

DIGIT HEALTH CARE PLUS POLICY
UIN: GODHLIP21013V032223
PROSPECTUS

Go Digit General Insurance Ltd.

Go Digit General Insurance Ltd. ("Digit") is a new general insurance company being set up in India and is backed by Fairfax Financial Holdings Ltd. Fairfax is a large Canada based diversified financial services group engaged in General Insurance, Reinsurance and Investment management across more than 30 countries.

At Digit, our mission is to make Insurance products that are simple and transparent. For us, making Insurance simple translates into – Easy interface for customers to interact with us, Simple products, Simple and effective claims' process. Our goal is to offer products and services that customer really wants and back it by service, that we can be proud of. We have a team that brings in years of experience in Insurance and technology companies. We want to become a part of consumers' lives and enable them to live without worrying about uncertain future.

Product Introduction

At Digit, we understand that some things are just beyond our control as no one really plans to get sick or hurt, but most people need medical care at some point of time. Digit Health Care Plus Policy is designed not only to protect you from unexpected, high medical costs but also to reduce the financial burden on you, arising from such costs.

What is covered under Digit Health Care Plus Policy?

There are 16 Base Sections and 6 Optional Covers under this Policy and Coverage under each Section and optional cover is as mentioned below:

SECTION 1. HOSPITALIZATION COVER

Digit Simplification: Hospital stays are never fun. And the less said about hospital food, the better! That said, it's good to know that Digit will try and make it easy, should you need to spend some time in a hospital, before you're back on your feet.

A. Accidental Hospitalization Cover

Digit Simplification: The day bad luck strikes.

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

Accommodation/Room Rent	<p>Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule against this Cover.</p> <p>Note: If You have opted for a Limit on "Accommodation/Room Rent" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule.</p> <p><i>Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-</i></p>
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	<p><i>third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i></p> <p><u>Inbuilt Cover: Daily Cash for choosing shared accommodation</u> <i>Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!</i></p> <p>If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule.</p> <p>Please note:</p> <ol style="list-style-type: none"> Your claim must be admissible under Section 1 Hospitalization Cover Your hospitalization must exceed 48 hours unless specifically agreed by Us For each policy period, there is a maximum number of days this can be paid, please check your policy schedule for the exact days Daily cash will be provided only for the days You were hospitalized in shared accommodation. Daily Cash will not be applicable in case Insured Person is admitted in the ICU. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

A1. Day Care Procedures

Digit Simplification: Why stay unnecessarily in a hospital when the required procedure requires just a day!

If You suffer an Accidental Injury during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement, We will pay the Medical Expenses Incurred for such Day Care Procedures.

Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

A2. Pre-Hospitalization Expenses

Digit Simplification: We all know that sometimes you need to shell out money way before you are

actually hospitalised; smile, you're covered.

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

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

A3. Post-Hospitalization Expenses***Digit Simplification: This covers for expenses incurred by You after you get discharged!***

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

- a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
- b) We have accepted an Inpatient Accidental Hospitalization Claim under **Section 1. A. Accidental Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum benefit, which shall be a percentage of the claim amount approved under **Section 1.A. Accidental Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

A4. Dental Treatment***Digit Simplification: Because you need to open your mouth and your wallet wide, at the dentist's.***

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

A5. Road Ambulance***Digit Simplification: Emergencies will and shall always be a top priority.***

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

- a) We have accepted a claim under **Section 1. A. Accidental Hospitalization Cover**.
- b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule against this Cover.
- c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

A6. Second Medical Opinion***Digit Simplification: We want nothing but the best for You. Which is why we encourage you to go in for a second opinion, wherever necessary!***

We shall arrange and bear the cost for Second Opinion from our panel of Medical Practitioners. This is for times when there has been a major accidental injury that requires your hospitalisation in a tertiary care facility during the Policy Period, provided that:

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

All the above Covers are Subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

B. **Accidental & Illness Hospitalization Cover**

Digit Simplification: The day bad luck strikes.

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

<p>Accommodation/Room Rent</p>	<p>Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You against this Cover. Note: If You have opted for a Limit on “Accommodation/Room Rent” and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule.</p>
	<p><i>Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one- third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor’s fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.</i></p> <p><u>Inbuilt Cover: Daily Cash for choosing shared accommodation</u> <i>Digit Simplification: If you choose a shared room accommodation while any hospitalization, we give you daily cash as a reward for saving money!</i></p> <p>If You choose a shared accommodation while any hospitalization during the policy period for which the claim is admissible, You will be eligible for a Daily Cash for every completion of 24 hours at the hospital. The daily cash amount is mentioned in Your Policy Schedule. Please note:</p> <ol style="list-style-type: none"> Your claim must be admissible under Section 1 Hospitalization Cover Your hospitalization must exceed 48 hours unless specifically agreed by Us For each policy period, there is a maximum number of days this can be paid, please check Your policy schedule for the exact days Daily cash will be provided only for the days You were hospitalized in shared accommodation. Daily Cash will not be applicable in case Insured Person is admitted in the ICU. Maximum per day room rent of shared accommodation claimed should not be more than the amount as specified in Policy Schedule
<p>ICU</p>	<p>Intensive Care Unit</p>
<p>Professional Fees</p>	<p>Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.</p>

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

B1. Day Care Procedures

Digit Simplification: Why stay unnecessarily in a hospital when the required procedure requires just a day!

