2. PART B

Tata AIA Vitality Health is a non-linked, non-participating Pure Risk Individual Health Rider.

DEFINITIONS

The words and phrases listed below will have the meanings attributed to them wherever they appear in this Rider unless the context otherwise requires. The terms used in this Rider but not defined will derive their meaning from the Policy.

1) "Annualized Rider Premium" means the premium payable in a year chosen by the Policyholder, excluding the taxes, underwriting extra premiums and loadings for modal Rider Premiums, if any, as specified in the Schedule.
2) "Base Plan" means the insurance policy to which this Rider is being attached.
3) "Coverage Term" means the term under the chosen benefit option as specified in the Schedule.
4) "Date of Commencement of Risk" means the date as specified in the Schedule, on which the coverage under this Rider/benefit option commences.
5) "Insured Amount" under a benefit option shall be the highest of:
   a) 11 times the Annualized Premium for Limited Pay/Regular Pay and 1.25 times for Single Premium [excluding the underwriting extra premiums, modal loading and applicable taxes, cess or levies (if any)] for the respective benefit option;
   b) 105% of Total Premiums Paid (excluding loading for modal Premiums) as up to the date of occurrence of the underlying insured event; and
   c) Sum Assured under the Benefit Option.
6) "IRDAI / Authority" means the Insurance Regulatory and Development Authority of India.
7) "Life Insured" shall mean the person insured under the respective benefit option as specified in the Schedule.
8) "Maturity/Expiry Date" means the date specified in the Schedule, on which the Coverage Term expires.
9) "Policy/Base Plan" means the base policy to which this Rider is attached.
10) "Rider" means this rider contract containing these terms and conditions.
11) "Rider Premium" means an amount specified in the Schedule against respective benefit option, payable by You, by the due dates to secure the benefits under the Rider, excluding applicable taxes, cesses or levies, if any.
12) "Rider Sum Assured" is the maximum of all "Sum Assured under Benefit Option" for the respective Benefit options chosen by the Policyholder.
13) "Sum Assured under the Benefit Option" shall be the sum of (a) lump sum and (b) present value of all future income streams chosen under the respective benefit option, and shall be as specified in the schedule.
14) "Schedule" means the Policy schedule and any endorsements attached to and forming part of the Base Plan and Rider and if any, updated Schedule is issued, then, the Schedule latest in time.
15) "Survival Period" in respect of a chosen benefit option shall be:

Benefit Option	Survival Period
Cancer Care	7 days
Cardiac Care	14 days
Multistage CritiCare	30 days

Survival Period shall not be applicable for Accidental Disability Care and Hospi Care.

16) "Total Rider Premiums Paid" shall be defined as the sum of all the premiums paid to date in respect of chosen benefit option/s, excluding Extra Premiums, applicable taxes, cesses or levies, if any.
17) "Underwriting Policy" means an underwriting policy approved by Our board of directors.
18) "We", "Us", "Our" or "Company" means Tata AIA Life Insurance Company Limited; and
19) "You", "Your" or "Policyholder" means the policyholder as named in the Schedule, who is the policyholder under the Base Plan and Rider.

The capitalized words used but not defined herein, shall borrow meaning as per the term and conditions of the Policy.

3. PART C

3.1. BENEFITS

The benefits shall depend on the plan option chosen by You at the inception of the Rider, which cannot be changed once chosen. However, You may propose to avail additional benefit/s under the Rider in future on one or more lives (may or may not include coverage on self) subject to insurable interest between the Policyholder and the Life Insured, and as per the Board Approved Underwriting Policy.

You may apply for addition or removal of Benefit Option/s under the Rider as per the process applicable from time to time.

Where the Rider coverage is opted on Life Insured/s other than the Life Insured under the Base Plan, the Rider coverage shall continue for such Life Insured/s under the Rider in case of death of the Base Plan Life Insured.

You may appoint a Contingent Policyholder at the inception of the Rider, who shall act as the Policyholder under the Rider, in the event of death of the original Policyholder under the Base Plan.

If there is an overlapping benefit between the Base Plan and the Benefit option, the Benefit option shall not be offered.

At no point both unit-deduction rider and this rider shall be allowed to be attached during the Policy Term of a unit-linked policy.

