

DIGIT LIFE HEALTHY GLOW POLICY

(Health Plus Life Combi Product from Go Digit General Insurance Ltd. and Go Digit Life Insurance Ltd.)

PROSPECTUS

UIN: GODHLIP25032V012425

Product Introduction

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

Key Features of this Product

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

Points to Note:

- The product is jointly offered by “Go Digit General Insurance Ltd” and “Go Digit Life Insurance Ltd.”
- You will purchase two policies, I. Digit Health Insurance Policy offered by Go Digit General Insurance Limited & II. Digit Glow Term Life Insurance offered by Go Digit Life Insurance Limited as part of this combo solution.
- You will receive the policy benefits as applicable for all the two policies as per standard terms & conditions of the respective products.
- The risks under the components of the Combi Product are distinct. Go Digit Life Insurance Ltd shall assume/accept the risk only in relation to the life insurance component of the Combi Product and Go Digit General Insurance Ltd shall assume/accept the risk only in relation to the health insurance component of the Combi Product.
- The premium of the life insurance and health insurance components of the Combi Product are separate and have been separately identified and disclosed in the Combi Product policy document. The health insurance component of the Combi Product is entitled to be renewed at the option of the policyholder of Go Digit General Insurance Ltd.
- You shall pay the integrated premium for the Combi Product to either of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. The insurer receiving the consolidated premium shall further transfer the relevant share of the premium to the other insurer. You shall be entitled to the underlying benefits of both life and health insurance components of the Combi Product from the date and time of acceptance of the integrated premium by Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd.
- The Combi Product shall have a free look option, which shall be applied to the Combi Product as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.
- At any time during the validity of the Combi Product policy, you shall be entitled to continue with either part of the Combi Product policy, discontinuing the other.
- The liability to settle the claim vests with respective Insurers, i.e., for life insurance benefits, Go Digit Life Insurance Ltd and for health insurance benefits, Go Digit General Insurance Ltd.
- All policy servicing requests pertaining to the Combi Product shall be received by either of the Insurers. However, Go Digit General Insurance Ltd, as the Lead Insurer of the Combi Product, shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.
- All requests pertaining to the Combi Product impacting premium or policy terms of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be serviced by Go Digit Life Insurance Ltd for life products and by Go Digit General Insurance Ltd for health products, as the case may be.
- Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall fulfil servicing requests received by them in accordance with the IRDAI (Protection of Policyholders’ Interests, Operations and Allied Matters of Insurers) Regulations, 2024, as amended from time to time. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective life insurance or health insurance components of the Combi Product. The claim process is available on the website of both Go Digit Life Insurance Ltd and Go Digit General Insurance Ltd.
- You may lodge a grievance with respect to either or both of the life insurance and health insurance components of the Combi Product at branches of either Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. Complaint belonging to any product shall be routed to the respective insurer viz. Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd, who shall then respond/address to the Customer directly. Complaints shall be forwarded by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd to each other for their respective Product. In the event you are not satisfied with the resolution offered, you may also approach the Insurance Ombudsman in your region. Please refer to the relevant grievance redressal mechanism section mentioned under each component of the Combi Product.

- The legal/quasi legal disputes, if any, are dealt by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd for their respective benefits. The legal disputes pertaining to life insurance benefits shall be dealt with by Go Digit Life Insurance Ltd and for health benefits all the legal disputes will be handled by Go Digit General Insurance Ltd.
- You are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.
- Withdrawal of tie up between the Insurers:

Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up between them after obtaining the requisite approval from the IRDAI. Upon receipt of such approval from the IRDAI, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up with notice period of ninety (90) days, or such other period as may be prescribed by the IRDAI, from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.

In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, with respect to health cover policy, the same will be subject to Migration guidelines.

In the event of termination of this tie up, Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall mutually cooperate for providing customer support and policy servicing post termination of the tie up between Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. Further, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd, as the case may be, shall remain liable for its respective life insurance or health insurance components for all Combi Product policies in force at the time of termination of this tie up until their expiry.

I. DIGIT HEALTH INSURANCE POLICY

What is covered under Digit Health Insurance Policy?

The coverage under this policy is as mentioned below:

SECTION 1. HOSPITALIZATION COVER

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. The claim can be made under the following benefits as mentioned below:

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room.
ICU	Intensive Care Unit when you require continuous monitoring and 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 is NOT included in the scope of this Cover.

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.

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.

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.

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 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) \geq 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 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 Schedule / Certificate of Insurance will be applied.
- f) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity.
- 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.
For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity.

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 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.

1.8. Health Check Up

Digit Simplification: We pay for your health check-up expenses up to the amount mentioned in your Plan. No restrictions on the kind of tests! Be it ECG or Thyroid Profile. Make sure you go through your policy schedule to check the claim limit.

If You have continued Your Policy with Us without any break, then at the end of each block of continuous years (as per plan opted), We will pay the expenses incurred towards cost of health check-up up to the Limits Per Policy (excluding any cumulative bonus) as per plan opted and mentioned in Your Policy Schedule. This shall be paid, provided that:

- a. This benefit will not be carried forward if not utilized.
- b. You submit a duly filled and signed claim form along with original bills and copy of medical reports.
- c. In case of Family Floater policy, Health Check-up Sum Insured as mentioned in Policy Schedule is the maximum total cost including taxes which is available for all insured persons put together.

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

1.9. 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** and as per plan opted and mentioned in Policy Schedule.

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

SECTION 2: 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 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.

SECTION 3. 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.

SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN COVER

A. Maternity Benefit Wallet

Digit Simplification: Parent-hood is the best-hood! No wonder you get a reduced waiting period of just 9 months. Also, you may include this benefit in your policy before even planning a baby! Because we magically keep on increasing your maternity sum-insured at every renewal, up to a set limit of Rs 1,00,000 if no maternity claim is made. That too at no extra cost of premium!

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

- a) This also has a waiting period. Waiting period of 9 months shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
Digit Simplification: To start availing the benefits of this cover, you have to wait for a period of 9 months, provided that you have an on-going policy with us without any break.
- b) 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.
- c) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
- d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.
- e) Sum Insured under this section:
 - i. Maternity Sum Insured under this section will be INR 15,000 for First Policy Year.
Digit Simplification: For the first year, you are covered for Rs. 15,000. You may utilize this amount after 9 months from the inception of the Policy.
 - ii. If no claim has been made under this section during the Policy Year, You will be eligible for enhanced Maternity Sum Insured as per table provided below. No extra premium will be charged for this enhanced Maternity Sum Insured.