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 Medical Expenses Incurred for such Day Care Procedure.

Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

B2. Pre-Hospitalization Expenses

Digit Simplification: Before you get hospitalized, there might be some expenses. This takes care of those!

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

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

B3. Post-Hospitalization Expenses

Digit Simplification: This covers expenses incurred by You after You get discharged!

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

- a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
- b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum which shall be a percentage of the claim amount approved under **Section 1.B. Accidental & Illness Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

B4. Dental Treatment

Digit Simplification: The dentist's chair is never fun, but we make sure you smile.

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

B5. Road Ambulance

Digit Simplification: In an emergency, getting to the hospital quickly is paramount!

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

- a) We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover**.
- b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule against this Cover.
- c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

B6. Bariatric Surgery Cover

Digit Simplification: Tackling obesity may require more than healthy eating and exercise.

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

- a) The Insured Person undergoing the surgery is minimum 18 Years old.
- b) The Medical Practitioner / Bariatric Surgeon confirms that Your Existing Body Mass Index (BMI) and health conditions fall within the below qualification requirements for Bariatric Surgery:
 - Class III Obesity (extreme obesity)- [Body Mass Index (BMI) \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 [*Example: Stroke, Myocardial Infarction, Poorly Controlled Hypertension*]
 - History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
 - Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.
- c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
 - Gastric Bypass-
 - The Roux-en-Y Gastric Bypass
 - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
 - Sleeve Gastrectomy
 - Laparoscopic Gastric Banding
- d) This particular cover has a waiting period. Waiting period shall be as per the “**Specific Waiting Period**” Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.
- e) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. *Example: Endocrine disorder.*
- f) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
- g) A prior approval should be taken from us before the Bariatric Surgery is performed.
- h) Our maximum liability under this benefit is restricted to the Limit as opted by You against this Cover.

Bariatric surgery for the following reasons is not covered:

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

Disorders-Induced Obesity. ***Digit Simplification: This is in such cases, treatment of the cause that has caused the obesity, will be more beneficial than treating obesity itself.***

B7. Psychiatric illness Cover

Digit Simplification: In a holistic health policy, mental health is as important as physical health.

We will pay up to the Sum Insured for the Medical Expenses, related to Psychiatric Illness, provided that:

- a) The first diagnosis and Hospitalization, as an inpatient, was during the Policy Period.
- b) This also has a waiting period and Sub-Limit as opted by You and mentioned in Your Policy Schedule for specific Psychiatric illnesses or disorders listed in the table below. Waiting period shall be as per the **“Specific Waiting Period”** Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Psychiatric as a benefit since inception of the first policy.

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

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

B8. Complimentary Health Check Up

Digit Simplification: Prevention is always better than cure!

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

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

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

B9. Second Medical Opinion

Digit Simplification: Any major illness (like cancer) dictates a second opinion.

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

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

Note: You can choose either one of the below covers or both the covers:

- Section 1.A. Accidental Hospitalization Cover
- Section 1.B. Accidental & Illness Hospitalization Cover

1. If You are opting only for Section 1.A, then coverage is only for Accidental Hospitalisation.
2. If You are only for Section 1.B, then coverage is for both Illness and Accidental hospitalisation.

Example:

If You are opting for both Section 1.A and 1.B and assuming Sum insured for Section 1.A is 1 Lakh and Section 1.B is 4 Lakhs, You are eligible for Maximum Single Claim of 5 lakhs for Accidental Hospitalisation and Maximum Single Claim of 4 lakhs for Hospitalisation due to Illness, however aggregate Sum Insured will be limited to 5 Lakhs for the Policy Period.

SECTION 2. INFERTILITY TREATMENT COVER

Digit Simplification: We make your road to parenthood easier.

If You have opted for this Cover, We will pay the Medical Expenses if You are hospitalized on the advice of

the Medical Practitioner for Infertility/ Subfertility Treatments. This includes, though not limited to, IVF, IUI, ZIFT, ICSI. Make sure the following conditions are met:

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

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

SECTION 3. ORGAN DONOR

Digit Simplification: Organ transplantation is the gift of life itself, and we are happy to be a part of it.

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

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

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

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

SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER

Digit Simplification: If you believe in the power of Alternate treatments, here's more power to you.

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

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

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

Specific Conditions applicable to this cover:

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

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

SECTION 5. EMERGENCY AIR AMBULANCE

Digit Simplification: When every minute counts. Sometimes when You meet with an Accident or have an Emergency Illness, time is of a lot of importance.

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

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

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

Note: This Section can be opted only where **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** Sum Insured exceeds INR 3 Lakhs.

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

SECTION 6. LONG HOSPITALIZATION CASH BENEFIT

Digit Simplification: If even ward boys seem to know You by name, this cover is for You.

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

- a) We have accepted a claim under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, and
- b) The benefit is payable only once to an Insured Person during the Policy Period.

For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.

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

SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER

A. Maternity Benefit

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

If You have opted for this Cover, We will pay the Maternity Expenses incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary termination.

This is up to the Sum Insured opted by You against this Section, during the Policy Period provided that:

- a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply.***) This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
- b) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
- c) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule applied to the increased part of the Sum Insured.