Provided the Rider is in force, the following benefit(s) shall be payable:

I. Hospi Care

In case of hospitalization, after completion of hospitalization for a minimum period of continuous 24 hours, for a medically necessary treatment of any illness or injury, We shall pay the Insured Amount as below:

a) Hospital Cash Benefit:
You can claim daily cash Benefit, i.e. 0.5% of the Insured Amount per day, payable from the first day for the duration of hospitalization. Hospital Cash Benefit is payable for a maximum 30 days per Policy Year.

b) ICU Benefit:
An additional 0.5% of Insured Amount per day shall be payable for each day of stay in the Intensive Care Unit (ICU) subject to the daily cash benefit being payable at the time of hospitalization. This benefit is payable for hospitalization up to 15 days per coverage year. This benefit is a fixed per-day benefit and will be paid irrespective of actual hospitalization expenses.

c) Recuperating Benefit:
A lump sum benefit equal to 1.5% of the Insured Amount shall be payable in case of continuous hospitalization in one or more hospitals for 7 or more days (excluding the time taken for transit between hospitals) for the same insured event, subject to the daily cash benefit under Clause I (a) being payable at the time of hospitalization.

This benefit shall be paid once in a coverage year. This benefit is not payable if the Life Insured dies during the hospitalization period.

The benefit can be claimed up to 100% of the Insured Amount under the benefit option throughout the chosen Coverage Term under the benefit option.

II. ACCIDENTAL DISABILITY CARE

In the event of Permanent and Partial Disability (as explained below) of the Life Insured due to an Accident within the Coverage Term, a percentage of Insured Amount shall be payable, provided the event occurs within 180 days from the date of that Accident (even if the event occurs beyond the Coverage Term).

Description of Disability	Amount of Benefit (% of Rider Insured Amount)
Total and Permanent Disability	100%
Partial and Permanent Disability: Permanent loss of -	
- each arm at the shoulder joint	60%
- each arm to a point above elbow joint	55%
- each arm below elbow joint	50%
- each hand at the wrist	50%
- each thumb	20%
- each index finger	10%
- each finger other than the thumb or index finger	5%
- each leg above center of the femur	60%
- each leg up to a point below the femur	55%
- each leg to a point below the knee	50%
- each foot at the ankle	40%
- each big toe	5%
- each toe other than the big toe	2%
Loss of sight in each eye	50%
Loss of Hearing in each ear	30%

Upon payment of a benefit under this benefit option, the Insured Amount shall be reduced to the extent of benefit paid and the cover shall continue for the balance Insured Amount, if any. This benefit option shall terminate on payment of a cumulative 100% of the Insured Amount under this benefit. For calculation of the cumulative value of Insured Amount, only the payout to the extent of percentage of the Insured Amount mentioned above shall be considered.

DOUBLE BENEFIT

If you have chosen Accidental Disability Care, We shall pay twice the amount of this benefit if the disability occurs under any of the following circumstances:

1. While the Life Insured is riding as a fare paying passenger on commercially licensed public land transportation over an established route such as a bus, tram or train. A taxi or any form of transport chartered for private travel is excluded.
2. While the Life Insured is in an elevator car (elevators in mines, rigs and on construction sites excluded) duly certified to carry passengers;
3. As a direct result of the burning of the following public buildings only: theatre, cinema, public auditorium, hotel, school and hospital; or
4. When the Life Insured is on a commercial passenger airline on a regular scheduled passenger trip over its established passenger route.

The evidence of travel in public land transportation, airline or visit to theatre, cinema, public auditorium, hotel shall be required for this benefit.

III. MULTISTAGE CRITICARE

This benefit is payable, if the Life Insured survives during the Survival Period following Diagnosis of any of the covered illness or actual undergoing of the procedure ("Critical Illness") below:

Minor Critical Illnesses/Procedure			
1	Severe Osteoporosis	5	Cirrhosis of the Liver
2	Brain Surgery	6	Nephrectomy/removal of one kidney
3	Pneumonectomy	7	Portal vein Thrombosis
4	Small Bowel Transplant	8	Ulcerative Colitis
Major Critical Illnesses/Procedure			
1	Apallic Syndrome	17	Aplastic Anaemia
2	Benign Brain Tumor	18	Deafness
3	Blindness	19	Loss of Speech
4	Severe Rheumatoid Arthritis	20	Medullary Cystic Kidney Disease
5	End Stage Lung Failure	21	Motor Neuron Disease with Permanent Symptoms
6	Coma of Specified Severity	22	Multiple Sclerosis with Persisting Symptoms
7	End Stage Liver Failure	23	Muscular Dystrophy
8	Kidney Failure requiring Regular Dialysis	24	Parkinson's Disease
9	Encephalitis	25	Progressive Scleroderma
10	Third Degree Burns	26	SLE with Renal Involvement
11	Major Head Trauma	27	Bacterial Meningitis
12	Major Organ (less heart)/ Bone Marrow Transplant	28	Chronic Recurrent Pancreatitis
13	Permanent Paralysis of Limbs	29	Loss of Independent Existence
14	Loss of limbs	30	Poliomyelitis
15	Fulminant Viral Hepatitis	31	Creutzfeldt - Jacob disease
16	Alzheimer's Disease	--	--

