Digit Top-Up Policy

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 1800-258-4242 or mail **Us** at healthclaims@godigit.com.

A. PREAMBLE

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

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

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule to know exact details of Sections as per plan 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 in 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 spell / words that instil power of understanding this policy better. Abra..ca..dabra!*** 🤩

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.
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. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
15. **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.
16. **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.
17. **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.
18. **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.
19. **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;
20. **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.

21. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        1. it needsongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        2. it needs ongoing or long-term control or relief of symptoms
        3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        4. it continues indefinitely
        5. it recurs or is likely to recur
22. **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.
23. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
24. **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.
25. **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.
26. **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.
27. **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.
28. **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.
29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
30. **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.
31. **Medical Practitioner/Doctor** 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.
32. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    a. is required for the medical management of the illness or injury suffered by the insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a medical practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

33. **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..
34. **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.
35. **New-born Baby** means baby born during the Policy Period and is aged upto 90 days.
36. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
37. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
38. **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.
39. **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
40. **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.
41. **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**.**
42. **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.
43. **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.
44. **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.
45. **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.
46. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
47. **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.
48. **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.
49. **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

50. **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. A deductible does not reduce the Sum Insured.
    The deductible will be applicable on per claim basis or in aggregate (as per plan opted by You) towards hospitalization expenses incurred which are admissible under this Policy (and not excluded) during the Policy Year by Insured Person (individual policy) or insured family (in case of floater policy).
51. **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.
52. **Policy** means the Proposal, the Policy Schedule (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
53. **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. For policies having annual term, Policy Period and Policy Year will be same. “Policy Year” term is used for long term policies.
54. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
55. **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.
56. **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.
57. **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.
58. **Sum Insured** means the amount as per plan opted by You and stated in the Policy Schedule for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy.
59. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
60. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule Members who has concluded this Policy with Us.

CRITICAL ILLNESS DEFINITIONS

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 leukaemia, 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 behaviour, 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 tumours 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

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:
Angioplasty and/or any other intra-arterial procedures

6. END STAGE LUNG FAILURE

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

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 t transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

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

II. **The following are excluded:**
   a. Other stem-cell transplants
   b. Where only Islets of Langerhans are transplanted

10. BENIGN BRAIN TUMOR

I. Benign brain tumour 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:
   Spinal cord injury;

13. PERMANENT PARALYSIS OF LIMBS

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

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

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

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

II. Neurological damage due to SLE is excluded.

II. SPECIFIC DEFINITIONS:

17. SURGERY TO AORTA

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

18. APALLIC SYNDROME

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

19. LOSS OF INDEPENDENT EXISTENCE

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

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

20. APLASTIC ANAEMIA

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

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

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

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

C. BENEFITS COVERED UNDER THE POLICY

I. BASE COVERAGE

SECTION 1. HOSPITALIZATION COVER

Under this section, **We** will pay You for the following as specified on the policy document, subject to **Deductible**. **Deductible** is a cost sharing requirement under this policy that provides that the **Company** will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the **Company**. A **Deductible** does not reduce the **Sum Insured**.
Under this policy, the **Deductible** will be applicable in aggregate/per claim (as per plan opted by You).

1.1. In-Patient Hospitalization

Digit Simplification: ***Hospital days can be exhausting. We understand this. That's why, we strive to make your days comfortable. After all, you are at the hospital to recover. Our Hospitalisation Cover is one such ray of hope that makes your stay comfortable, so that you only focus on getting healthy!***

If 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 upto the **Sum Insured** as mentioned in **Your Policy Schedule** and as per plan opted by **You,** subject to the **Deductible** as mentioned in **Policy Schedule**.
The claim can be made under the following benefits as mentioned below:

Accommodation/Room Rent	Room Rent & Proportionate deduction: Insured Person is eligible for Room Rent category of up to Single Standard Private AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/ payment of Room Rent charges including all Associated Medical Expenses incurred at Hospital shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges except for the cost of medicines and consumables. This condition is not applicable in respect of Hospitals where differential billing for associated Medical Expenses is not followed based on Room Rent.
ICU	Intensive Care Unit ***when you require continuous monitoring or life support***
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

1.2. Day Care Procedures

Digit Simplification: ***Technology has speed up healthcare. Get covered for treatments such as, shoulder dislocation, dialysis, etc. that are completed in a day. Say bye to hospital staff as soon as you get your treatment done! No more staying in the hospital overnight.***

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 Procedures

Note - This is NOT OPD: Treatment normally taken on an out-patient basis (OPD) is NOT included in the scope of this Cover.