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

Digit Simplification: Sticking with us has its advantages

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

We shall not pay for the following under this Section:

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

B. New Born Baby Benefit

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

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

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

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

SECTION 8. OUT-PATIENT (OPD) BENEFIT

Digit Simplification: Expenses like doctor's consultation fees, health check-ups, pharmacy bills, dental treatment, diagnostic tests, etc... when You are not hospitalized are covered under this!

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

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

Basis 2: Nil Co-payment

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any Illness.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner
Out-Patient Dental Treatment	Out-patient dental treatment for the immediate relief of dental Pain; taken by You from a dentist, provided that We will pay only for X-rays, Extractions, Amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.
Hearing Aids	One pair of hearing aids (Excluding Batteries), provided that: <ul style="list-style-type: none"> ▪ These have been prescribed by an ENT specialist or Network Medical Practitioner. ▪ You have continuously renewed the Policy with Us without break for a period of 36 months with Out-Patient (OPD) Benefit as a benefit, since inception of the first policy.
Psychiatric Illness	Specialist Consultation, assessment, treatment and medication for Psychiatric Disorders.

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

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

SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION

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

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

- a) The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
- b) The patient takes treatment at home on account of non-availability of room in a Hospital, and
- c) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period
- d) No Payment will be made if the condition for which You require medical treatment is due to: Asthma, Bronchitis, Tonsillitis, Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, Cough and

Cold, Influenza, Arthritis, Gout and Rheumatism, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, any kind of rehabilitation or therapy or counselling related to Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin.

- e) Subject to availability of the sum insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**.

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

SECTION 10. SUM INSURED REFILL BENEFIT

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

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

- a) The refilled Sum Insured would be triggered only if the cause of the Hospitalization is not related to /arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy period for the same Insured Person, unless this condition is specifically waived by us and mentioned in Your Policy Schedule.
- b) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
- c) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**.
- d) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule against this Section during each Policy Period.
- e) In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.

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

SECTION 11. DAILY HOSPITAL CASH COVER

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

A) Accidental Hospitalization Cover

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

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

Payment of claim under this benefit is subject to the time excess as opted by You against this Section.

B) Accidental & Illness Hospitalization Cover

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

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

Payment of claim under this benefit is subject to the time excess as opted by You Schedule against this

Section.

SECTION 12. CRITICAL ILLNESS BENEFIT COVER

Digit Simplification: We are with you for the best of times, and the worst of times.

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

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

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

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

SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER

Digit Simplification: In times like these, You'll need all the help You can get.

If You have opted for this Cover and You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below, during the Policy Period, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an

admissible hospitalization claim, up to the Sum Insured mentioned in Your Policy Schedule against this Section. Provided that,

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

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

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

Sr. No.	Category	Critical Illness
1	Malignancy	Cancer of Specified Severity
2	Cardiovascular system	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7		Major Organ Transplant
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
20	Aplastic Anaemia	

Critical Illness Definitions Applicable to Section 12 & Section 13 Above:

Digit Simplification: What all is covered and what is not. Everything in black and white for You!

1. CANCER OF SPECIFIED SEVERITY

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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

- i. Other acute Coronary Syndromes
- ii. Any type of angina pectoris
- iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. SURGERY TO AORTA

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

5. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

- I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
- II. The NYHA Classification of Cardiac Impairment are as follows:
 - i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
 - ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
- III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

6. OPEN CHEST CABG

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

7. END STAGE LUNG FAILURE

- I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
 - i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
 - ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
 - iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less

- (PaO₂ < 55mmHg); and
 iv. Dyspnoea at rest.

8. END STAGE LIVER FAILURE

- I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
 - i. Permanent jaundice; and
 - ii. Ascites; and
 - iii. Hepatic encephalopathy.
- II. Liver failure secondary to drug or alcohol abuse is **excluded**.

9. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

10. MAJOR ORGAN /BONE MARROW TRANSPLANT

- I. The actual undergoing of a transplant of:
 - v. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
 - vi. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
- II. **The following are excluded:**
 - i. Other stem-cell transplants
 - ii. Where only Islets of Langerhans are transplanted

11. APALLIC SYNDROME

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

12. BENIGN BRAIN TUMOR

- I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
- II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
 - i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
 - ii. Undergone surgical resection or radiation therapy to treat the brain tumor.
- III. The following conditions are **excluded:**
 Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. COMA OF SPECIFIED SEVERITY

- I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
 - i. no response to external stimuli continuously for at least 96 hours;
 - ii. life support measures are necessary to sustain life; and
 - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
- II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

14. MAJOR HEAD TRAUMA

- I. Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
 - vii. Spinal cord injury;

15. PERMANENT PARALYSIS OF LIMBS

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

16. STROKE RESULTING IN PERMANENT SYMPTOMS

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
- II. The following are excluded:
 - iii. Transient ischemic attacks (TIA)
 - iv. Traumatic injury of the brain
 - v. Vascular disease affecting only the eye or optic nerve or vestibular functions.

17. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

18. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

19. LOSS OF INDEPENDENT EXISTENCE

- I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living Activities of Daily Living:
 - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - iv. Mobility: the ability to move indoors from room to room on level surfaces;
 - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - vi. Feeding: the ability to feed oneself once food has been prepared and made available.