Policy Year	Maternity Sum Insured	Remarks
1 st Policy Year	15,000	If no claim is made in 1 st policy year then Sum Insured will be increased by INR 10,000 in 2 nd year.
2 nd Policy Year	15,000 + 10,000 = 25,000	Similarly, If no claim is made under this section in 2 nd policy year then Sum Insured will further be increased by INR 10,000 in 3 rd year.

iii. Third year onwards if no claim has been made under this section, then the Maternity Sum Insured will increase every year by INR 10,000 per policy year subject to maximum of INR 1,00,000.

iv. In case of a claim under this section Maternity Sum Insured on renewal/next Policy Year will go back to INR 15,000.

We shall not pay for the following under this Section:

- Expenses for the harvesting and storage of stem cells when carried out as a preventive measure against possible future illness.
- Medical Expenses for Ectopic Pregnancy will be covered under **Section 1. Hospitalization Cover** and not under the Section 4 - Maternity Benefit Wallet and New-born Cover.
- Pre-natal and Post-natal Medical Expenses are not covered.

B. New-born Cover

Digit Simplification: We treat your new-born as ours and provide all the love & care it needs! Your baby is covered upto 90 days from the date of delivery. This includes vaccinations as per National Immunization Schedule as defined by Government of India.

Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 4. A Maternity Benefit Wallet Section** of the Policy, provided that We have accepted a claim under **Section 4. A. Maternity Benefit Wallet**, incurred towards:

- The medical treatment of the Insured Person's New Born Baby while the Insured Person is hospitalised as an inpatient for delivery.
- The New Born Baby's hospitalisation charges as a result of any medical complications, up to 90 Days from the date of delivery.
- Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India, up to 90 Days from the date of delivery.
- If the Policy Expires before 90 days from the date of delivery, the New Born Baby will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of any additional premium.
- After 90 Days from the date of delivery, the New Born Baby will be covered under the existing Policy only if it is Endorsed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of the Pro-Rata Additional Premium, for the balance period.

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

SECTION 5: WORLDWIDE COVERAGE

Digit Simplification: Get a world class treatment with the Worldwide Coverage! If your doctor identifies an illness during your health examination in India and you wish to get a treatment abroad, then we're there for you. You're covered!

We will pay You for the Medical Expenses incurred by You outside India. This is up to the Sum Insured as mentioned in your Policy Schedule against this section and as per plan opted by You. The coverage under this section shall be limited to below mentioned covers:

Section 1	Hospitalization Cover
1.1	In-Patient Hospitalization
1.2	Day Care Procedures
Section 2	Organ Donor Expenses

Specific terms and conditions applicable to Section 5 – Worldwide Coverage:

- Claims will be payable on reimbursement basis only. For Cashless it will be decided on case-to case basis.
- Medical expenses under this cover will be payable if diagnosis is made in India and insured travels outside India for treatment.
- All the payments will be made in Indian Rupees only based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion.

4. Prior approval should be taken from Us for any treatment taken Outside India.
This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 6. SUM INSURED BACK UP

Digit Simplification: We will provide a back-up Sum Insured which will be 100% of your Sum Insured amount.

We shall provide you 100% of the Sum Insured as a backup under **Section 1. Hospitalization Cover** for that particular Policy Year, provided that:

- a) The backup Sum Insured would be utilized if the cause of the Hospitalization is related or not related (as per plan opted) to or arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy year for the same Insured Person.
- b) In case of related Hospitalization cooling off period of 45 days will be applicable. ***Interval between two related hospitalizations should be minimum 45 days.***
- c) The maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.**
- d) If the first claim amount exceeds the Sum Insured under **Section 1. Hospitalization Cover**, the backup Sum Insured will not be utilized for the same hospitalisation.
- e) The number of times the backup Sum Insured may be extended shall be as per the plan opted and mentioned in Your Policy Schedule against this Section during each Policy Period.
- f) In case of Floater Policy, the backup Sum Insured will be applicable on family floater basis.
- g) The Back-up Sum Insured can only be utilized for hospitalization in India only.

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

SECTION 7. IN-BUILT 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 death.

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

SECTION 8. AYUSH HOSPITALIZATION (Mandatory In-Built Cover In Section 01 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** and as per plan opted by You. 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).

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	Network Hospital Discount	Section 1- Hospitalization Cover
3	Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	Section 1 – Hospitalization Cover Section 2 – Organ Donor Expenses Section 3 – Emergency Ambulance Section 4 - Maternity Benefit Wallet and New-born Cover Section 5 – Worldwide Coverage

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

1) Consumables Cover

Digit Simplification: Before, during & after hospitalization, there are many more medical aids & expenditures to be taken care of. This covers the ones that are otherwise excluded from the policy like walking aids, crepe bandages, belts & more.

(Applicable under Section 1 Hospitalization Cover)

If You have opted for this cover and 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 and as per plan opted by You.

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 General Exclusions section, 'Non-medical Expenses' as exclusion no. 25 will not be applicable.

2) 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 optional 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.

3) Pre-existing Disease/Specific Disease/Initial Waiting Period Modification:

Digit Simplification: Restrictions on waiting period, pre-existing or specific diseases can be modified with this optional cover!

If You have opted for this cover then the waiting period as mentioned under exclusion D.I.1, D.I.2 and D.I.3 shall stand modified as mentioned in Policy Schedule.

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.

CARRY FORWARD SUM INSURED

(Available only if Cumulative Bonus is not opted)

Digit Simplification: Used a portion of your sum-insured or didn't use it at all? Then carry it to your next policy year with a maximum limit of 100% base sum-insured! No strings attached.

At the time of renewal/or policy year completion in case of term more than one year of the policy, sum insured under Section 1 - Hospitalization Cover of the renewed policy will be increased based on the unused base sum insured of Section 1 – Hospitalization Cover of the expiring policy, subject to the following:

- i. Maximum 100% of the unused Base Sum Insured will be carried forward at the time of renewal.
- ii. Maximum carried forward of unused Base Sum Insured, year on year, will be limited to 100% of Base Sum Insured of the expiring policy.
- iii. No cumulative bonus benefit will be provided under the product if this cover is opted.

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

PLEASE NOTE THE BELOW CONDITION AT THE TIME OF OPTING COVERAGES:

1. Both Individual and Floater Options are available.
2. Cumulative Bonus is applicable only for Section 1.
3. Separate Sum Insured will be available for Section 4 and Section 7
4. Section 2, Section 3, Section 5 and Section 7 Sum Insured will be linked with Sum Insured of Section 1 – Hospitalization Cover.
5. Geographical Limits can be opted outside India as per plan opted.

6. Family Definition

- a) Self, Spouse, Dependent Children, Grand Children, Parents, Sister, Brother, Father-in-Law, Mother In Law, Aunt, Uncle, can be covered on Individual Sum Insured Basis.
- b) Self, Spouse, Children & Grand Children can be covered under floater option. Member with the highest age will be considered for calculating Premium in floater option.