This space needs your special attention!

✗: Day to day doctors' consultations and minor treatments such as stiches and plaster for fractures, etc. are not covered.

☺: Pre and post expenses related to day care procedures will be covered under this section.

1.3. Pre-Hospitalization

Digit Simplification: There is so much to be taken care of before you get on the hospital bed. Doctors may recommend various tests and medication 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. So that you have a smooth treatment without looking into your pocket!

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as 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- Hospitalization Cover** of this **Policy**.

This space needs your special attention!

✗: Medical expenses which are not related to the current treatment for which you're admitted in the hospital are not covered.

☺: Expenses related to the hospitalization such as X-rays, CT scans, MRIs, investigative procedures, medication, etc., are covered for 30-60 days prior to the date of your hospitalisation, as per your chosen plan.

1.4. Post-Hospitalization

Digit Simplification: After treatment, do nothing but rest & recover. 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 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- Hospitalization Cover** of this **Policy**.

This space needs your special attention!

✗: Medical expenses which are not related to the current hospitalization are not covered.

😊: Just look at the bright side of recovering with this cover. Expenses related to hospitalization such as follow-up treatments, medical consultations, diagnostic tests, medication, etc., are covered for 60-90 days from the date of your discharge, as per your chosen plan.

1.5. Road Ambulance

Digit Simplification: Get reimbursed for the expenses of road ambulance, in case of emergency hospitalization. Please note: 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. Hospitalization Cover.**
b) The maximum liability per **Policy Year** is restricted to the amount as mentioned in **Your Policy Schedule**.
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.

😊: Don't worry if You spend for an ambulance in case of a health emergency, because it'll be reimbursed by Us!

1.6. Bariatric Surgery

Digit Simplification: Obesity may be the root cause of so many health issues. We absolutely 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 for cosmetic reasons.

If **You** are hospitalized for a Bariatric Surgery which is medically necessary, on the advice of a **Medical Practitioner**, **We** will cover the related **Medical Expenses** subject to maximum of Sum Insured limit mentioned in the Policy Schedule against this cover and 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
     - 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 apnoea (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
- Any similar procedures used which qualifies for Bariatric treatment and approved by relevant authority.

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

e) If **You** are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if **You** are adding this cover while renewing our health policy, a fresh waiting period as opted by **You** and mentioned in **Your Policy Schedul**e will be applied.

f) Confirmation from **Medical Practitioner** / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity.

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

h) A prior approval should be taken from **Us** before the Bariatric Surgery is performed.

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.

This section needs your special attention!

✗: Bariatric surgery for treating obesity caused due to hormonal imbalance, psychiatric and bad eating habits is not covered.

😊: Treatment for obesity with an underlying medical condition like uncontrolled diabetes, heart disease etc., is covered.

1.7. Psychiatric Illness

Digit Simplification: Never ignore your mental health. Just breathe. Because we're here to cover you for expenses related to psychiatric disorders and illnesses.

We will pay 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) Waiting period for this cover for the below mentioned ICD codes shall be as per the '"**Specific Waiting Period**'" stated in **Your Policy Schedule** 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 Illness** Cover 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) If **You** are porting an existing policy under **Portability** Guidelines, from some other General or Health Insurance Company where this cover was not there or if you are adding this cover while renewing our health

policy, a fresh waiting period as opted by **You** and mentioned in **Your Policy Schedule / Certificate of Insurance** will be applied.

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

This section needs your special attention!

✗: This does not cover psychologist and psychiatric therapy expenses unless you are hospitalized with such a condition.

😊: Hospitalisation related to mental illness is covered.

SECTION 2. LONG HOSPITALIZATION CASH BENEFIT

Digit Simplification: Hospitalised for more than 10 days? Well, it can be exhausting, we understand. As a token of our care, we provide a lump sum amount of ₹10,000 on the completion of 10th day of your hospitalization to help you ease the burden.