a) Minor Critical Illness –

Upon Diagnosis of illness or actual undergoing of the procedure of the covered Minor Critical Illness (as detailed in Annexure A), 25% of the Insured Amount shall be payable.

Multiple claims for different Minor Critical Illness shall be admissible till the aggregate payout under the benefit does not exceed 100% of the Insured Amount. For multiple claims (except Major Critical Illness), there needs to be a period of at least 180 days between the date of occurrence of insured event and the date of occurrence of a subsequent insured event. A particular Minor Critical Illness can be claimed only once during the Coverage Term.

b) Major Critical Illness –

On Diagnosis of illness or actual undergoing of the procedure of the covered Major Critical Illness (as detailed in Annexure A), We shall pay the Insured Amount less any already payments already made for Minor Critical Illness or Women Specific Critical Illness.

Upon payment of a benefit under this Rider, the Insured Amount shall be reduced to the extent of the benefit paid and the benefit will continue for the balance Insured Amount, if any. This benefit shall terminate upon payment of a cumulative 100% of the Insured Amount under this benefit.

The benefit will be payable only if the Diagnosis/procedure of the covered Critical illness is the first Diagnosis/procedure of that condition in the lifetime of the Life Insured.

IV. CANCER CARE

This benefit shall cover below cancer conditions:

Minor Stage Cancer	Major Stage Cancer
Early stage Cancers	Cancer of Specified Severity
Carcinoma-in-Situ	

a) Minor Stage Cancer –

Upon Diagnosis of a Minor Stage Cancer (as detailed in Annexure A), 25% of the Insured Amount will be paid.

Multiple claims for different Minor Stage Cancer shall be admissible till the aggregate payout under the benefit does not exceed 100% of the Insured Amount. For multiple claims, there needs to be a period of at least 180 days between the date of Diagnosis of a Minor Stage Cancer and date of Diagnosis of the subsequent Minor Stage Cancer. A particular Minor Stage Cancer can be claimed only once during the Coverage Term. However, more than one unrelated Minor Stage Cancer condition may be claimed. Unrelated Minor Stage Cancer condition means a cancer which does not belong to the same organ and same histological type or has not metastasized and occurred because of a prior cancer. Where the

organs are in a pair such as breasts, lungs, kidneys, testes, ovaries etc., the entire pair is considered as one organ.

b) Major Stage Cancer –

Upon Diagnosis of Major Stage Cancer (as detailed in Annexure A), We shall pay an amount equal to the Insured Amount less any payout made previously under Cancer Care, if any.

c) Reconstructive Breast Surgery (Only for Female Life Insured) –

If the Life Insured is diagnosed as suffering from Breast Cancer as defined under "Major stage cancer of specified severity" (as detailed in Annexure A), an additional benefit amount of 30% of the Insured Amount shall be payable for reconstructive breast surgery. This benefit shall be paid on the actual undergoing of Reconstructive Breast Surgery on the Diagnosis of the Breast Cancer confirmed by an Oncologist supported by surgical, clinical, radiological, histological and laboratory evidence acceptable to the Company.

Upon payment of a benefit under this benefit option, the Insured Amount shall be reduced to the extent of the benefit paid and the benefit shall continue for the balance Insured Amount, if any. This cover shall terminate on payment of a cumulative 100% of the Insured Amount.

The benefit will be payable only if the Diagnosis of any of the covered condition is the first Diagnosis of that condition in the lifetime of the Life Insured.

V. CARDIAC CARE

If the Life Insured survives during the Survival Period following the Diagnosis of illness or actual undergoing of the procedure of covered Cardiac Condition and subject to conditions specified below, We shall pay the Insured Amount.