7. Zone Classification

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

Zone 1 Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan) and Greater Hyderabad Area

Zone 2 Rest of India apart from Zone 1 cities are classified as Zone 2.

- Zone opted by you is mentioned in your Policy Schedule.
- At the time of claim, Insured needs to provide address proof as per the declaration in proposal form.
- In the absence of Address proof provided which validates the pricing zone opted, and if the place of hospitalization belongs to Higher Zone Category – then Co-pay of 10% would be applicable on admissible claim amount.
- If address proof as per declaration in Proposal form and Address proof provided at the time of claim is same, Zone based Co-pay will not be applicable.
- Zone based Co-Pay, as mentioned above, will not be applicable in case of hospitalization due to Accidental Injury.

What are the exclusions under Digit Health Insurance Policy?

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 disease or condition that you are already suffering with and have disclosed to us before taking the policy and has been accepted by us has a waiting period as per plan opted 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 (not applicable for new-born baby),
- xii. Psychiatric illness and Disorders listed below:

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

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

xiv. Joint Replacement, Bariatric Surgery and Organ Transplant

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

3. 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 number of days as per plan opted and from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b. If you have opted for a plan which provides coverage outside India, then the waiting period for hospitalization outside India shall be 30 days.
- c. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- d. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
- e. The waiting period for Critical illness irrespective of plan opted shall be 30 days.
- f. 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

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

4. Investigation & Evaluation- Code- Excl04

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 1.9 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 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://d2h44aw715xdvz.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 health 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.

Please note: This exclusion stands deleted to the extent of the coverage provided under **SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS**19. Artificial Life Maintenance**

Digit Simplification: Artificial life maintenance means ventilator support to someone 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. Take care! 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;
- b. To the extent covered under **SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN BABY COVER** if opted by You.

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

We do not cover treatment for:

- a) 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 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 prostate (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 2. 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.

What are the Minimum & Maximum Entry age for Adults & Children?

Below is the Minimum & Maximum Entry age for Adults & Children:

Type	Entry Age	Minimum	Maximum
Hospitalization Cover	Proposer	18yrs	No Limit
	Child**	91days	No Limit
	Adult Insured	18yrs	No Limit

What is the minimum and maximum policy period available under this policy?

The Policy Period Options are 1 Year, 2 Years and 3 Years.

What are the Sum Insured options under this Policy?

Below mentioned are the Section wise Minimum and Maximum Sum Insured options available under this Policy:

Section Details	Sum Insured (INR)	
	Minimum	Maximum
SECTION 1 - Hospitalization Cover	2,00,000	3,00,00,000
SECTION 2 – Organ Donor Expenses	2,00,000	3,00,00,000
SECTION 2 - Emergency Air Ambulance Expenses	2,00,000	3,00,00,000
SECTION 3- Maternity Benefit Wallet and New-born Cover	15,000	1,00,000
SECTION 4 – Worldwide Cover/Global Cover	2,00,000	3,00,00,000

SECTION 5 - Sum Insured (SI) Restoration	2,00,000	3,00,000
SECTION 6. Accidental Death Benefit	50,000	1,00,000
SECTION 7. In built Personal Accident	50,000	1,00,000
SECTION 8 – Ayush Hospitalization (Mandatory In-Built Cover In Section 01 Hospitalization Cover)	2,00,000	3,00,00,000
OPTIONAL COVERS		
1. Consumable Covers	2,00,000	3,00,00,000
2. Network Hospital Discount	NA	NA
3. Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	NA	NA

How much premium, I have to pay to buy this policy?

You can contact us either through our call center or on our website or based on submission of complete proposal form, we will let you know the premium details

What are the waiting period and survival periods under this Policy?

There are various options for Waiting Period. You can choose the option of Your Choice:

Description	Waiting Period Options
Initial Waiting Period Option	7 days, 15 days, 30 days
Pre-existing Disease Waiting Period Options	0 months, 3 months, 6 months, 9 months, 1 Year, 2 Years, 3 Years
Specific Waiting period	0 months, 3 months, 6 months, 9 months, 1 Year, 2 years
Maternity Benefit Wallet and New-born Cover	9 months
Worldwide Cover Waiting period	30 days initial waiting period
Critical Illness Waiting Period	30 days initial waiting period

Are there any Sub-Limits under this Policy?

Yes, Section wise Sub-Limits are as mentioned below:

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

Section Details	Sub Limits (Options)
SECTION 1-HOSPITALIZATION COVER	
1.1 In Patient Hospitalization	
1.2 Day Care Procedures	NA
1.3 Pre-Hospitalization	NA
1.4 Post-Hospitalization	NA
1.5 Road Ambulance	1% of Section 1 Sum Insured Max up to the INR 10,000/15,000/20,000 as per plan opted
1.6 Bariatric Surgery	NA
1.7 Psychiatric Illness	NA
1.8 Health Check Up	Up to 0.25% of the Sum Insured (excluding any cumulative bonus) Subject to maximum of INR 1,000/1,500/2,000 Per Policy as per plan opted
1.9 Home (Domiciliary) Hospitalization	NA
SECTION 2. Organ Donor Expenses	NA. However donor's Pre and Post Hospitalization expenses up to 5% of the admissible harvesting expenses
SECTION 3. EMERGENCY AIR AMBULANCE	NA
SECTION 4. MATERNITY BENEFIT WALLET AND NEW -	NA

BORN COVER	
SECTION 5. WORLDWIDE COVERAGE	NA
SECTION 6. SUM INSURED BACK-UP	NA
SECTION 7. INBUILT PERSONAL ACCIDENT	NA
SECTION 8. AYUSH Hospitalization (Mandatory In-Built Cover In Section 01 Hospitalization Cover)	NA
OPTIONAL COVERS	
Consumables Cover	NA
Network Hospital Discount	NA
Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	NA

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

What are the Deductible/Co-payments under this Policy?

There are various Deductible/Co-payment options available under this Policy as mentioned below:

Name of the Benefit	Deductible allowed	If Yes, range of Deductible		Co-Pay allowed	If yes, range of Co-Pay	
		Min	Max		Min	Max
SECTION 1 – Hospitalization Cover	Yes	2500	50,000	NA	NA	NA
SECTION 2 – Organ Donor Expenses	Yes	2500	50,000	NA	NA	NA
SECTION 3- Emergency Air Ambulance Expenses	Yes	2500	50,000	NA	NA	NA
SECTION 4- Worldwide Coverage	Yes	2500	50,000	NA	NA	NA
SECTION 5. Maternity Benefit Wallet and New-Born Cover	Yes	2500	50,000	NA	NA	NA
SECTION 6. Sum Insured Back-up	NA	NA	NA	NA	NA	NA
SECTION 7. In Built Personal Accident	NA	NA	NA	NA	NA	NA
Network Hospital Discount (Co-pay will be applicable if treatment is taken in non-network hospital)	NA	NA	NA	Yes	0%	20%

Do I need to go undergo any medical test and who will bear the costs?