If **You** are Hospitalized for a minimum number of consecutive days as 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 1.1. In-Patient Hospitalization,** 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, co-payment, limitations and exclusions mentioned in the **Policy**.

This section needs your special attention!

✗: To be eligible for this benefit, it's important that we have approved your claim under In-Patient Hospitalisation. If not, unfortunately, you won't be able to take advantage of this section.

😊: This section covers all the insured persons of the policy. Each person can enjoy this benefit once during the policy period.

SECTION 3: ORGAN DONOR EXPENSES

Digit Simplification: Your organ donor gets covered in your policy. We also take care of the pre and post hospitalization expenses of the donor. Organ donating is one of the kindest deeds ever and we thought to ourselves, why not be a part of it!

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 plan opted and availability of the Sum Insured under **Section 1. 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**" stated in **Your Policy Schedule** 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.

f) If **You** are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if **You** are adding this cover while renewing our health policy, a fresh waiting period as opted by **You** and mentioned in **Your Policy Schedule / Certificate of Insurance** will be applied.

Provided that, **We** have accepted a claim under **Section 1. 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!

✗: 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 - HOME (DOMICILIARY) HOSPITALIZATION

Digit Simplification: Hospitals can go out of beds, or the patient's condition may be rough to get admitted in a hospital. Don't panic! We cover you for the medical expenses even if you get treatment at home.

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- 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!

✗: If you are home hospitalised for a period less than 3 days, then the expenses for your treatment will not be payable.

😊: Medical consultation charges, tests and medical expenses can be reimbursed for the treatment taken at home.

SECTION 5. EMERGENCY AIR AMBULANCE

Digit Simplification: There may be emergency life-threatening health conditions which may require immediate transportation to hospital. We absolutely understand this and reimburse for expenses incurred for your transportation to a hospital in airplane or helicopter.

We will pay **You** the expenses incurred for **Your** transportation to the nearest hospital in an airplane or helicopter (registered Air Ambulance Service Provider) for emergency life threatening health conditions which requires immediate and rapid ambulance transportation.

Provided that,

1. **We** have accepted a claim under Section 1. Hospitalization Cover.
2. This transportation will be from the location where the **Illness /Accident** happened the first time and subject to availability of **Sum Insured** as mentioned in **Your Policy Schedule** against Section 1 and as per plan opted by **You**.
3. Such Transportation in an airplane or helicopter has been prescribed by a **Medical Practitioner** and/or is Medically Necessary.

Conditions applicable to Emergency Air Ambulance

1. Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.
2. The **Insured Person** should be in India when the emergency life threatening health condition arises.
3. The Air ambulance services will be limited within India only and NOT overseas in any condition whatsoever.
4. For cases where transportation to the hospital is possible through road ambulance then claim should not be admissible under this section unless it is prescribed by Medical Practitioner.
5. Prior approval should be taken from **Us** for availing Air Ambulance Services.

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.

😊: When your health requires immediate attention during an emergency life threatening health condition, don't panic, we are there for you!

SECTION 6. PERSONAL ACCIDENT

Digit Simplification: Some accidents can result in one's death within 12 months from date of Accident. In such cases, we pay 100% of the sum insured to the nominee.

If **You** sustain an Accidental Bodily Injury during the **Policy Period**, which is the sole and direct cause of **Your** Death within twelve (12) months from the date of accident, then We will pay 100% of the **Sum Insured** as mentioned in **Policy Schedule** against this cover and as per plan opted.

Under this section, claim will also be payable for the below mentioned events:

a. Disappearance:, If the Insured Person's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Person was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such **Insured Person** has died as a result of an Accidental Injury.

Digit Simplification: We will be liable to pay if the insured's full body cannot be located within a period of 12 months consecutively and if we have all the reasons to believe that the person has died due to an accident.

b. Drowning: If the Insured Person's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the **Policy Period**, where it is reasonable to believe that such **Insured Person** has died as a result of drowning.

Digit Simplification: We will be liable to pay if the insured's full body cannot be located within a period of 12 months consecutively and if we have all the reasons to believe that the person has died due to drowning.