Minor Stage Cardiac Conditions		Major Stage Cardiac Conditions	
1	Angioplasty	1	Myocardial Infarction (First Heart Attack of specified severity)
2	Balloon Valvotomy or Valvuloplasty	2	Open Chest CABG (Coronary Artery Bypass Graft)
3	Carotid Artery Surgery	3	Open Heart Replacement or Repair of Heart Valves
4	Implantable Cardioverter Defibrillator	4	Major surgery of Aorta
5	Implantation of Pacemaker of Heart	5	Heart transplant
6	Infective Endocarditis	6	Cardiomyopathy (of specified severity)
7	Minimally Invasive Surgery of Aorta	7	Stroke resulting into permanent symptoms
8	Pericardiectomy	8	Primary (Idiopathic) Pulmonary Hypertension
9	Pulmonary Thromboembolism	-	--
10	Surgery for Cardiac Arrhythmia	-	--
11	Surgery to Place Ventricular Assist Devices or Total Artificial Hearts	-	--
12	Renal Angioplasty	-	--
13	Pulmonary Artery Graft	-	--
14	Percutaneous Procedures for Heart Valve Surgery	-	--

a) Minor Stage Cardiac Condition –

Upon Diagnosis of illness or actual undergoing of procedure of Minor Stage Cardiac Condition (as detailed in Annexure A), We shall pay 25% of the Insured Amount. In case the Life Insured undergoes angioplasty (as detailed in Annexure A), the amount of benefit shall be subject to a maximum of Rs.5 Lacs.

A claim can be preferred for a particular condition under the Minor Stage Cardiac Condition only once during the Coverage Term. Multiple claims for different Minor Stage Cardiac Condition shall be admissible till the aggregate payout under the benefit does not exceed 100% of the Insured Amount. For multiple claims, there needs to be a period of at least 180 days between the date of occurrence of insured event and the date of occurrence of a subsequent insured event.

b) Major Stage Cardiac Condition –

Upon Diagnosis of illness or actual undergoing of procedure of Major Stage Cardiac Condition (as detailed in Annexure A), We shall pay an amount equal to Insured Amount less any payout made previously under Minor Stage Cardiac Condition, if any.

Upon payment of a benefit under this benefit option, the Insured Amount shall be reduced to the extent of the benefit paid and the cover will continue for the balance Insured Amount, if any. This cover shall terminate on payment of a cumulative 100% of the Insured Amount under this benefit.

The benefit shall be payable only if the Diagnosis/procedure of any of the condition is the first Diagnosis/procedure of that condition in the lifetime of the Life Insured.

3.2. MATURITY BENEFIT

If You have chosen Return of Balance Premium option, on survival till end of the Coverage Term provided the Rider/Benefit Option is not terminated, the Total Rider Premiums Paid towards the respective benefit option shall be returned, after deduction of

- any claim payout made under the under the respective benefit option and
- any Premium discounts availed under the Wellness Program (if opted as per Clause 3.3.2 below) as Premium discounts or Premium cashback.

This option can be chosen only at the inception of the Rider and cannot be changed later.

3.3. SERVICE FEATURE

3.3.1. Health Management Services:

Life Insureds of TATA AIA Vitality Health, who are eligible for the Health Management Services, will be eligible to avail second opinion/personal medical case management services/medical consultation from the service provider/s affiliated to/registered with Us. The services are expected to assist the Life Insured with an independent diagnosis of the medical condition, thus helping the Life Insured to take the required steps. These services are subject to:

- the availability of a suitable service provider/s;
- primary diagnosis (wherever applicable) has been done by a registered medical practitioner as may be authorized by a competent statutory authority;
- Health Management Service is available to be utilized throughout the policy term, subject to prevailing eligibility conditions;
- the eligibility conditions of the Life Insured will be determined as per the Company's extant Underwriting Policy;
- the eligibility will be reviewed periodically and changes shall apply without any discrimination to all existing and new customers of the product.
- In case of any change, the eligibility details will be displayed on Our website (www.tataaia.com) or You may contact Our helpline number 1-860-266-9966 (local charges apply), before using the services;
- Whenever the eligibility criteria changes or the service is withdrawn, the same shall be communicated to all the policyholders. Prior to effecting any changes, we shall inform the same to IRDAI; and
- The current eligibility is of a minimum total Sum Assured of Rs. 30 Lakhs [under base plan and rider/s (if any)].

Note:

- These services are aimed at improving Policyholder engagement.
- These Value-added Services are completely optional for the eligible Life Insured to avail.
- For Life Insured availing such services, they are offered at no additional cost.

