Routine Urine Analysis	Routine Urine Analysis	Routine Urine Analysis	Routine Urine Analysis	Routine Urine Analysis
	Thyroid Profile	Thyroid Profile	Thyroid Profile	Thyroid Profile	Thyroid Profile
	T3	T3	T3	T3	T3
	T4	T4	T4	T4	T4
	TSH	TSH	TSH	TSH	TSH
	KFT	KFT	KFT	KFT	KFT
	Serum Creatinine	Serum Creatinine	Serum Creatinine	Serum Creatinine	Serum Creatinine
	Uric Acid	Uric Acid	Uric Acid	Uric Acid	Uric Acid
	Blood Urea Nitrogen (BUN)	Blood Urea Nitrogen (BUN)	Blood Urea Nitrogen (BUN)	Blood Urea Nitrogen (BUN)	Blood Urea Nitrogen (BUN)
	BUN/ Sr. Creatinine Ratio	BUN/ Sr. Creatinine Ratio	BUN/ Sr. Creatinine Ratio	BUN/ Sr. Creatinine Ratio	BUN/ Sr. Creatinine Ratio
		Calcium	Calcium	Calcium	Calcium
			ECG	ECG	ECG
				Chest Xray	Knee Joints Xray

Annexure A

List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(Payable incases where insured has undergone Surgery of thoracic or lumbar spine)*
5.	BUDS *(Not Payable)*
6.	COLD PACK/HOT PACK *(Not Payable)*
7.	CARRY BAGS *(Not Payable)*
8.	EMAIL/ INTERNET CHARGES *(Not Payable)*
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) *(Not Payable)*
10.	LEGGINGS *(Payable in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable)*
11.	LAUNDRY CHARGES *(Not Payable)*
12.	MINERAL WATER *(Not Payable)*
13.	SANITARY PAD *(Not Payable)*
14.	TELEPHONE CHARGES *(Not Payable)*
15.	GUEST SERVICES *(Not Payable)*
16.	CREPE BANDAGE *(Not Payable)*
17.	DIAPER OF ANY TYPE *(Not Payable)*
18.	EYELET COLLAR *(Not Payable)*
19.	SLINGS *(Reasonable costs for one sling in case of upper arm fractures should be considered)*
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES *(Part Of Cost Of Blood, Not Payable)*
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges *(Payable Under Room Charges Not if separately levied)*
23.	SURCHARGES *(Part of Room Charge Not Payable Separately)*
24.	ATTENDANT CHARGES *(Part of Room Charge Not Payable Separately)*
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) *(Patient Diet provided by hospital is Payable)*
26.	BIRTH CERTIFICATE *(Not Payable)*
27.	CERTIFICATE CHARGES *(Not Payable)*
28.	COURIER CHARGES *(Not Payable)*
29.	CONVEYANCE CHARGES *(Not Payable)*
30.	MEDICAL CERTIFICATE *(Not Payable)*
31.	MEDICAL RECORDS *(Not Payable)*
32.	PHOTOCOPIES CHARGES *(Not Payable)*
33.	MORTUARY CHARGES *(Payable upto 24 Hours. Shifting charges not Payable)*
34.	WALKING AIDS CHARGES *(Not Payable)*
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) *(Not Payable)*
36.	SPACER *(Not Payable)*
37.	SPIROMETRE *(Device Not Payable)*
38.	NEBULIZER KIT *(Not Payable)*
39.	STEAM INHALER *(Not Payable)*
40.	ARMSLING *(Not Payable)*
41.	THERMOMETER *(Not Payable)*
42.	CERVICAL COLLAR *(Not Payable)*
43.	SPLINT *(Not Payable)*
44.	DIABETIC FOOTWEAR *(Not Payable)*
45.	KNEE BRACES (LONG/ SHORT/ HINGED) *(Not Payable)*
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER *(Not Payable)*
47.	LUMBO SACRAL BELT *(Payable only where Insured has undergone Surgery of Lumbar Spine)*
48.	NIMBUS BED OR WATER OR AIR BED CHARGES *(Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at reasonable cost of approximately Rs. 200 / day*