For both (a) and (b) above, **We** will only pay, when the nominee or the legal heir provides a legally binding indemnity bond or any other document as required by **Us** which guarantees, that, if at any time, after the payment of the Accidental death benefit, it is discovered that the **Insured Person** is still alive, all payments shall be repaid in full to **Us.**

Digit Simplification: If later, it is found that the insured person is still alive, then all the money that was paid by us will have to be repaid to us in full.

1. This benefit will be applicable only to the proposer of the **Policy during** the **Policy Period**. In case if proposer is not covered in the policy this benefit will be applicable to the eldest member of the **Policy** during the **Policy Period.** This is applicable for both individual base sum insured as well as floater-based **Sum Insured** policy.
2. Once a claim has been accepted under this Section, this **Policy** will immediately and automatically cease in respect of that Particular **Insured Person**.

Digit Simplification: This policy will no longer exist for the insured person for whom the claim was made under Accidental death.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the **Policy**.

This section needs your special attention!

✕: **Person other than proposer or the eldest member of the family (as applicable) is not covered under this section.**

😊 **: This cover is over and above the indemnity sum-insured and expenses incurred in treatment.**

SECTION 7. CRITICAL ILLNESS BENEFIT

Digit Simplification: 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.

P.S. – This coverage is only for the proposer. In case the proposer is not insured then the eldest member of the family will be covered under this section, ensuring that the necessary support is extended to your loved ones when they need it the most.

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 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 30 days 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 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, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.
f) This benefit will be applicable only to the proposer of the **Policy during** the **Policy Period**. In case if proposer is not covered in the **Policy** this benefit will be applicable to the eldest member of the **Policy** during the **Policy Period.** This is applicable for both individual base sum insured as well as floater-based **Sum Insured** policy.
g) Once a claim has been accepted under this Section, this section will immediately and automatically cease in respect of that Particular **Insured Person**.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the **Policy**.

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, instead of the Sum-insured amount, we give you a lump sum amount which can be utilized for your treatment.

SECTION 8 - NETWORK HOSPITAL DISCOUNT
(Applicable under Section 1 Hospitalization Cover)

Digit Simplification: Well, if you choose to be treated at our Network hospital, we have something for you. A discount! Add this cover for a discount on your policy!

Please note: After opting this cover, if you get treatment in a hospital that does not fall under our network hospitals, you'll be liable to pay a percentage of amount [Co-pay] as mentioned in your policy schedule.

If **You** have opted for this Cover, **You** will be eligible for premium discount of 10% as You agree for hospitalization* in Our network hospitals only. In case, **You** are hospitalized in any of the non-network hospital, then **You** shall bear a co-payment of 20% on each and every admissible claim under Section 1.
*(under Section 1 Hospitalization Cover)

Specific Conditions applicable to this cover:

i. **Co-payment** will be applicable if **Insured Person** is hospitalized in non-network hospital and on admissible claim amount under Section 1.
ii. **Co-payment** will not be applicable in case of an accidental hospitalization and on capped ailments.
iii. For complete list of **Network Hospitals**, kindly refer Company's Website.

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

SECTION 9 – AYUSH HOSPITALIZATION
(Mandatory In-Built cover in Section-1 Hospitalization Cover)

Digit Simplification: Natural treatment has its own power! That is why, we cover your hospitalization expenses when you choose a registered AYUSH Hospital.

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** as mentioned in Your **Policy Schedule** against **Section 1. 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).

II. OPTIONAL COVERS

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

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

S.No.	Optional Covers	Section Admissibility
1	Consumables Cover	Section 1- Hospitalization Cover
2	Bariatric Surgery Limit Booster	Section 1- Hospitalization Cover
3	Psychiatric Illness Sub-Limit	Section 1 – Hospitalization Cover

Please note, the below cover is subject to terms, conditions, warranties, **Deductible**, co-payment, limitations and exclusions mentioned in the **Policy**.

