AROGYA SANJEEVANI POLICY, GO DIGIT
PROSPECTUS

UIN: GODHLIP20168V011920

Go Digit General Insurance Ltd.

Go Digit General Insurance Ltd. ('Digit') is a new-age general insurance company that is backed by the Fairfax Group – one of the world's largest financial holding companies which is engaged in General Insurance, Reinsurance and Investment management across more than 30 countries.

Digit's singular mission is to make insurance simple for all. With that mission in mind, we are reimagining products and redesigning processes. Our products are designed keeping the consumer in mind, our processes are simple, fast and transparent & our documents are easy to understand. With the help of cutting-edge technology and people who bring in years of experience in both the insurance and technology domain, we want to be the new-age insurance company that's revolutionising the insurance industry. And by doing so, we want to be part of our consumers' lives by enabling them to live life, without worrying about an uncertain future.

Product Introduction

Arogya Sanjeevani Policy is designed to bring about a standardized product which provides basic coverage to the customers intending to ease the problem of vast number of choice and portability.

What is covered under this policy?

If during the policy period one or more Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions as mentioned in the policy wording. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

The covers listed below are inbuilt Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000 /-, per day.
ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1. other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

4. Pre-Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. 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, specified in the policy schedule, during the policy period:

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

7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

What are the exclusions under this 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:

1. Investigation & Evaluation (Code- Excl04)

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

2. 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.

3. **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
4. **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.
5. **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.
6. **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.
7. **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.
8. **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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**
11. 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)**
12. **Refractive Error:(Code- Exc115)**
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

13. **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.
14. **Sterility and Infertility: (Code- Excl17)**
    Expenses related to sterility and infertility. This includes:
    (i) Any type of 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
15. **Maternity Expenses (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.
16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment
19. Treatment taken outside the geographical limits of India
20. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

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

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

Entry Age	Minimum	Maximum
Proposer	18yrs	65 years
Dependent Child	3 months	25 years
Adult Insured	18yrs	65 years

*there is no age limit for renewals

What is the Policy tenure under this policy?

This Policy tenure shall be for a period of one year.

What is the definition of Family under this Product?

Family consists of the proposer and any one or more of the family members as mentioned below:

1. legally wedded spouse.
2. Parents and Parents-in-law.
3. dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

Can the Policy be opted on Floater Basis?

Yes, this Product can be opted either on Individual Sum Insured basis or Family Floater Basis.

What is the Sum Insured options under this Policy?

You can opt for a minimum Sum Insured of INR 1 lakh and maximum up to INR 5 lakhs in the multiples of INR 50,000.

What are the waiting periods under this Policy?

Waiting Period applicable to this Policy are as mentioned below:
The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

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 48 months of continuous coverage after the date of inception of the first policy with us.
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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First Thirty Days 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.

3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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.

i. **24 Months waiting period**
   1. Benign ENT disorders
   2. Tonsillectomy
   3. Adenoidectomy
   4. Mastoidectomy
   5. Tympanoplasty
   6. Hysterectomy
   7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
   8. Benign prostate hypertrophy
   9. Cataract and age-related eye ailments
   10. Gastric/ Duodenal Ulcer
   11. Gout and Rheumatism
   12. Hernia of all types
   13. Hydrocele
   14. Non-Infective Arthritis
   15. Piles, Fissures and Fistula in anus
   16. Pilonidal sinus, Sinusitis and related disorders
   17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
   18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
   19. Varicose Veins and Varicose Ulcers
   20. Internal Congenital Anomalies

ii. **48 Months waiting period**
   1. Treatment for joint replacement unless arising from accident
   2. Age-related Osteoarthritis & Osteoporosis

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

There is no deductible under this policy. However, there shall be 5% co-pay on all claims.

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.

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

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

What are the renewal conditions under this Policy?

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

What is the Grace Period under this Policy?

For Yearly payment mode, a fixed period of 30 days is allowed as Grace Period and for other modes of payment a fixed period of 15 days will be allowed as Grace Period.

What are benefits if I renew this Policy?

You are eligible for a cumulative bonus of 5% on Sum Insured, provided you have had a claim free year preceding the renewal. This benefit will be accumulated based on claim free years up to a maximum bonus of 50% of Sum insured.

What are the cancellation terms under this Policy?

a) The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund%	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

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) 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.

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

Portability and Continuity Benefits are as mentioned below:

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.

iii. Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by our company. The credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by our company. Application for this Policy is made within 45 days before, but not earlier than 60 days from the expiry of that insurance policy.

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

There is a possibility of revision/ modification of terms, conditions, coverages and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, We will inform you at least 3 months prior to the date of such revision/modification comes into effect.

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

There is possibility of withdrawal of this product at any time in future with appropriate approval from IRDAI, as We reserve Our right to do so with an intimation of 3 months to all the existing insured members. In such an event of withdrawal of this product, at the time of Your seeking extension of this Policy, you can

choose, among Our available similar and closely similar Health Insurance Products. Upon Your so choosing Our new product, you will be charged the Premium as per Our Underwriting Policy for such chosen new product, as approved by IRDAI.

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

You can opt for premium payment on an instalment basis i.e. Half Yearly, Quarterly or Monthly. 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 Benefits provided under - " Waiting Periods", "Specific Waiting Periods" Sections shall continue 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.

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

1. Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/ TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

SI No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

A. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

B. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

What discounts/loading are available on the premium?

Premium Payment Terms 2% loading on Annual Premium shall be applicable for Half-yearly premium options, 4% loading on annual premium shall be applicable on Quarterly premium option and 8% loading shall be applicable on monthly premium option.

Age at entry discount: 10% for first two years and 5% for third and fourth year of the Arogya Sanjeevani policy with us, provided insured member is less than 40 years of age at the time of buying policy for the first time with us. This discount is not applicable for portability / migration cases and all family members should be less than 40 years of age in family floater Sum Insured options.

Family Discount: 5% Discount shall be applicable for two members in a family and 10% shall be applicable for more than two members in a family. This discount is applicable only on Individual Sum insured option and not on family floater Sum Insured option.

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.

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