Based on the Proposal Form shared by You, we will advise if any medical tests are required. For all proposals accepted by US, We will bear the costs of pre-policy medical check-ups.

What are the discount/loadings available under this Policy?

Discounts/Loadings available under this Policy, are as below:

- 1. Long-Term Discount:** For 2 Years Policy: 7% & For 3 Years Policy: 10%. This Discount shall not be applicable in case of instalment premium.
- 2. Digit Loyalty Discount:** 5% discount will be offered on the policy premium, if the proposer has been a digit customer under both active and expired policy in any line of business. This discount will only be applicable at the time of enrolment.
- 3. Good Health Discount:** 5% discount will be offered on the Policy premium, if the insured declares himself as a healthy person and follow good health practices which may include but not limited to no Smoking/Tobacco, regular exercise, eating healthy diet and monitoring diet regularly. This discount will be applicable at the time of enrolment as well as at subsequent renewals.
- 4. Credit Score Discount:** 5% discount will be offered on the policy premium to the proposer with credit score above 750. In case the proposer is not an insured member, then Credit Score discount shall not be extended. This discount will be applicable at the time of enrolment as well as at subsequent renewals.
- 5. Corporate Discount:** 5% discount will be offered on policy premium, if proposer is already enrolled under their Company's

GMC (Group Medi Claim) policy. This discount will only be applicable at the time of enrolment.

6. **Early Renewal Discount:** 5% discount will be offered on Renewal premium, if proposer/Insured renews the policy at least 7 days prior to the Policy Expiry Date. This discount will only be applicable at the time of renewals.
7. **City Discount:** 10% discount will be offered on Policy premium, if proposer opts for Zone 2 (Rest of India apart from Delhi/NCR, Mumbai including Navi Mumbai, Thane and Kalyan). This discount will be applicable at the time of enrolment as well as at subsequent renewals.
8. **Family Discount:** In case of an individual policy, if 2 persons are insured under a single policy then 5% discount and if more than 2 persons are insured under a single policy then 10% discount will be offered on Policy premium. This discount will be applicable at the time of enrolment as well as at subsequent renewals.
9. **Network Hospital Discount:** 10% discount will be offered on premium, if insured opts for hospitalization in Network Hospitals only. This discount will be applicable at the time of enrolment as well as at subsequent renewals.
10. **Small Fixed Deductible Discount:** Discounts will be offered on the Policy premium basis the deductible opted by the proposer. This discount will be applicable at the time of enrolment as well as at subsequent renewals. The deductible shall be applicable on each claim under section 1,2,3 and 5.

Maximum capping of 20% is applicable for discounts including Network Hospital Discount, Credit Score Discount, Good health Discount, Digit Loyalty Discount, Corporate Discount, City Discount, Early Renewal Discount.

Is there any provision to enhance the Sum Insured under this Policy?

- i. Sum Insured enhancement can be done only at the time of renewal. You need to submit fresh proposal for Sum Insured Enhancement.
- ii. The acceptance of enhancement of Sum Insured would be at Our discretion, based on the health condition of the insured members & claim history of the policy.
- iii. 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.

Can I Change my Plan during the mid-term of the Policy?

No, mid-term change of plan is not allowed.

What are the renewal conditions under this Policy?

- i. The policy shall ordinarily be renewable except on grounds of fraud, 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.

What are benefits if I renew this Policy?

Below are the renewal benefits available if you renew this Policy:

- For Claim Free Renewals, Cumulative bonus opted at the inception of the first policy with us can't be changed during the policy period and subsequent renewals. Details of each are as given below: **Cumulative Bonus:**
 - 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.
 - We will be offering multiple options for Cumulative Bonus to the Insured to choose from. These options are:
 - Cumulative Bonus of 10% and 50% can be accrued each policy period up to a maximum of 100%.
 - In case a person enjoying Cumulative Bonus, makes a claim in a year, his cumulative Bonus will decrease by the same percentage, it increases each year.
- **Carry Forward Sum Insured**
(Available only if Cumulative Bonus is not opted)

At the time of renewal/or policy year completion in case of term more than one year of the policy, sum insured under Section 1 -Hospitalization Cover of the renewed policy will be increased based on the unused base sum insured of Section 1 – Hospitalization Cover of the expiring policy, subject to the following:

- i. Maximum 100% of the unused Base Sum Insured (i.e sum insured less any carry forward Sum Insured) will be carried forward at the time of renewal.
- ii. Maximum carried forward of unused Base Sum Insured, year on year, will be limited to 100% of Base Sum Insured of the expiring policy.
- iii. No cumulative bonus benefit will be provided under the product if this cover is opted.

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

What are the cancellation terms under this Policy?

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.

Free Look Period

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

The insured person shall be allowed free look period of thirty (30) days from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;
- 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.

What benefits are available if I transfer(renew) my policy from some other insurer to this Policy?

Continuity Benefits

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

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

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

Portability

In case of Indemnity based Insurance sections:

- 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.
- 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.
- The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
- 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

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.

Will I be informed about any revision or modification made to this Policy?

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.

What happens to my policy in case this Product is withdrawn?

- 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.
- 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

Can I pay premium in instalments and what are the term and conditions related to this?

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)

- 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.
- During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by company.
- 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.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

How do I make a claim under the Policy and what are the documents required?

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:

- 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.
- For Cashless Facility You shall follow the below Procedure:
 - Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
 - 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 reimburse the claim amount to Your Nominee as named in Your Policy Schedule or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Hospitalization Claim	Personal Accident
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	x	√
21	Attested Copy of Statement of Witness, if any lodged with police authorities	x	√
22	Attested Copy of FIR / Panchnama / Inquest Panchnama	x	√
23	Attested Copy of Viscera report if any (Only if Post Mortem is conducted)	x	√
24	*KYC (Photo ID card) (If applicable)	√	√
25	Address Proof		
26	Bank Details with Cancelled Cheque	√	√

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

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.

What Should I Do In Case of Any Grievance?

Customer Grievance Redressal Policy:

In case of any grievance the insured person may contact the company through

Website: <https://www.godigit.com>

Toll Free: 1-800-258- 4242

Email: hello@godigit.com

Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@godigit.com

For updated details of grievance officer, kindly refer the link: → [Click Here](#)

<https://www.godigit.com/claim/grievance-redressal-procedure>

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017

Grievance may also be lodged at IRDAI Integrated Grievance Management System- <https://irdai.gov.in/igms1>

INSURANCE ACT 1938 SECTION 41- Prohibition of Rebates

No person shall allow or offer to allow either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. ANY PERSON MAKING FAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKHS RUPEES.