1) CONSUMABLES COVER
(Applicable under Section 1 Hospitalization Cover)

***Digit Simplification:** Before, during & after hospitalization, there are many other medical aids & expenditures such as walking aids, 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 optional cover and on payment of additional premium and if **Your** claim is approved under **Section 1- Hospitalization Cover**, **We** will compensate for non-medical expenses incurred by **You** (You can check them under Annexure A below) during the Policy period directly related to the **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 – Hospitalization Cover.
Please note:

i. Coverage will be limited to the actual expenses incurred during the **Hospitalisation** but not paid under **Section 1 – Hospitalisation Cover** as Non-Medical expenses.
ii. In the Specific Exclusions section, 'Non-medical Expenses' as exclusion no. 25 will not be applicable if **You** have opted for this optional cover.

2) BARIATRIC SURGERY LIMIT BOOSTER
***Digit Simplification:** Your policy already covers you for 5% of your Sum Insured (SI) for Bariatric surgery. But by paying just a little extra premium for this optional cover, you can boost this limit to 20% or even 100% of your SI.*

If **You** have opted for this optional cover then the **Sum Insured** as mentioned under section "1.6 Bariatric Surgery" cover shall stand modified upto the percentage as mentioned in **Policy Schedule**.

3) PSYCHIATRIC ILLNESS SUB-LIMIT
***Digit Simplification:** If you are certain that you will not be diagnosed with a psychiatric illness, then this optional cover is for you! It allows you to choose a limit of either 5% or 10% of your Sum Insured specifically for this condition.*

If **You** have opted for this optional cover then the **Sum Insured** as mentioned under section "1.7 Psychiatric Surgery" cover shall be limited upto the percentage as opted by You and mentioned in **Policy Schedule**.

III. CUMULATIVE BONUS

***Digit Simplification:** No claims in the Policy year? You get a bonus - an additional amount in your total sum-insured for staying healthy & claim free!*

If **You**'ve been safe and healthy and have had No Claims made under the **Section 1. Hospitalization Cover** in the expiring **Policy Period**, **You** would be eligible for **Cumulative Bonus** at the time of renewal/or policy year completion in case of term more than one year as per plan opted and 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. For an individual **Sum Insured** policy, the **Cumulative Bonus** shall only be accrued for a member, if he/she has completed at least 12 months at the time of policy renewal.
7. In policies with a tenure of more than one year, the above guidelines of **Cumulative Bonus** shall be applicable post completion of each **Policy Year**.
8. The **Cumulative Bonus** will be Calculated on the **Sum Insured** as opted by **You** under **Section 1. Hospitalization Cover.**

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

This section needs your special attention!

X: You will not be able to use this benefit if there is a claim in expiring policy.

😊***: If there is no claim under the policy you will be rewarded with some bonus***

D. EXCLUSIONS

Digit Simplification: We have always been transparent. Time to discuss what you're not covered for or when you do not get a claim.

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

Digit Simplification: The pre-existing disease or condition that you disclosed, and we accepted before issuing the policy has a waiting period. This waiting period is based on the plan chosen by you and mentioned in your Policy Schedule.

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 per plan 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.
Digit Simplification: For instance, if you opt for ₹ 3,00,000 sum-insured at the start of your policy and after 2 years increases it to ₹ 5,00,000. Then, waiting period will be applicable on the enhanced sum-insured i.e., ₹ 2,00,000.
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

Digit Simplification: There are certain disease or procedures which has a specific waiting period as per plan opted by You.

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as per plan opted by You and specified in the Policy Schedule, of

continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures

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

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

xiii. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease
xiv. **Joint Replacement, Bariatric Surgery and Organ Transplant**
Any Medical Expenses incurred as a result of Joint Replacement, Bariatric Surgery and Organ Transplant Surgery will be covered subject to a waiting period as opted by You and mentioned in Your Policy Schedule as long as the Insured Person has been insured continuously under the Policy without any break, unless due to an accident.
xv. Chronic Kidney disease and Chronic Kidney failure,
xvi. Ischemic heart disease and Valvular heart diseases

3. Initial Waiting Period- Code- Excl03

Digit Simplification – You need to wait for a defined period from the first day of your policy to get covered for treatment related to any non-accidental illness.

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.

d. The waiting period for Critical illness irrespective of plan opted shall be 30 days.
e. List of critical illnesses in which this waiting period is applicable is mentioned 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

4. Investigation & Evaluation- Code- Excl04

Digit Simplification: You are not covered in case you get hospitalised only for investigation and evaluation purposes.