- The Premiums charged shall not depend on whether such a service(s) is offered or availed.
- The Life Insured may exercise his/her own discretion to avail the services.
- These services shall be directly provided by the service provider(s).
- The services can be availed only where the Policy / rider is in-force.
- All the supporting medical records should be available to avail the service.
- We reserve the right to change the service provider(s) at any time.
- The services are being provided by third party service provider(s) and We will not be liable for any liability.

3.3.2. Renewability Option at Maturity

At maturity, you can choose to extend the term of their respective benefit option. You can opt to renew the cover by another 5-year subject to maximum maturity age by paying additional Premium(s) for the period extended subject to Underwriting Policy. The following conditions will apply:

- You will be eligible for extension provided the policy is in force and all due premiums till date have been paid.
- You can select policy term and premium payment term of another 5 year as per other minimum/maximum limits under the rider.
- Benefit(s) shall continue as per the outstanding coverage applicable at the time of extension of the rider term.
- In case of Hospi Care benefit options, the applicable lifetime limits shall be restored at the renewal of new tranche.
- In case of Multistage Criticare, Cancer Care and Cardiac Care benefit options, the outstanding coverage, at the time of extension, would be defined as the lifetime limit available under this benefit option less any claims settled on account of Minor condition as mentioned under Part C. You will not be able to extend the policy term in case 100% of claims have been settled.
- In case of Accidental Disability Care, the outstanding coverage, at the time of extension, would be defined as the lifetime limit available under this benefit option less any claims settled as mentioned in Part C. You will not be able to extend the policy term in case 100% of claims have been settled.
- The additional Premium(s) will be calculated as per the attained age of the Life Insured at the date of extension depending on the policy term and premium payment term opted (SP/LP/RP), then applicable premium rate.
- The additional Premium will be based on outstanding coverage at the date of extension.
- No policy alteration (except change in policy term/premium payment term) shall be allowed at the time of extension.

3.3.3. LOYALTY DISCOUNT:

If you opt for the rider(s) any time after the inception of this Policy, the Company shall offer a loyalty discount of 1% of Single Premium and 10% of first year premiums for regular/limited policies.

You can opt either the digital/online sales discount or "First-year Premium Discount" for as Employees as may applicable or Loyalty Discount.

3.4. Wellness Program

Provided the Life Insured opts to enroll for the Wellness Program and all due premiums are paid, this plan offers rewards that incentivizes the Insured to maintain a healthy lifestyle. This program comes with no additional cost to the policyholder.

The engagement level of the Life Insured shall be monitored over the duration of each policy year and a Wellness Status shall be earned throughout the year. At the end of each policy year, the Wellness Status shall be used to determine the Rewards under benefit option as applicable, in the following year.

The Wellness Status shall not be at the discretion of the Insurer and shall be driven by an objective criterion in line with the Underwriting Policy. The Wellness Status attributed to the Insured shall be based on a point based structure and shall be either Bronze, Silver, Gold or Platinum. The Wellness Status is an effective measure of engagement in the Wellness Program which improves the risk profile of the Insured life resulting in an enhanced insurance savings, which is in turn shared with the policyholder in the form of rewards.

The level of improvement in the risk profile and hence the resultant insurance saving depends on the Wellness Status. A higher Wellness Status translates to a higher level of rewards, i.e. with Bronze being the lowest and Platinum being the highest.

Rewards Program during premium payment term

- **Up-front reward at benefit inception**

  Provided the Insured opts to enroll for the Wellness Program, an up-front reward equivalent to 5% of annualized premium for ADC and 10% of annualized premium for all other benefit options shall be offered for the first policy year.

  The above Up-front reward structure shall be subject to review and revision based on objective measurable criteria in line with the underwriting policy. Any revision thereof shall be filed with the Authority

- **Annual Rewards Flex**

  Annual Rewards Flex is offered based on the Wellness Status of the Insured during premium payment term.

Wellness Status (at the end of the policy year)	ADC	Other Benefit Options
Bronze	-2.5%	-5%
Silver	-1.25%	-2.5%
Gold	0.5%	+1%
Platinum	1%	+2%

*negative reward refers to a reduction in total rewards

The rewards are offered on cumulative basis and in any year, the maximum rewards in view of both the Up-front Rewards and Annual Rewards Flex together shall be 15% for ADC and 30% for all other benefit options. Further, the premium payable in any year shall not exceed annualized premium at inception without any wellness rewards.

For example, Total Rewards in the 2nd year for HC = (Upfront Reward + Annual Rewards Flex earned in the first year) x Annualized Premium. Hence if the Wellness Status earned at the end of the first policy year is Platinum and the applicable upfront reward is 10%, the total reward in the second policy year shall be 12% of annualized premium.