20. APLASTIC ANAEMIA

- I. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
 - (a) Blood product transfusion;
 - (b) Marrow stimulating agents;
 - (c) Immunosuppressive agents; or
 - (d) Bone marrow transplantation.

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

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

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 14. CANCER BENEFIT COVER

Digit Simplification: The big C requires another C: Cover

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

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

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

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

SECTION 15. CANCER HOSPITALIZATION COVER**Digit Simplification: There is life after cancer. And we make sure you have quality of life.**

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

Provided that,

- a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity and hospitalized within the number of days (i.e. Initial Waiting Period) opted by You, from the date of inception of first policy with us..
- b) No Claim under this option shall be admissible if Cancer is a consequence of or arising out of any pre-

existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.

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

For this Cover, “CANCER OF SPECIFIED SEVERITY” means:

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

HPFs;

SECTION 16. WELLNESS BENEFIT PROGRAM

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

You can opt any of the 12 services under Wellness Benefit Program.

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.

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 and online platform provide You information on wellness coaching in areas such as:

- 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 (Home Collection)

Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc from Your home address 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 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) such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device. It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.

6. Reminder Notifications

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

7. Medical Wallet

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

8. Report Aggregation

Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical records/reports 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 any of 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.

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 treatment/diagnostics subject to availability of the service(s).

The cost of the Consultancy/Diagnostic will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program

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

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 they are mentioned your Policy Schedule.

If the policy is issued on individual basis, each insured person can opt for the available optional covers as per requirement and if it is arranged on a floater basis, the optional covers will be applicable to all the insured person(s), without any individual selection.

In short in an individual policy, you will have to select these individually and in a floater/family policy it will be applicable for all.

S.No	Optional Covers	Section Admissibility
1	Payment of Non-Medical Expenses	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
2	Daily Cash for accompanying an Insured Child	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
3	Loss of Income Cover	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
4	Cumulative Bonus Protection Cover	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover Section 13. Critical Illness Hospitalization Cover Section 15. Cancer Hospitalization Cover
5	Unused Sum Insured Benefit	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover
6	Network hospital Co-payment	Section 1A. Accidental Hospitalization Cover Section 1B. Accidental & Illness Hospitalization Cover Section 13. Critical Illness Hospitalization Cover Section 15. Cancer Hospitalization Cover

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

1) Payment of Non-Medical Expenses

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 – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness 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). The compensation will be maximum upto a percentage of the approved claim amount. This percentage will be mentioned in the Policy Schedule.

Please note:

- Coverage will be limited to the actual expenses incurred during the Hospitalisation but not paid under Section 1 – Hospitalisation Cover as Non-Medical expenses.
- In the General Exclusions section, you will see 'Non-medical Expenses' as exclusion no. 25, if you have this cover, that is not valid obviously 😊 but since this is a standard document, it will be mentioned for people who don't opt for this cover.

2) Daily Cash for accompanying an Insured Child

Digit Simplification: Children need extra care! If a child is hospitalized, an adult is definitely required to

take care, so extra cash for them!

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If the Insured Person hospitalized is a child aged 14 years or less, then we will pay you a Daily Cash for an accompanying adult for every completion of 24 hours at the hospital. The daily cash amount is mentioned in your Policy Schedule. Please note:

- a. The claim must be admissible under Section 1 Hospitalization Cover
- b. Hospitalization must exceed 48 hours unless specifically agreed otherwise by us
- c. For each policy period, there is a maximum number of days this can be paid, please check your policy schedule for the exact days

Daily cash will be provided only if an adult aged 18 years or more is accompanying the Insured Child during the said hospitalization.

3) Loss of Income Cover

Digit Simplification: The losses of being hospitalized sometimes is beyond the hospitalization expenses as it disrupts your flow of income. This cover helps there!

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover)

If you have this cover and are continuously hospitalized for certain number of days, mentioned in your policy schedule, you will receive a pre-set amount for every block of specified number of days, again mentioned in your policy schedule. Please note:

- a. Your claim should be admissible under Section 1- Hospitalization Cover
- b. For each policy period, there is a maximum number of days this can be paid, please check your policy schedule for the exact days

4) Cumulative Bonus Protection Cover

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

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

If you have opted for this cover and you make any claim in the expiring policy*, your cumulative bonus will never reduce. The following two scenarios are possible:

- It will remain same on renewal in case total claim amount is more than the cumulative bonus protection cover amount chosen by you or
- It will increase on renewal (like how it is when there is no claim made) in case the total claim amount is less than the cumulative bonus protection cover amount chosen by you.

*Claim made under the **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover**

Please note, there is an upper limit to the Cumulative Bonus you can earn, it will be mentioned in your Policy Schedule. Also, Point no 2 and 3 as provided under “Cumulative Bonus” stands deleted in case you have opted this cover.

5) Unused Sum Insured Benefit

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

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover). This cover can only be provided if there is no Cumulative Bonus or Cumulative Bonus Protect Cover opted under the policy.