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

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

Digit Simplification: If you get hospitalised only for the purpose of bed rest and not to receive treatment, you do not get covered.

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 4 - Home (Domiciliary) Hospitalization** if opted by **You**.

6. Obesity/ Weight Control: Code- Excl06

Digit Simplification: Surgery related to weight loss is not covered until and unless it is advised by your doctor and is totally on medical grounds. Any surgery done just to enhance your outer appearance is not covered.

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 Apnoea
      iv. Uncontrolled Type2 Diabetes

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

Digit Simplification: Medical expenses related to treatment for changing characteristics of the body in order to change one's gender is not covered under your policy.

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

Digit Simplification: You are covered for plastic surgery only if it is medically necessary due to Accident, Burn or Cancer.

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

Digit Simplification: You are covered for hazardous or adventure sports only if you are not a professional in this field and have met with an accident under the supervision of a trained personnel.

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

Digit Simplification – Any claim reported from non-preferred hospital will not be considered. Please refer here for the list of the non-preferred hospitals:
https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/hospital-list-one-pager.pdf

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

12. Substance Abuse – Code- Excl12-

Digit Simplification – Any illness or injury arising while under the influence of drinking alcohol, taking drugs or any other type of addictive substance will not be covered.

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

13. Domestic Treatment- Code- Excl13-

Digit Simplification – Any treatment taken at a place which qualifies as a domestic treatment such as in spas, nature cure clinics etc, is not covered in your policy.

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.

14. Non-prescribed Medicine – Code- Excl14 –

Digit Simplification – Medicines and supplements such as vitamins, organic substances, minerals etc. which can be bought without doctor's prescription are not covered. P.S. – These are only covered if they're part of your hospitalization claim and prescribed by the doctor.

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.

15. Refractive Error: Code- Excl15

Digit Simplification – Only surgery for Refractive error more than 7.5 dioptres will be covered but expenses toward Implantable collamer lens will not be payable.

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

16. Unproven Treatments: Code- Excl16

Digit Simplification: Any treatment which is not approved/authorized by Medical Council of India or any other regulatory body within India is not covered.

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

Digit Simplification: Any treatment or medical expenses arising from Sterility or Infertility (a condition where a person is not able to produce offspring) is not covered.

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

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.

II. SPECIFIC EXCLUSIONS

19. Artificial Life Maintenance

Digit Simplification: Your policy does not cover Artificial Life Maintenance. This refers to ventilator support given to an individual who is in a vegetative state with an irreversible condition due to permanent damage.

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

Digit Simplification: We do not cover for hospitalisation arising due to intentionally harming yourself. Stay safe! Remember, there is always help available. Suicide is not the solution.

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

Digit Simplification – Aesthetic surgeries that are done to alter ones physical appearance not due to any illness but to enhance ones beauty or physical appeal are not covered.

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

Digit Simplification – Any condition that is since birth and is visible externally is not covered.

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geographical Limits

This Policy covers all treatments received within India. However, based on the plan opted, the Geographical limits will be extended to places outside India. Our liability will be to make Payment in Indian Rupees Only.

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

Digit Simplification – Expenses incurred on personal comfort during and related to hospitalisation as mentioned in Annexure A are covered only if the optional cover "Consumables Cover" is opted.

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. Preventive Treatment

Digit Simplification – Any treatment/therapy for example vaccination given to prevent any possible condition is not covered.

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;

27. 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.

28. Unjustified or Unwarranted Hospitalization

Digit Simplification – Hospitalisation only for investigations, diagnosis is not covered.

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section1 – Hospitalization Cover.**

29. 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.

30. Legal Liability

Digit Simplification – Any legal expenses incurred due to any fault or error at hospital's end is not covered.

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.

31. Substance abuse and Addictions by the Insured

Digit Simplification – Any expenses incurred on the hospitalisation caused due to the influence of substances such as drugs, alcohol etc. are not covered.

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

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

SPECIFIC ONES (CAN'T BE WAIVED)

32. Ear, Eyesight & Optical Services

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

33. Prosthetics and other devices

Digit Simplification – Expenses related to supporting devices such as wheelchair, artificial limbs etc. which can be removed and can be reusable are not covered.