IMPORTANT NOTE: Above is a summary of Coverage and Exclusions, please refer to detailed Policy Terms & Conditions and Policy Schedule for full description which shall prevail in the event of any claim/complaint/dispute.

Disclaimer: The description mentioned under "Digit Simplification" / "Examples" / throughout the Insurance Policy is only to aid your understanding of the coverage / benefit offered. In case of dispute, the terms and conditions detailed in the policy document and policy schedule shall prevail.

Plan Chart:

Sections	Coverages	Double Wallet Plan	Infinity Wallet Plan	Carry Forward Sum Insured Plan	Worldwide Treatment Plan	Early Start Plan	Senior Priority Plan
BASE COVERAGES							
	Sum Insured Options	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores
I	Hospitalization Cover						
i	Inpatient Hospitalization Cover	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent
ii	Day Care Procedures	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
iii	Pre-Hospitalization	30 days	60 days	90 days	60 days	30 days	30 days
iv	Post Hospitalization	60 days	180 days	180 days	180 days	60 days	60 days
v	Road Ambulance	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 15,000	1% of Sum Insured max upto INR 20,000	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 10,000
vi	Bariatric Surgery	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
vii	Psychiatric Illness	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
viii	Health Check-up	0.25% of Sum Insured max upto INR 1,000 after every two year	0.25% of Sum Insured max upto INR 1,500 after every year	0.25% of Sum Insured max upto INR 2,000 after every year	0.25% of Sum Insured max upto INR 2,000 after every year	0.25% of Sum Insured max upto INR 1,500 after every year	0.25% of Sum Insured max upto INR 1,500 after every year
x	Home (Domiciliary) Expenses	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
II	Organ Donor Expenses	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Not Applicable
III	Emergency Air Ambulance	Not Applicable	Upto B Sum Insured	Upto Sum Insured	Upto Sum Insured	Not Applicable	Not Applicable
IV	Maternity Benefit Wallet and New-born Cover	Not Applicable	Not Applicable	Not Applicable	Not Applicable	INR 15,000 it will increase by INR 10,000 per year maximum upto INR 1,00,000	Not Applicable
V	Worldwide Coverage	Not Applicable	Not Applicable	Not Applicable	Upto Sum Insured	Not Applicable	Not Applicable
VI	Sum Insured Back-up	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Unlimited Reinstatement in a policy period - related and unrelated illness	Upto Sum Insured Unlimited Reinstatement in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - Unrelated illness
VII	In-built Personal Accident	INR 50,000	INR 1,00,000	INR 1,00,000	INR 1,00,000	INR 1,00,000	Not Applicable
VIII	AYUSH Hospitalization (Mandatory In-Built Cover In Section 01 Hospitalization Cover)	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
OPTIONAL COVERAGES							
1	Consumables Cover	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
2	Network Hospital Discount	Available	Available	Available	Available	Available	Available

3	Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	Available	Available	Available	Available	Available	Available
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OTHER FEATURES

1	Cumulative Bonus	10% of sum insured per claim free year, Max upto 100%	50% of sum insured per claim free year, Max upto 100%	Not Applicable	50% of Sum Insured per claim free year, Max up to 100%	10% of sum insured per claim free year, Max upto 100%	10% of sum insured per claim free year, Max upto 100%
2	Carry Forward Sum Insured	Not Applicable	Not Applicable	Applicable	Not Applicable	Not Applicable	Not Applicable
3	Initial Waiting Period	7 days	7 days	7 days	7 days	30 days	30 days
4	Pre-existing Waiting Period	3 years	3 years	3 years	3 years	1 year	3 years
5	Specific Disease Waiting Period	2 years	2 years	2 years	2 years	1 year	2 years

Benefit illustration

Digit Health Insurance Plus Policy

Premium Illustration representing how the prices would vary for different family composition according to different age groups and policy types is mentioned below:

Plan Name	Double Wallet Plan			
Family Composition	2A+1C			
Sum Insured	3,00,00,000			
Policy Type	Floater	Individual		Ratio
Age of the members insured	Consolidated Premium for all members of the family	Premium	Consolidated Premium for all members of the family	
18	34,789	15,472	54,560	64%
38		19,544		
43		19,544		

Note:

Premium figures are for Digit Health Insurance Plus Policy containing features which are typically opted for by our website customers. Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable.

Rate Chart (Excluding GST)

Double Wallet Plan

Family Composition - 1A

76-80	65,377	73,018	80,660	84,905	1,01,886	1,10,377	1,17,169	1,27,358	1,46,886	1,68,112	1,93,584	2,22,451
81-85	80,900	90,356	99,812	1,05,065	1,26,078	1,36,585	1,44,990	1,57,598	1,81,763	2,08,029	2,39,548	2,75,270
86-120	99,069	1,10,648	1,22,228	1,28,661	1,54,393	1,67,259	1,77,552	1,92,991	2,22,584	2,54,749	2,93,347	3,37,092

II. DIGIT GLOW TERM LIFE INSURANCE

A Non-Linked, Non-Participating, Individual Pure Risk Premium Life Insurance Plan

(This product is also available for online sale)

Digit Glow Term Life Insurance is a pure risk premium plan that provides life insurance coverage to you for the chosen policy term and financially protects your family in your absence.

It also offers a range of other inbuilt optional benefits to provide financial protection against accidental death, total permanent disability and terminal illness and provides a comprehensive protection solution.

Key Features of the Plan

- Life Insurance Cover for financial security of your family
- Inbuilt Optional Benefits for protection against Accidental Death, Accidental Total and Permanent Disability and Terminal Illness
- Flexibility to pay premium only Once, pay for a limited period or pay regularly
- Option to pay the premium as per preferred premium payment frequency (Single, Annually, Half-Yearly, Quarterly, Monthly)
- Wellness Benefits to Life Assured

Please note: Premium will vary depending upon the variants/ options chosen.