If you have opted for this cover, then at the time of renewal of the policy, sum insured under the renewed policy will be increased based on the unused sum insured of the expiring policy, subject to the following:

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

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

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

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

6) Network Hospital Co-payment

Digit Simplification: If you choose a network hospital and choose reimbursement claim method, there will be a co-payment, share of claim paid by you.

(Applicable under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

If you have opted for this cover and are hospitalized* in any of the network hospital, and if you choose the claim on reimbursement basis, then you shall bear a co-payment of a specified percentage as opted by you and mentioned in Policy Schedule on each and every claim.

*(under Section 1 Hospitalization Cover – 1A Accidental Hospitalization Cover and 1B. Accidental & Illness Hospitalization Cover, Section 13 – Critical Illness Hospitalization Cover and Section 15 – Cancer Hospitalization Cover)

Specific Conditions applicable to this cover:

- i. This co-payment will be applicable on admissible claim amount and will be over and above any other co-payment applicable in the policy.
- ii. Co-payment will not be applicable on capped ailments.
- iii. Co-payment will not be applicable for treatment taken on cashless basis.
- iv. For complete list of Network Hospitals, kindly refer Company's Website.

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

1. All the Sections above are optional. However, only Section 1, Section 11 and Section 12, Section 13, Section 14 & Section 15 may be opted on standalone basis. Rest of the Section must be opted with Section 1.
2. Both Individual and Floater Options are available. However, Floater Policy is not available for Section 11, Section 12 & SECTION 14. Floater for Section 13 & Section 15 will on Case to Case basis depending on the Medical Condition, Age Etc.
3. Cumulative Bonus is applicable only for Section 1, Section 13 and Section 15.
4. Separate Sum Insured will be available for Section 1, Section 6, Section 7, Section 8, Section 11, Section 12, Section 13, Section 14 and Section 15.

5. Section 2, Section 3, Section 4 and Section 7 shall be available only if Section 1 B Cover is opted.
6. Geographical Limits can be opted outside India on payment of additional Premium.
7. Section 5. Emergency Air Ambulance can be opted only where Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover Sum Insured exceeds INR 3 Lakhs.

8. 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 considered for calculating Premium in floater option.

9. Zone Classification

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

- Zone A: Delhi / NCR, Mumbai including (Navi Mumbai, Thane and Kalyan),
- Zone B: Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.
- Zone C: Rest of India apart from Zone A and Zone B cities are classified as Zone C.

In case policy is underwritten with Zone wise premium differentiation then a Co-pay as mentioned below would be applicable:

- a) In the event, The Insured person who is in Zone B, pays premium for Zone B and avails treatment in a hospital which is in Zone A, 10% Co-pay would be applicable.
- b) Similarly, if an Insured Person who is in Zone C, pays premium for Zone C and avails treatment in Zone A, 20% co-payment will be applicable.
- c) Similarly, if an Insured Person who is in Zone C, pays premium for Zone C and avails treatment in Zone B, 10% co-payment will be applicable. This co-payment will not be applicable for Accidental injury cases.
- d) Zone based Co-Pay, as mentioned above, will not be applicable in case of Accidental Injury.

You also have option to Pay Premium for Zone A irrespective of the City you are residing so that Zone Co-payment will not be applicable at the time of Claim.

What are the exclusions under Digit Health Care Plus Policy?

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:

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

I. **STANDARD EXCLUSIONS**

1. Pre-Existing Diseases - Code- Excl01

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

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

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

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

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

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

- a. Expenses related to the treatment of any illness within 30 days from the first policy

commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

- b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

4. Investigation & Evaluation- Code- Excl04

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

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

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

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

6. Obesity/ Weight Control: Code- Excl06

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

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

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

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

8. Cosmetic or plastic Surgery: Code- Excl08

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

9. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering,

rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional

10. Breach of law: Code- Excl10

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

11. Excluded Providers: Code- Excl11

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

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

13. Treatments received in 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. Code- Excl13

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

15. Refractive Error: Code- Excl15

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

16. Unproven Treatments: Code- Excl16

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

17. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

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

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

18. Maternity: Code Excl18

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

This exclusion stands deleted to the extent of the coverage provided under **SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS

19. Artificial Life Maintenance

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

20. Suicide and Self-Injury

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

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

21. Circumcision, Aesthetic reasons

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

22. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geographical Limits

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

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

24. Defence Operation

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

25. Non-Medical Expenses

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

26. Insufficient Document

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

27. Preventive Treatment

We do not cover inoculations, vaccinations or other treatment, for example drugs or Surgery, which

aims to prevent a disease or illness except:

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

28. Spectacles, Hearing aids & other Expenses

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

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

30. Unjustified or Unwarranted Hospitalization

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

31. War and hazardous substances

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

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

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

32. Legal Liability

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

33. Substance abuse and Addictions by the Insured

- 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)

34. Ear, Eyesight & Optical Services

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

35. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

36. Specific Treatments

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

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

- A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy - Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. Bronchial Thermoplasty
- J. Vaporisation of the 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.

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

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

38. Dental Treatment

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

39. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment. However, We will pay for treatments mentioned under **SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER**, if You have specifically opted for it.