Prosthetics and other devices NOT implanted internally by surgery.

34. 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. 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
    Digit Simplification - The tests that confirm only the possibility of severity of disease is not covered.

35. New Age Treatment

Digit Simplification - New age treatments such as Oral Chemotherapy, Stem Cell Therapy etc. can be covered only upto 50% of the Sum Insured.

Our Maximum Liability in respect of the following procedures or new age treatments 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. 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.

36. Dental Treatment

Digit Simplification: We only cover for the dental treatment expenses if you require hospitalisation due to accident.

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**.**

37. Organ Donor

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

38. Weight loss Surgery

***Digit Simplification: Any treatment that is related to your Bariatric Surgery is not covered unless covered under Section 1 – Hospitalization Cover*.**

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. Hospitalization Cover** which covers Bariatric Surgery.

39. Any loss arising out of the **Insured Person**'s actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES

Digit Simplification: Time to remind you some basic conditions that were taken up before we issued 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 take 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 in case of death –

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.

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

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

i. 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 be available** from the instalment premium payment due date till the date of receipt of premium by company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy

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

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

6. Withdrawal of Policy

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

7. Moratorium Period:

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on any grounds of non-disclosure and/or, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is

called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits**.** The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

8. 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

i. 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.

ii. 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, subject to the terms and conditions of the Policy.There will be no change in premium for other family members covered under the policy for the remaining duration of the policy.

ii.Family Floater Policy.

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

9. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

iv. 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.

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

10.Multiple Policies

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

11.Fraud

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

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

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

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

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

12.Claim Settlement (provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
b. In 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.

13.Complete Discharge

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

14.Renewal

i. The policy shall ordinarily be renewable provided the product is not withdrawn except on grounds of 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.

15.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

16.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.

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

17.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

18. Conversion to Indemnity Policy

Deductible option can be altered without any medical underwriting or pre policy medical check-up, subject to the following conditions:

i. This option can be availed only once in a lifetime and at the time of Renewal, post completion of 5 Policy Years; and
ii. The eldest member's Age in the Policy has not crossed 50 years.
iii. In case of waiver of Deductible, We will offer an option, at the time of renewal, to opt for an equivalent indemnity health insurance Policy (without any Deductible) offered by Us for same Sum Insured. Your current Policy will lapse in case You exercise the option of waiver of Deductible.

19.Alterations to the Policy

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

20.Non-Disclosure or Misrepresentation:

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

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

21.Insured Person

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

22.Arbitration

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

23.Claims Notification and Procedure

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

A. Cashless Claim Process:

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

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.

c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India (except for Section 5 – Worldwide coverage where treatment can be taken outside 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 pay 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	Personal Accident	Critical Illness
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 payment receipt			×
7	Original Pharmacy Bills	√	×	×
8	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	×	×
9	Consultation Papers	√	×	√
10	Investigation Reports	√	×	√
11	Digital Images/CDs of the Investigation Procedures (if required)	√	×	×
12	MLC/FIR Report (If applicable)	√	×	√
13	Original Invoice/Sticker (If applicable)	√	×	×
14	Post Mortem Report (If applicable)	√	√	×

15	Disability Certificate (If applicable)	√	×	√
16	Attending Physician Certificate (If applicable)	√	×	√
17	Ante-natal Record (If applicable)	√	×	×
18	Birth discharge Summary (If applicable)	√	×	×
19	Death Certificate (If applicable)	√	√	√
20	Burial Certificate	×	√	×
21	Attested Copy of Statement of Witness, if any lodged with police authorities	×	√	×
22	Attested Copy of FIR / Panchnama / Inquest Panchnama	×	√	×
23	Attested Copy of Viscera report if any (Only if Post-mortem is conducted)	×	√	×
24	*KYC (Photo ID card) (If applicable)	√	√	√
25	Address Proof	√	√	√
26	Proof of previous claims during the Policy Period	√	×	×
27	Bank Details with Cancelled Cheque	√	√	√
28	Additional documents on case-to-case basis	√	√	√

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 may be considered where the reason for delay is proved to our satisfaction.