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

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

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

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

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

Sl No.	Item
1	HAIR REMOVAL CREAM *(Not Payable)*
2	DISPOSABLES RAZORS CHARGES (for site preparations) *(Payable for site preparations)*
3	EYE PAD *(Not Payable)*
4	EYE SHIELD *(Not Payable)*
5	CAMERA COVER *(Not Payable)*
6	DVD, CD CHARGES *(Payable only if CD is specifically sought by Insurer/TPA)*
7	GAUSE SOFT *(Not Payable)*
8	GAUZE *(Not Payable)*
9	WARD AND THEATRE BOOKING CHARGE *(Payable Under OT Charges, Not Payable Separately)*
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS *(Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)*
11	MICROSCOPE COVER *(Payable Under OT Charges, Not Payable Separately)*
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER *(Payable Under OT Charges, Not Payable Separately)*
13	SURGICAL DRILL *(Payable Under OT Charges, Not Payable Separately)*
14	EYE KIT *(Payable Under OT Charges, Not Payable Separately)*
15	EYE DRAPE *(Payable Under OT Charges, Not Payable Separately)*
16	X-RAY FILM *(Payable Under Radiology Charges, Not as Consumable)*
17	BOYLES APPARATUS CHARGES *(Part Of OT Charges, Not Separately)*
18	COTTON *(Not Payable-Part of Dressing Charges)*
19	COTTON BANDAGE *(Not Payable-Part of Dressing Charges)*
20	SURGICAL TAPE *(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)*
21	APRON *(Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)*
22	TORNIQUET *Not payable (service is charged by hospital, consumables cannot be separately charged.*
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES *(Not Payable)*
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE *Unless A Claim Is Accepted Under Section1 - A. Accidental Hospitalization Cover And/Or B. Accidental & Illness Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(Device Not Payable)*
7	INFUSION PUMP- COST *(Device Not Payable)*
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES *(Patient diet provided by*

	hospital is payable)
10	HIV KIT *(Payable Only as Pre-Operative Screening)*
11	ANTISEPTIC MOUTHWASH *(Payable when prescribed)*
12	LOZENGES *(Payable when prescribed)*
13	MOUTH PAINT *(Payable when prescribed)*
14	VACCINATION CHARGES *(Except to the extent covered under SECTION 6. MATERNITY BENEFIT & NEW BORN BABY COVER if opted & For dog or animal bite)*
15	ALCOHOL SWABES *(Not Payable. Part of hospital's own internal cost)*
16	SCRUB SOLUTIONISTERILLIUM *(Not Payable. Part of hospital's own internal cost)*
17	Glucometer& Strips *(Not Payable pre hospitalization or post hospitalization / Reports and Charts required/ Device not payable)*
18	URINE BAG *(Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs)*

List V – Additional Non-Payable Items

Sr. No	List of Expenses Generally Excluded ("Non-medical")
1.	Brush
2.	Cosy Towel
3.	Moisturiser Paste Brush
4.	Powder
5.	Barber Charges
6.	Oil Charges
7.	Bed Under Pad Charges
8.	Cost Of Spectacles/ Contact Lenses/ Hearing Aids, Etc.,
9.	Dental Treatment Expenses That Do Not Require Hospitalisation
10.	Home Visit Charges
11.	Donor Screening Charges
12.	Band Aids, Bandages, Sterile Injections, Needles, Syringes
13.	Blade
14.	Maintenance Charges
15.	Preparation Charges
16.	Washing Charges
17.	Medicine Box
18.	Commode
19.	Digestion Gels
20.	Novarapid
21.	Volini Gel/ Analgesic Gel
22.	Zytee Gel
23.	AHD (Ancillary And Hospital Disinfection (Eg.,Biomedical Waste Disposal/Management, Sanitation, Sanitization/Fumigation Charges Etc.)
24.	Visco Belt Charges
25.	Examination Gloves
26.	Outstation Consultant's/ Surgeon's Fees
27.	Paper Gloves
28.	Referral Doctor's Fees
29.	Sofnet
30.	Softovac
31.	Stockings

Annexure B

Address and contact number of Council For Insurance Ombudsman

Office Location	Contact Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 – 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi,

		Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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