Eligibility Conditions

Minimum Entry Age (as per last birthday)	18 years			
Maximum Entry Age (as per last birthday)	65 years			
Minimum Maturity Age (as per last birthday)	19 years			
Maximum Maturity Age (as per last birthday)	85 years 65 years (for policies sourced under Point of Sale)			
Minimum Sum Assured on Death (in Rs.)	2,25,000 (For policies sourced under Point of Sale, Sum Assured on Death would be in the multiple of Rs. 50,000 only)			
Maximum Sum Assured on Death (in Rs.)	1,00,00,000 (subject to prevailing Board approved underwriting policy of Digit Life Insurance) (For policies sourced under Point of Sale, Sum Assured on Death would be in the multiple of Rs. 50,000 only)			
Minimum and Maximum Premium	Minimum and Maximum premium will be based upon the entry age, Premium Payment Term, Policy Term and will be consistent to the Minimum and Maximum Sum Assured on Death respectively.			
Policy Term	Premium Payment Option	Single Pay	Limited Pay	Regular Pay
	Minimum	1 year	Premium Payment Term + 5 years	3 years
	Maximum	40 years		
	<i>For policies sourced under Point of Sale, minimum policy term allowed will be 5 years</i>			
Premium Payment Term (PPT)	Single Pay	Limited Pay	Regular Pay	
	Single Pay	5, 10, 15 years	3 years to 40 years (5 to 40 years for policies sourced under Point of Sale)	
	<i>(In case of regular pay, premium payment term will be equal to chosen policy term)</i>			

Premium Payment Frequency	Single Pay Annual , Half-Yearly, Quarterly, Monthly for Limited and Regular Pay
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Benefits in detail

A. Death Benefit

Digit Glow Term Life Insurance ensures that your family is financially protected in your absence by paying them the Death Benefit as a lumpsum amount as follows, subject to the policy being in-force:

Death Benefit payable will be higher of the following:

- 105% of total premiums paid as on date of death, or
- 10 times the Annualized Premium, or
- Sum Assured on Death

Where, **Total Premiums Paid** means total of all the premiums received, excluding any extra premium, any rider premium and taxes.

Annualized Premium means the premium amount payable in a year chosen by you, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any. The applicable taxes, if any, will be collected from you separately as over and above such premium.

Sum Assured on Death means an absolute amount of Benefit which is guaranteed to become payable on occurrence of the event of death of the Life Assured after the Risk Commencement Date and during the Policy Term and in accordance with the terms and conditions of the Policy.

Upon the payment of the death benefit, the policy will terminate and no further benefits shall be payable.

B. Inbuilt Optional Benefits

You can choose one or more inbuilt optional benefits at the inception of the policy by paying extra premium, subject to terms and conditions of the policy. These optional benefits are not applicable for point of sale (POS) policies.

B.1 Additional Accidental Death Benefit (ADB)

If this benefit is chosen, then upon death of the life assured due to an accident, where such accident has happened during the policy term and the policy is in-force, in addition to the death benefit, the accidental death benefit will be paid in lumpsum.

Additional accidental death benefit payable will be equal to 100% of sum assured on death. A claim under this benefit option will be admitted provided that the death:

- i. is caused by injury resulting from an accident,
- ii. occurs solely and directly due to the injury, and independent of any other causes,
- iii. occurs within 180 days of the occurrence of accident and
- iv. is not a result from any of the causes listed in the exclusions for additional accidental death benefit specified under general policy provisions/definitions/exclusions section below.

In case, the accident occurs while the life assured's additional accidental death benefit is in-force, but the accidental death occurs after the completion of policy term and within 180 days of the accident, additional accidental death benefit will be paid to the claimant.

Upon payment of additional accidental death benefit, the policy will terminate and no further benefits shall be payable.

B.2 Additional Accidental Total and Permanent Disability (ATPD) Benefit

If this benefit is chosen, then upon occurrence of total and permanent disability due to an accident, where such accident has happened during the policy term and the policy is in-force, additional accidental total and permanent disability benefit will be paid in lumpsum. Additional accidental total and permanent disability benefit payable will be equal to 100% of sum assured on death and will be in addition to death benefit and other inbuilt optional benefits chosen (if any).

In case, the accident occurs while the life assured's additional accidental total and permanent disability benefit is in-force, but the accidental total and permanent disability (ATPD) occurs after the completion of policy term and within 180 days of the accident, additional accidental total and permanent benefit will be paid to the claimant.

On payment of the additional ATPD benefit, coverage for this benefit under the policy terminates, however, the policy will continue for in-force death benefit and other in-force inbuilt optional benefits (if any) for the remaining policy term.

Definitions and exclusions pertaining to additional accidental death benefit and additional accidental total and permanent disability benefit are provided under general policy provisions/definitions/exclusions section below.

B.3 Accelerated Terminal Illness Benefit

Under this benefit, upon diagnosis of terminal illness during the policy term, accelerated terminal illness benefit will be paid in lumpsum. It is payable only once during the lifetime of the life assured and will be equal to the death benefit under the policy. It is an accelerated benefit which means this benefit facilitates an earlier payment of death benefit in lumpsum on prior occurrence of terminal illness. Upon payment of accelerated terminal illness benefit, the policy will terminate and no further benefits shall be payable.

Terminal Illness means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent medical practitioners, chosen by Digit Life Insurance and specializing in treatment of such illness, certify that the illness is expected to lead to death of the life assured within 6 months of the date of diagnosis of the terminal illness. The terminal illness must be diagnosed and confirmed by medical practitioners. We reserve the right for an independent assessment by two different medical practitioners other than the medical practitioner whose diagnosis has been provided by the life assured.

C. Survival/ Maturity Benefit

This policy does not provide any survival or maturity benefit on survival of the life assured.

Other important benefits

D. Wellness benefit

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

The applicability of the wellness benefit program and its features may be amended from time to time as per the availability of suitable service providers. The list of benefits under this program and terms and conditions applicable to it are provided in Annexure I.

E. Tax Benefit

You may be eligible for tax benefits as per prevailing tax laws:

- On the premiums paid*
- On proceeds of the policy*

* The aforesaid tax benefits are subject to change in tax laws. We therefore urge you to carefully analyse in consultation with your advisor the tax benefits/tax implications, if any that may arise on opting for this policy.

General Policy Provisions / Definitions / Exclusions:

Digit Simplification: You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them. Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

Grace Period: Grace Period means the extra time provided to you from the due date for the payment of premium without any penalty or late fee, during which time the policy is considered to be in-force with the risk cover and other applicable benefits without any interruption, as per the terms and conditions of the policy.

The grace period for payment of premium shall be fifteen (15) days, where you pay the premium on a monthly basis and 30 days in case of other applicable premium payment frequencies. Grace period is not applicable for single pay policies.

Any unpaid due premium is deductible from the benefits that may be payable during the Grace Period. The Company will pay the applicable benefit during grace period, subject to the deduction of the premiums due as well as balance premiums, if any, for the policy year during which death has happened.

Grace period is not applicable for single pay policies.

Lapsation: In case of policy with limited and regular premium payment term, if premiums have not been paid within the grace period, the policy will lapse on the date of expiry of grace period. All the applicable benefits will cease and no benefits will be payable in case of lapsed policies.

However, for limited pay policies, if at least three full year's premiums are paid and no further premium is paid by the policyholder, then only in case of death of life assured after the grace period, death benefit equal to prevailing unexpired risk premium value payable on early termination of the policy, as applicable on the date of death will be paid to the claimant. In any case, inbuilt optional benefits (if chosen) shall not be payable for the policy in lapsed status.