Insufficient Document

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

*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, address and ID proof is required

24.Sum Insured Enhancement/Plan Change

a. Sum Insured enhancement/Plan Change 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 or plan change 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 from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

25.Continuity Benefits

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

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

Annexure-A

List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(Payable in cases 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
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,	West Bengal, Sikkim,

	KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	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

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

Plan Chart:

Sections	Coverages	Silver Top Up	Gold Super Top Up	Diamond Super Top Up	Platinum Super Top Up	Flex Plan*
Base Coverages						
I	**Hospitalization Cover**					
1.1	In patient hospitalization	Upto Single Standard Private AC Room	Upto Single Standard Private AC Room	Upto Single Standard Private AC Room	Upto Single Standard Private AC Room	Upto Single Standard Private AC Room
1.2	Day Care Procedures	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured
1.3	Pre-Hospitalization	30 days	30 days	30 days	60 days	30 days/60 days
1.4	Post Hospitalization	60 days	60 days	60 days	90 days	60 days/90 days
1.5	Road Ambulance	Covered upto INR 5,000	Covered upto INR 5,000	Covered upto INR 10,000	Covered upto INR 10,000	Covered upto INR 5,000/10,000
1.6	Bariatric Surgery	Covered upto 5% of Sum Insured	Covered upto 5% of Sum Insured	Covered upto 5% of Sum Insured	Covered upto 5% of Sum Insured	Covered upto 5% of Sum Insured
1.7	Psychiatric Illness	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
2	Long Hospitalization	Not Covered	Not Covered	Not Covered	Not Covered	Not covered/ (INR 10,000 with 10 days deductible)
3	Organ Donor Expenses	Not Covered	Not Covered	Covered upto 100% of SI	Covered upto 100% of SI	Not covered/100% of Sum Insured
4	Home (Domiciliary Hospitalization)	Not Covered	Not Covered	Not Covered	Not Covered	Not covered/ 100% of Sum Insured
5	Emergency Air Ambulance	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered/ 100% of Sum Insured
6	Personal Accident	Not Covered	Not Covered	Not Covered	Not Covered	Not covered/ Upto Sum Insured
7	Critical Illness Benefit	Not Covered	Not Covered	Not Covered	Not Covered	Not covered/ Upto Sum Insured
8	Network Hospital Discount	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered / Covered
9	AYUSH Hospitalization (Mandatory In-Built cover in Section-1 Hospitalization Cover)	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured
Optional Coverage						
1	Consumables Cover	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured	Upto the Sum Insured

2	Bariatric Surgery Limit Booster	20% of Sum Insured/ 100% of Sum Insured	20% of Sum Insured/ 100% of Sum Insured	20% of Sum Insured/ 100% of Sum Insured	20% of SI/ 100% of SI	20% of SI/ 100% of SI
3	Psychiatric Illness Sub-Limit	5%/ 10% of Sum Insured	5%/ 10% of Sum Insured	5%/ 10% of Sum Insured	5%/ 10% of Sum Insured	5%/ 10% of Sum Insured
Other Features						
1	Cumulative Bonus	Not Covered	Not Covered	5% per claim free year, Max 100%	10% per claim free year, Max 100%	Not Covered/ (5% max 100%), (10% max 100%), (50% max 100%)
2	Initial Waiting Period	30 days	30 days	30 days	30 days	30 days
3	Specific Disease Waiting period	2 Years	2 Years	2 Years	2 Years	2 Years/ 1 year/9/6/3/0 months
4	Pre-existing Waiting Period	3 Years	3 Years	3 Years	3 Years	3 Years/2 years/1 year/9/6/3/0 months
5	Co-Payment	0%	0%	0%	0%	0%, 5%, 10%

Note:

"Silver Top Up" Plan is available on per claims deductible basis, while other plans (ie. Gold Super Top up, Diamond Super Top Up and Platinum Super Top Up) are available on aggregate claims deductible basis. Silver Top Up, Gold Super Top up, Diamond Super Top Up and Platinum Super Top Up Plans are fixed plans and no changes in coverage provided under the plans are allowed.

*Flex plan is not a fixed plan and can be customized as per customer's requirement. Options available in Flex Plan are mentioned in the table and customer can choose from the option(s) provided under the said plan. Flex Plan can be opted on per claims deductible basis or on aggregate claims deductible basis.