40. Organ Donor

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

41. Weight loss Surgery

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

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 & Daily Hospital Cash Cover	Proposer	18yrs	No Limit
	Child	91days	No Limit
	Adult Insured	18yrs	No Limit
Critical Illness Cover	Proposer	18yrs	65yrs*
	Child	181days	NA*
	Adult Insured	18yrs	65yrs*
Daily cash for accompanying an Insured Child	Proposer	18yrs	No Limit
	Child	91 days	14 yrs
Loss of Income Cover	Proposer	18yrs	No Limit
	Adult Insured	18yrs	No Limit

*there is no age limit for renewals, however policy will be terminated in case of claim settlement

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		
A. Accidental Hospitalization Cover	10,000	Unlimited Sum Insured
B. Accidental & Illness Hospitalization Cover	10,000	Unlimited Sum Insured
SECTION 2. INFERTILITY TREATMENT COVER	10,000	10% of the Section 1.B Sum Insured
SECTION 3. ORGAN DONOR	10,000	Unlimited Sum Insured
SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER	10,000	Unlimited Sum Insured
SECTION 5. EMERGENCY AIR AMBULANCE	10,000	Unlimited Sum Insured
SECTION 6. LONG HOSPITALIZATION CASH BENEFIT	5,000	10,000
SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER	10,000	5,00,000
SECTION 8. OUT-PATIENT (OPD) BENEFIT	2,500	50,000
SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION	10,000	Unlimited Sum Insured
SECTION 10. SUM INSURED REFILL BENEFIT	10,000	Unlimited Sum Insured
SECTION 11. DAILY HOSPITAL CASH COVER	100 per day	5000 per day
A. Accidental Hospitalization Cover	100 per day	5000 per day
B. Accidental & Illness Hospitalization Cover	100 per day	5000 per day
SECTION 12. CRITICAL ILLNESS BENEFIT COVER	10,000	3,50,00,000
SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER	10,000	3,50,00,000
SECTION 14. CANCER BENEFIT COVER	10,000	3,50,00,000
SECTION 15. CANCER HOSPITALIZATION COVER	10,000	3,50,00,000
SECTION 16. WELLNESS BENEFIT PROGRAM	NA	NA
OPTIONAL COVERS		
1. PAYMENT OF NON-MEDICAL EXPENSES	1% of approved claim amount	10% of approved claim amount
2. DAILY CASH FOR ACCOMPANYING AN INSURED CHILD	1000 per day, max upto 7 days	1000 per day, max upto 7 days
3. LOSS OF INCOME COVER	1,000	20,000
4. CUMULATIVE BONUS PROTECTION COVER	INR 30,000	Upto Sum Insured
5. UNUSED SUM INSURED BENEFIT	100% unused Base Sum Insured	100% unused Base Sum Insured
6. NETWORK HOSPITAL CASHLESS	NA	NA

Note: For this policy Unlimited Sum Insured means Sum Insured more than INR 3 crore without any limitation. Premium for Unlimited Sum Insured will be calculated by multiplying 1.15 to the premium of Sum Insured INR 3 crore.

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	No Initial Waiting Period, 2 days, 7 days, 15 days, 30 days
Pre-existing Disease Waiting Period Options	No Pre-existing Disease Waiting Period, 3 months, 6 months, 1 Year, 2 Years, 3 Years, 4 Years
Specific Waiting period	No Specific Waiting Period, 3 months, 6 months, 1 Year, 2 years
Section 2. Infertility Treatment Cover	No Waiting Period, 1 Year, 2 Years, 3 Years, 4 Years
Section 7. Maternity Benefit and New Born Baby Cover	No Waiting Period, 1 Year, 2 Years, 3 Years, 4 Years
Section 12. Critical Illness Benefit Cover	No Waiting Period, 30 days, 60 days, 90 days
Section 14. Cancer Benefit Cover	No Waiting Period, 30 days, 60 days, 90 days

We also Survival Period Applicable for below Cover:

Cover Description	Survival Period
Section 12. Critical Illness Benefit Cover	30 Days
Section 14. Cancer Benefit Cover	30 Days

Are there any Sub-Limits under this Policy?

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

Section Details	Sub Limits (Options)
SECTION 1-HOSPITALIZATION COVER	
A. Accidental Hospitalization Cover	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 1.A Sum Insured)
A1. Day Care Procedures	NA
A2. Pre-Hospitalization Expenses	NA
A3. Post-Hospitalization Expenses	NA
A4. Dental Treatment	NA
A5. Road Ambulance	1% of Section 1.A Sum Insured Max up to the INR 5000
A6. Second Medical Opinion	NA
B. Accidental & Illness Hospitalization Cover	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 1.A Sum Insured)
B1. Day Care Procedures	NA
B2. Pre-Hospitalization Expenses	NA
B3. Post-Hospitalization Expenses	NA
B4. Dental Treatment	NA
B5. Road Ambulance	1% of Section 1.B Sum Insured Max up to the INR 5000
B6. Bariatric Surgery Cover	5%/10%/20% / 100% of Section 1.B Sum Insured
B7. Psychiatric Illness Cover	NA
B8. Complimentary Health Check Up	Up to 0.25%/0.5% of the Sum Insured (excluding any cumulative bonus) Subject to maximum of INR 5,000 Per Policy
B9. Second Medical Opinion	NA
SECTION 2. INFERTILITY TREATMENT COVER	10% of the Section 1.B Sum Insured