The policyholder can choose to utilize the Rewards (both up-front reward at policy inception and Rewards offered during premium payment term) in one of the following two available modes. The policyholder needs to make this choice at the time of purchase and then alter it during the premium payment term with effect from immediate next policy anniversary by writing to us at least 30 days before the immediate next policy anniversary:

- Premium discount: The policyholder will be able to offset the premium payable towards the rider against the Rewards.
- Premium Cashback: The customer will have an option to convert the cashback points into cash balance and utilize it towards health expenses such as Health checks/ diagnostics, Pharmaceuticals/ Medicines / nutritional supplements as prescribed by his / her medical practitioner, Dental treatments, hearing aids, vision improvement treatments, physiotherapy, Ayurvedic treatments, and such health-related services. The customer can choose to receive and utilize the cash balance through a digital health wallet/ e-card service provider(s) empaneled with the Company, from time to time. Benefits payable under the policy (including towards Health Wallet) shall be governed in accordance with the prevailing provisions of Income Tax Act, 1961.

Rewards Program post premium payment term

Provided the Insured has paid all premiums, the Insurer may opt for Cover Booster or Annual Health cashback Program, the eligibility of which will be subject to Underwriting Policy. The insured can opt for either of this program at any time until 30 days before end of last premium payment term. This program will be applicable for limited pay and single pay policies only.

1. Cover Booster Structure
   - **Accumulated Cover Booster**

     Accumulated Cover Booster will increase the amount of benefit payable if the insured event for which the benefit is payable occurs. Accumulated Cover Booster is equivalent to rewards applicable in the last policy anniversary.

Example 1– For a limited pay HC policy with premium payment term of four years, if the Wellness Status maintained throughout premium payment term is Platinum. The policyholder has accumulated Total Rewards of 16%. The accumulated cover booster at the end of premium payment term is equivalent to 16%.
Example 2 - For a single pay HC policy, the accumulated cover booster at the end of first year is equivalent to 10%.

- Cover Booster Flex

Annual Cover Booster flex will increase the amount of benefit payable if the insured event for which the benefit is payable occurs based on the Wellness Status of the Insured after premium payment term.

Wellness Status at the end of the policy year	ADC	Other Benefit Options
Bronze	-2.5%	-5%
Silver	-1.25%	-2.5%
Gold	0.5%	+1%
Platinum	1%	+2%

*negative Cover Booster flex refers to a reduction in benefit payable

The Cover Boosters are offered on cumulative basis. Any accumulated rewards at the end of policy term will be carried forward at the time of the renewal. The maximum rewards during the lifetime in view of both the Accumulated Cover Booster and Cover Booster Flex together shall be 15% for AD & ATPD and 30% for all other benefit options. Further, the total Cover Booster in any year shall not be lower than zero.

Example 1 - For a limited pay HC policy as above, if the Wellness status earned at the end of the premium payment term is Platinum, the applicable Cover Booster Flex will be 2%. The total cover booster on the benefit payable will be 18% in 5th policy year.

Please refer to Annexure-B for sample illustration of rewards and cover booster for sample model points.

In case policy is renewed under Renewability option, the accumulated premium discount, if any shall be applicable during PPT of the renewed period and accumulated cover booster, if any shall be applicable post PPT of the renewed period.

2. Annual Health Cashback

Alternatively, the Life Insured can opt to receive Annual health cashback based on the Wellness Status of the Insured attained each year. The Annual health cashback will be applicable on the Cover Booster as mentioned above.

You will be able to convert the Annual health cashback points into cash balance and utilize it towards health expenses such as Health checks/ diagnostics, Pharmaceuticals/ Medicines / nutritional supplements as prescribed by your medical practitioner, Dental treatments, hearing aids, vision improvement treatments, physiotherapy, Ayurvedic treatments, and such health-related services.
You can choose to receive and utilize the cash balance through a digital health wallet/ e-card service provider(s) empaneled with the Company, from time to time. Benefits payable under the policy (including towards Health Wallet) shall be governed in accordance with the prevailing provisions of Income Tax Act, 1961.

The cash balance once earned can be carried forward each Policy Year till the expiry of the term of benefit option.

The points are allocated through a range of parameters comprising of online assessments, physical activity & health check-up. The same shall be as per the objective criterion in line with the underwriting policy and may be reviewed from time to time for any revisions. Any change in parameters will be subject to prior approval of the Authority. The proposed points architecture with which Insurer proposes to launch this product has been detailed below.