You may revive your lapsed policy subject to conditions stated in revival section.

Please Note: Single Pay policies will not lapse.

Reduced Paid-up

This Policy does not have any reduced paid-up benefit.

Early Termination of Policy:

For Single Pay Policies, Policy can be terminated any time before the completion of policy term and unexpired risk premium value, if any, will be paid on such early termination of the policy.

Unexpired risk premium value on early termination of single pay policies = $60\% \times \text{Single Premium amount} \times (\text{Outstanding Policy Term} / \text{Policy Term})$

For Limited Pay Policies, policy can be terminated any time before the completion of policy term and unexpired risk premium value, if any, will be payable on such early termination of the policy, provided three full years' premiums are received by us before such termination.

Unexpired Risk Premium Value on early termination of limited pay policies = $60\% \times \text{Total Premiums Paid} \times (\text{Outstanding Policy Term} / \text{Policy Term}) \times (1 - \text{Premium Payment Term} / \text{Policy Term})$

In case, any limited pay policy is terminated where three full years' premiums are not paid, the unexpired risk premium value shall not be applicable.

For Regular Pay Policies: No unexpired risk premium value will be payable for regular pay policies.

All the rights / title and interest under the policy shall stand extinguished upon early termination of the policy.

Any change to the above-mentioned formula for deriving unexpired risk premium value shall be subject to the prior approval of the Authority.

Revival of the Policy: A policy in lapsed status can be revived during the policy term but within a period of five years from the date of first unpaid premium by submitting the proof of continued insurability to the satisfaction of the board approved underwriting policy and making the payment of all due premiums together with payment of late fees calculated at such interest rate as per formula below and as may be prevailing at the time of the payment.

(10-year benchmark G-Sec Yield + 1.5%) rounded up to multiple of 25 basis points. The revival interest rate will be reviewed on 31st March of every year and any change in revival interest rate will be applicable from the following 1st July to 30th June period. The current rate of interest for revival is 9.00% p.a. Interest rate will be as prevailing from time to time.

Any change in the basis of determination of interest rate for revivals shall be done only after prior approval of the Authority.

If needed the company may refer it to its medical examiner in deciding on revival of lapsed policy.

Policy Loan Policy loan is not available under this Policy.

Free Look Period: You will have a period of 30 days from the date of receipt of the policy document to review the terms and conditions of this policy and if you disagree with any of the terms and conditions, you will have the option to return the policy document to the Company stating the reasons for the cancellation upon which the Company shall return the premium paid subject to deduction of a proportionate risk premium for the period of insurance cover in addition to the expenses incurred on medical examination (if any) and the stamp duty charges. All benefits and rights under this policy shall immediately stand terminated on the cancellation of the policy.

Risk factors:

- Digit Glow Term Life Insurance is a Non-Linked, Non-Participating Individual Pure Risk Premium Life Insurance Plan.
- Go Digit Life Insurance Limited is only the name of the Insurance Company and Digit Glow Term Life Insurance is only the name of the product and does not in any way indicate the quality of the product, its future prospect or returns.
- This product guarantees the benefits stated herein subject to all premiums being paid as and when due and policy being in force.
- The purpose of this brochure is to provide a general overview about this policy. The information herein is indicative of the terms, conditions and exceptions contained in the policy terms and conditions of Digit Glow Term Life Insurance. Please refer to the policy terms and conditions to understand in detail the associated risks, benefits, etc.
- In the event of any inconsistency / ambiguity between the terms contained herein and the policy terms and conditions, the policy terms and conditions will prevail.
- The acceptance of the proposal shall be subject to prevailing board approved underwriting policy.

Policy changes/alterations:

Change the Premium Payment Frequency as per your need

For limited and regular pay policies, you may choose to pay your premiums annually, half-yearly, quarterly or monthly at inception of the policy. Furthermore, you can also change the premium payment frequency during the premium payment term by providing the written request to the Company, provided the limits of minimum premium for the chosen premium payment frequency under this policy are adhered to, the benefits remain unchanged and in accordance with terms and conditions of the policy. Such change will become effective on the policy anniversary date following the receipt of such request, subject to policy being in force.

For non-annual premium payment frequency, instalment premiums are calculated by applying the loading factor as given below on annual premium:

Premium frequency	Loading factor
Monthly	4%
Quarterly	3%
Half-yearly	2%

Suicide Exclusion

In case of death of the life assured due to suicide within 12 months from the date of commencement of risk under the policy or from the date of revival of the policy, as applicable, the nominee or beneficiary of the policyholder shall be entitled to at least 80% of the total premiums paid till the date of death or unexpired risk premium value available as on the date of death whichever is higher, provided the policy is In Force. The policy will terminate thereafter.

Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family.

The person shall not be:

- The Policyholder/ Life Assured himself/herself; or
- An authorized Insurance Intermediary (or related persons) involved with selling or servicing the insurance contract in question; or
- Employed by or under contractual engagement with the Policyholder / Life Assured;
- Related to the Policyholder/ Insured person by blood or marriage.

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

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

Accidental Death The Accident shall result in Bodily Injury or injuries to the life assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the death of the life assured. Such a death is defined as “Accidental Death”. The date of the accident should be after the additional accidental death benefit coverage start date and before the completion of policy term.

Accidental Total & Permanent Disability (ATPD) refers to a disability, which

- Is caused by bodily injury resulting from an accident; and
- Occurs solely and directly due to the said bodily injury and shall be independent of any other cause; and
- Occurs within 180 days of the occurrence of such accident; and

- d) Results in (i) Total and irrecoverable loss of sight of both eyes, or; (ii) Physical separation or loss of use of both hands or feet, or; (iii) Physical separation or loss of use of one hand and one foot, or; (iv) loss of sight of one eye and Physical separation or loss of use of hand or foot; (v) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Life Assured from engaging in any employment or occupation of any description whatsoever. .

The above is exclusive of and without prejudice to the other causes of total and permanent disability.

Where, Physical separation shall mean physical severance of the hand at or above the wrist or physical severance of the foot at or above the ankle.

The date of the accident should be after the additional accidental total and permanent disability benefit coverage start date and before the completion of policy term.