SECTION 3. ORGAN DONOR	NA. However donor's Pre and Post Hospitalization expenses up to 5% of the admissible harvesting expenses
SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER	NA
SECTION 5. EMERGENCY AIR AMBULANCE	NA
SECTION 6. LONG HOSPITALIZATION CASH BENEFIT	NA
SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER	NA
SECTION 8. OUT-PATIENT (OPD) BENEFIT	NA
SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION	NA
SECTION 10. SUM INSURED REFILL BENEFIT	NA
SECTION 11. DAILY HOSPITAL CASH COVER	
A. Accidental Hospitalization Cover	NA
B. Accidental & Illness Hospitalization Cover	NA
SECTION 12. CRITICAL ILLNESS BENEFIT COVER	NA
SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 13 Sum Insured)
SECTION 14. CANCER BENEFIT COVER	NA
SECTION 15. CANCER HOSPITALIZATION COVER	Accommodation/Room Rent: 1%, 1.5% or 2% or No Limit (as a % of Section 15 Sum Insured)
SECTION 16. WELLNESS BENEFIT PROGRAM	NA
OPTIONAL COVERS	
PAYMENT OF NON-MEDICAL EXPENSES	1%/2%/5%/10% of Approved claim amount
DAILY CASH FOR ACCOMPANYING AN INSURED CHILD	NA
LOSS OF INCOME COVER	NA
CUMULATIVE BONUS PROTECTION COVER	NA
UNUSED SUM INSURED BENEFIT	NA
NETWORK HOSPITAL CASHLESS	NA

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

- Hyaluronic acid, Remicade or similar medications
- 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					
A. Accidental Hospitalization Cover	Yes	NIL	15 Lakhs	Yes	0%	50%
B. Accidental & Illness Hospitalization Cover	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 2. INFERTILITY TREATMENT COVER	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 3. ORGAN DONOR	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 5. EMERGENCY AIR AMBULANCE	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 6. LONG HOSPITALIZATION CASH BENEFIT	No	-		No	-	

SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER	No	-		No	-	
SECTION 8. OUT-PATIENT (OPD) BENEFIT	No	-		Yes	0%	25%
SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 10. SUM INSURED REFILL BENEFIT	Yes	NIL	15 Lakhs	Yes	0%	50%
SECTION 11. DAILY HOSPITAL CASH COVER				No		
A. Accidental Hospitalization Cover	Yes	0 Days	2 Days	No		
B. Accidental & Illness Hospitalization Cover	Yes	0 Days	2 Days	No		
SECTION 12. CRITICAL ILLNESS BENEFIT COVER	No			No		
SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER	No			No		
SECTION 14. CANCER BENEFIT COVER	No			No		
SECTION 15. CANCER HOSPITALIZATION COVER	No			No		
SECTION 16. WELLNESS BENEFIT PROGRAM	NA			NA		
OPTIONAL COVERS						
Network Hospital Co-Payment	NA			NA	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:

Bariatric Surgery Sub-Limit Discount: You have an option to choose a sublimit on Bariatric Surgery of either 5%, 10% or 20%. In Case the You opt for any of these sublimit, we would extend discount of 2%, 1.5% and 1% respectively.

Direct Business Discount: Up-to 15%

Long-Term Discount: For 2 Years Policy: 7% & For 3 Years Policy: 10%.

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

- Sum Insured enhancement can be done only at the time of renewal. You need to submit fresh proposal for Sum Insured Enhancement.
- 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.
- All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

Can I opt for any Section during mid-term of the Policy?

No, mid-term inclusion of any Section is not allowed, however, separate Policy can be issued subject to Our Underwriting Policy.

What are the renewal conditions under this Policy?

- The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
- The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- 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.

What are benefits if I renew this Policy?

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

- Complimentary Health Check Up
- Where Out-Patient (OPD) Benefit is opted on Basis 1- From the Second Renewal, there will be no Co-payment, provided the Policy is renewed with Us continuously without a break with this benefit.
- 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.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover and/or Section 13. Critical Illness Hospitalization Cover and/or Section 15. Cancer 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:
 - No Cumulative Bonus of 5%, 10%, 20%, 50% and 100% Cumulative Bonus each year. Cumulative Bonus can be accrued up to a maximum of 25%, 50%, 100%,150% and 200% respectively.
 - There is one more option for Cumulative Bonus to be accrued up to 100% for 50% increase each year.
 - 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.

What are the cancellation terms under this Policy?

A. Cancellation by You

1. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Short Period Scale

Period on Risk	Premium Refund based on Policy Term		
	1 Year	2 Year	3 Year
Within 15 days	As Per Free Look Cancellation Mentioned Below		
Exceeding 15 days but less than 3 months	65.0%	65%	60%
Exceeding 3 months but less than 6 months	45.0%	55%	55%
Exceeding 6 months but less than 9 months	25.0%	45%	50%
Exceeding 9 months but less than 12 months	0.0%	35%	45%
Exceeding 12 months but less than 15 months	NA	30%	40%
Exceeding 15 months but less than 18 months	NA	20%	35%
Exceeding 18 months but less than 21 months	NA	10%	30%
Exceeding 21 months but less than 24 months	NA	0%	25%
Exceeding 24 months but less than 27 months	NA	NA	15%
Exceeding 27 months but less than 30 months	NA	NA	10%
Exceeding 30 months but less than 33 months	NA	NA	5%
Exceeding 33 months	NA	NA	0%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been

availed by the insured person under the policy.