Thus, whilst all policyholders are given the same upfront reward at inception, only those who maintain or improve their health continue to enjoy the benefit of a rewards or enhanced rider sum assured.
The above rewards structure and cover booster framework shall be subject to review and revision based on objective measurable criteria in line with the underwriting policy. Any revision thereof shall be filed with the Authority and shall apply to both existing and prospective policyholders.

Health Screening

The Wellness Program offers an inbuilt health screening which shall not be mandatory. The following tests will be performed as part of health screening.

1) Physical Medical Examination to include: Height, Weight, Waist Circumference, Blood pressure, Pulse
2) Fasting Blood Glucose / Fasting Blood Sugar/ Hb1AC
3) Total Cholesterol

The Insured will be encouraged to go for health screenings for which points will be allocated, as detailed below. This health check will be defined in the product literature and will be offered once a year.

The points (contributing to the determination of the Wellness Status) will be predefined for this health check and will be awarded to the Insured only once a policy year upon completion of the Health Screening.

The health screening benefit provided to the policyholder is fixed benefit and not an indemnity benefit.

Wellness Status – Points

The Wellness Status is driven by an objective criterion where the Life Insured attains the status by accumulation of points. The points are allocated through a range of parameters comprising of online assessments, physical activity & health check-up.

The table below gives point distribution structure for determining Wellness status:

Status	Accumulated Points
Bronze	0 – 9,999
Silver	10,000 – 19,999
Gold	20,000 – 24,999
Platinum	25,000 and above

Points Accumulation Structure

The Life Insured can earn points through a range of parameters as provided below:

Details	Limits
Online Assessment	3,900
Health Screening	12,000
Physical activity	15,000

Online Assessment – Annual

Points/ Activity	Activity	Max Points (limit p.a.)	Remarks
Assessments	Health Review	1,000	Assessment are available for all Life Insured irrespective of Wellness Status. Points are allocated to all Life Insured who have completed the assessment.
	Nutrition Assessment	1,000	
	Mental Wellbeing	900	
	Declaration: Smoker / Non-Smoker	1,000	

Health Screening – Annual

Details	Points for doing the health screening	Additional Points if the results are within the clinically accepted range	Remarks
BMI	1,500	1,500	All Life Insured are eligible for Annual Health Screening and points are
Blood Pressure	1,500	1,500	

Cholesterol	1,500	1,500	allocated to Life Insured basis health screenings conducted and also if the results of the test being in line with WHO recommended clinical range
Glucose	1,500	1,500	

Physical Activity – Daily[$]

Steps / Heart Rate	Points per day
Steps: 7,500-9,999 Or, Heart rate: At least 30 mins of physical activity in one exercise session a day at an average heart rate of 60% or more of your age-related maximum heart rate	50
Steps: ≥10,000 Or, Heart rate: At least 30 mins of physical activity in one exercise session a day at an average heart rate of 70% or more of your age-related maximum heart rate Or, Heart rate: At least 60 mins of physical activity in one exercise session a day at an average heart rate of 60% or more of your age-related maximum heart rate	100

[$] *A maximum of one exercise event is allowed per day to earn points for physical activity. If more than one event is recorded in a single day, the event with the highest number of points will be awarded*

Each of these parameters have capping limits to ensure that the Life Insured engages in all the parameters defined above as this will lead to overall improvement of life insured's health.

The underlying principle in setting of the objective criteria is to ensure all the Life Insured get equal opportunity for participating in Wellness Program and all similarly placed Life Insured (basis engagement in wellness activities) derive similar benefits.

The reward point structure not limited to status, parameters, points to be allotted to the parameters, sub limits on each parameter, will be subject to change in the future basis experience trends and will be subject to criteria defined in the board approved policy (as amended from time to time). Any such change in the reward point structure will be communicated to the Life Insured with a notice of minimum 30 days in advance.

The communication with respect to Wellness Benefit shall be notified to You as and when required on Your registered email id or contact number.

3.5. PAYMENT OF PREMIUM

You may pay the Rider Premiums in annual, semi-annual, quarterly or monthly payment modes, as specified below, provided that the Rider Premium payment mode under this Rider shall always be same as the premium payment mode of the Base Plan and can only be changed with the change of premium payment mode of the Base Plan. The Rider Premium will change, if the premium payment mode under Base Plan is changed by You.