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

Exclusions to additional accidental death benefit (ADB) and additional accidental total and permanent disability (ATPD) benefit

Additional accidental death benefit or additional accidental total and permanent disability (ATPD) benefit will not be payable if death or total and permanent disability respectively occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily due to or caused, occasioned, accelerated or aggravated by, any one of the following:

1. Any injury before commencement of additional accidental death benefit or additional accidental total and permanent disability benefit coverage.
2. Infection: Death or ATPD caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
3. Death or ATPD arising due to any condition other than death or ATPD solely and directly as a result of an accident.
4. Intentional self-inflicted injury, attempted suicide / suicide while sane or insane.
5. Insured Person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
6. War, invasion, act of foreign enemy, hostilities, war like operations (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
7. Taking part in any naval, military or air force operation during peace time or during service in any police, paramilitary or any similar organization;
8. Participation by the Insured Person in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
9. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities
10. Participation by the Insured Person in a criminal or unlawful act with criminal intent.
11. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing, diving or riding or any kind of race.
12. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

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

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

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

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

2. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

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

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

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

Annexure I – Wellness Benefit Program

Following services are applicable under Wellness Benefit Program, subject to availability of suitable service providers.

1. Doctor on Call

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

2. Wellness Coach

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

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

3. Lab Services and Imaging (For Diagnostic Services)

Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc or imaging for further testing and analysis.

The cost of these tests and reports will have to be borne by You.

4. Pharmacy (Home Delivery)

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

The cost of the medication will have to be borne by You.

5. Vital/Physical Activity Monitoring Services

Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s), or Digital Wearables or trackers such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, heart rate monitors, pulse oximeters, non-invasive wearable blood-sugar sensors, Smart Watches etc. to an online database that will track and assess Your vitals as reported by the device.

It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.

6. Reminder Notifications

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

7. Medical Wallet

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

8. Report Aggregation

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

9. Home Care Services

Upon Your request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for You in case You are in need of services , including but not limited to the following:

- a. Home Care Nursing
- b. Patient Assistant
- c. Physiotherapy
- d. Yoga Trainer
- e. Psychologist
- f. Palliative Care
- g. Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.
- h. Doctor Visit
- i. Elderly care and senior living assistance related to their health condition

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

10. Ambulance Arrangement Services

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

The cost of the transportation will have to be borne by You.

11. Pick-up and Drop Services for Consultation

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

The cost of the transportation will have to be borne by You.

12. Prioritizing Appointments

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

- Doctors' services
- Nursing services
- Dietitian services

13. Mental wellbeing - Upon Your request, We will facilitate, through Our empanelled Service Provider, self-assessments, therapy sessions, activities and educational/awareness blogs, videos and webinars. The cost of these sessions will have to be borne by You.

14. Physiotherapy - Upon Your request, We will facilitate, through Our empanelled Service Provider, consultation and treatment sessions/packages, pain management sessions, ergonomics sessions The cost of these services will have to be borne by You.

15. Childcare/Children's activities - Upon Your request, We will facilitate, through Our empanelled Service Provider, recreational/developmental activities for children of different age groups. The cost of these services will have to be borne by You.

16. Out-Patient (OPD) Services - Upon Your request, We will facilitate, through Our empanelled Service Provider, outpatient care services like doctor consultation, pharmacy and diagnostics, both online and onsite. The cost of these services will have to be borne by You.

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

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by You shall be kept confidential.
2. Wellness benefit services are extended through 3rd party Empanelled Service Provider/Medical Experts/Centres. We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. You need to pay directly to the Service Provider/Medical Experts/Centres for the services availed.

3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Person may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Person.
4. We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person/You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
7. Digit Life Insurance is not responsible in any manner for nature or quality of product/services or discounts provided by the empanelled Service Providers. You can refer to respective Service Provider's terms and Conditions before availing any services.
8. The offerings of the Service Providers, including any discounts or complimentary access / service are subject to change from time to time. For more details, please read policy terms and conditions carefully before concluding sale.

Subject otherwise to all the other terms, conditions, warranties, limitations and exceptions of the Policy to which this Benefit is attached.

Annexure II – Grievance Redressal Mechanism

1) Contact Information for Complaints & Grievance Redressal

- a) Meet your Grievance Officer at Your nearest Digit Life Branch Office
- b) Write to life@godigit.com from Your registered email address.
- c) Call 9960126126 from your registered mobile number.

2) Grievance Escalation Matrix

- a) **Level 1:** In case the complainant is not satisfied with the response, the complainant can escalate the grievance to Chief Grievance Redressal Officer within 8 weeks from date of complaint resolution at lifegro@godigit.com.

Address:

The Chief Grievance Redressal Officer

Go Digit Life Insurance Limited.

Atlantis,95,4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

- b) **Level 2:** In case the complainant is not satisfied with the response or does not receive any response from the Chief Grievance Redressal Officer within 15 days, complainant may approach the grievance cell of the Insurance Regulatory and Development Authority of India (IRDAI):

IRDAI Grievance Call Centre (IGCC) Address:

Consumer Affairs Department, Insurance Regulatory and Development Authority of India

Survey No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad

Telangana State – 500032

Toll Free Number: 155255 (or) 1800 4254 732

Timings: 8 AM to 8 PM (Monday to Saturday)

Email: complaints@irdai.gov.in

Website: <http://igms.irda.gov.in>

- c) **Level 3**

Manner of making complaints to Insurance Ombudsman: In case the complainant is not satisfied with the decision/resolution of the Company, or does not receive any response from the Company within 30 days of filing the complaint, the complainant may approach the nearest Insurance Ombudsman. For latest updated list of Ombudsman Office addresses, kindly visit this website <https://www.cioins.co.in/Ombudsman>

As per the provisions of Rule 13(1) of Insurance Ombudsman Rules, 2017, the Ombudsman shall receive and consider complaints or disputes relating to:

- i) delay in settlement of claims
- ii) any partial or total repudiation of claims
- iii) disputes over premium paid or payable in terms of the policy
- iv) misrepresentation of policy terms and conditions
- v) legal construction of insurance policies in so far as the dispute relates to claim.
- vi) servicing related grievances against insurers, their agents and intermediaries
- vii) issuance of policy not in conformity with Proposal form submitted.
- viii) non-issuance of insurance policy after premium receipt; and

ix) any other matter resulting from regulatory violation, related to issues mentioned at clauses a. to h.

As per the provisions of Rule 14 of Insurance Ombudsman Rules, 2017:

Rule 14(1), any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

Rule 14(2), the complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

Rule 14(3), no complaint to the Insurance Ombudsman shall lie unless:

- i) the complainant makes a written representation to the insurer named in the complaint and
 - (1) either the insurer had rejected the complaint; or
 - (2) the complainant had not received any reply within a period of one month after the insurer received his representation; or
 - (3) the complainant is not satisfied with the reply given to him by the insurer
- ii) The complaint is made within one year—
 - (1) after the order of the insurer rejecting the representation is received; or
 - (2) after receipt of decision of the insurer which is not to the satisfaction of the complainant.
 - (3) after expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant.

Rule 14(4), the Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

Rule 14(5), no complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

Go Digit General Insurance Limited, IRDAI Reg No. 158, Corporate Identification Number U66010PN2016PLC167410, Reg. Office Address Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office Address- Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com

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