B. Cancellation by Company

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

C. In Case of Death of Insured Person

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 a portion of the premium as per short term premium mentioned in 8.A.1, 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 short-term basis as per table mentioned in 8.A.1, subject to the terms and conditions of the Policy. Difference between short-term premium of new family composition with old family composition shall be considered for refund.

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

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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

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

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health

insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link [🔗 Click Here](#)

<https://d2h44aw715xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf>

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the [🔗 Click Here](#)

<https://d2h44aw715xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf>

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?

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

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)

1. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
2. 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.
3. 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 .
4. No interest will be charged If the instalment premium is not paid on due date.
5. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
6. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
7. 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:

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:

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

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
 - a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
 - b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
 - c. However, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
 - d. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
 "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.
 - e. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Hospitalization Claim	Out-Patient (OPD) Claim	Critical Illness/Cancer Claim	Daily Hospital Cash Claim
1	Duly Filled and Signed Claim form	√	√	√	√
2	Discharge Summary	√	×	×	√

3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	x	√	x
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4	Original Hospital Main Bill	√	×	×	×
5	Original Hospital Bill Break Up	√	×	×	×
6	Original Pharmacy Bills	√	√	×	×
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	×	×
8	Consultation Papers	√	√	√	×
9	Investigation Reports	√	√	√	×
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	×	×
11	MLC/FIR Report (If applicable)	√	×	√	×
12	Original Invoice/Sticker (If applicable)	√	×	×	×
13	Post Mortem Report (If applicable)	√	×	×	×
14	Disability Certificate (If applicable)	√	×	√	×
15	Attending Physician Certificate (If applicable)	√	×	√	×
16	Ante-natal Record (If applicable)	√	×	×	×
17	Birth discharge Summary (If applicable)	√	×	×	×
18	Death Certificate (If applicable)	√	×	√	×
19	*KYC (Photo ID card) (If applicable)	√	√	√	√
20	Bank Details with Cancelled Cheque	√	√	√	√

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

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

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.

Go Digit General Insurance Ltd, A Company incorporated under Indian Companies Act, 2013 and licensed by Insurance Regulatory and Development Authority of India [IRDAI] vide Reg No. 158, Corporate Identification Number U66010PN2016PLC167410, Reg. Address Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru 560095. Website: www.godigit.com Toll free no. 1800 103 444

Benefit illustration Digit Health Care 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:

Family Composition	Age of the members insured	Coverage opted on Individual basis covering each member of the family separately (at a single point in time) <i>Which means: If you were to purchase a policy for all members of a family, separately.</i>		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured available for each member of the family) <i>Which means: If you were to purchase a policy for all members of a family, together, under the same policy, but with individual Sum insured</i>				Coverage opted on family floater basis with overall Sum Insured (Only one sum insured is available for the entire family) <i>Which means: If you were to purchase a policy for all members of a family, together, under the same policy, sharing the same Sum insured</i>			
		Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of the family (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)
2 Adults + 2 Children	51	8,162	5,00,000	8,162	10%	7,346	5,00,000	14,568	NA	14,568	5,00,000
	48	7,014	5,00,000	7,014	10%	6,313	5,00,000				
	22	3,268	5,00,000	3,268	10%	2,941	5,00,000				
	18	3,268	5,00,000	3,268	10%	2,941	5,00,000				
		Total premium for all members of the family is Rs. 21,713, when each member is covered separately. Sum Insured available for each individual is Rs. 5,00,000.		Total premium for all members of the family is Rs. 19,541, when they are covered under a single policy. Sum Insured available for each family member is Rs. 5,00,000.				Total premium when policy is opted on floater basis is Rs. 14,568. Sum Insured of Rs. 5,00,000 is available for the entire family			

Family Composition	Age of the members insured	Coverage opted on Individual basis covering each member of the family separately (at a single point in time) <i>Which means: If you were to purchase a policy for all members of a family, separately.</i>		Coverage opted on Individual basis covering multiple members of the family under a single policy (Sum Insured available for each member of the family) <i>Which means: If you were to purchase a policy for all members of a family, together, under the same policy, but with individual Sum insured</i>				Coverage opted on family floater basis with overall Sum Insured (Only one sum insured is available for the entire family) <i>Which means: If you were to purchase a policy for all members of a family, together, under the same policy, sharing the same Sum insured</i>			
		Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of the family (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)
2 Adults	62	11,048	300,000	11,048	5%	10,496	300,000	20,104	NA	20,104	300,000
	66	13,403	300,000	13,403	5%	12,733	300,000				
		Total premium for all members of the family is Rs. 24,451, when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000.		Total premium for all members of the family is Rs. 23,228, when they are covered under a single policy. Sum Insured available for each family member is Rs. 3,00,000.				Total premium when policy is opted on floater basis is Rs. 20,104. Sum Insured of Rs. 3,00,000 is available for the entire family			

Note:

Premium figures are for Digit Health Care Plus Policy (UIN: GODHLIP21486V022021) 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.