MODE	MODAL LOADING
Annual	Multiply Annual Premium Rate by 1
Half -Yearly	Multiply Annual Premium Rate by 0.51
Quarterly	Multiply Annual Premium Rate by 0.26
Monthly	Multiply Annual Premium Rate by 0.0883

3.6. MODE OF PAYMENT

You may choose one of the following options to receive benefit, depending on the benefit option selected:

a) **Lump Sum**: 100% of the Insured Amount chosen is paid as a lump sum.

b) **Income for Specified Period**: Income chosen will be paid for the chosen income period (A period up to 10 years as chosen).

c) **Combination of Lump sum and Income for the Income Period Chosen**: 100% of the Insured Amount chosen to be received in lump sum is paid as a lump sum. Along with the lump sum amount, the Claimant shall also receive regular income in arrears as per the chosen frequency chosen for income period (A period up to 10 years as chosen), starting from the date of occurrence of insured event.

The income frequency can be Annual / Half Yearly / Quarterly / Monthly. The regular income shall be paid in arrears as per the chosen payment frequency for the income period (up to 10 years) selected, from the date of occurrence of insured event. The payment frequency can't be changed once the regular income commences. Any accrued income, due before intimation of the insured event, shall be paid along with the first payout under this option. The income option is not applicable for the Hospi Care Benefit. The payment frequency cannot be changed once the regular income commences.

The regular income instalments for frequencies other than annual shall be as specified below, where the Yearly Income below refers to the regular income payable in respect of annual frequency:

Frequency	Income Instalment (per frequency)
Half-yearly	98% of Yearly Income x ½
Quarterly	97% of Yearly Income x ¼
Monthly	96% of Yearly Income x $^{1}/_{12}$

Where the Insured Amount is higher than the Sum Assured under Benefit Option, the amount in excess of Sum Assured under Benefit Option shall be paid in lump sum.

Under sub-clause (b) & (c) of this clause, the Claimant shall have an option to receive the commuted value of the future income benefits as a lump sum, discounted at the higher of:

- 4.00%,
- SBI domestic term deposit rate for '5 years and up to 10 years' + 2.00%).

3.7. WAITING PERIOD

'Waiting Period' means a period during which specified diseases/treatments which have been diagnosed and/or have received medical advice/treatment are not covered. In the event of occurrence of any of such scenarios during the applicable Waiting Period,

- No benefit shall be payable
- the Premiums paid towards the benefit option during the Waiting Period will be refunded without any interest (Not applicable in Hospi Care Option); and
- the benefit option shall terminate and no future Premiums and benefits shall be payable (Not applicable in Hospi Care Option).

Waiting Period as per the chosen benefit option shall be as under:

Benefit Option	Waiting Period applicable^
Hospi Care Benefit	A waiting period of 90 days is applicable for all benefits payable under Hospi Care (except for hospitalization due to an accident). A specific waiting period of 2 years for the specific conditions as mentioned in the Annexure A – Definitions and Exclusions will be applicable for all benefits covered under the benefit.
Multistage CritiCare Cancer Care Cardiac Care	A waiting period of 90 days is applicable on the first diagnosis of any of the major illness covered under the respective benefit option. A waiting period of 180 days is applicable on the first diagnosis of any of the minor illness covered under the respective benefit option.

^ The Waiting Period for all benefits shall be applicable from later of:

- Date of commencement of risk, if benefit option is opted at inception;
- Policy Anniversary at which benefit option is opted (if benefit option is opted for on the Policy Anniversary); or
- Date of revival (in case of revival of the benefit option).

'Waiting period' is not applicable if the insured event occurs as a result of an Accident (e.g.: Major Head Trauma due to an Accident)

3.8. GRACE PERIOD

A Grace Period of fifteen (15) days for monthly mode and thirty (30) days for all other modes, from the due date of Rider Premium will be allowed for payment of each subsequent Rider Premium. The Grace Period applicable to the Rider shall be same as per the Base Plan. The coverage under the chosen benefit option will remain in force during this period. If the full Rider Premium remains unpaid at the end of Grace Period shall lapse or be converted to reduced paid-up from the due date of the first unpaid Rider Premium. If any claim occurs during the Grace Period, any due Rider Premium (without interest) for the full coverage year, in which the insured event has occurred will be deducted from the claim pay-out.

4. PART D

4.1. FREE LOOK PERIOD

You have a free look period of 30 days from the date of receipt of the Rider document, received electronically or otherwise, to review the terms and conditions of the Rider. If You disagree to any of those terms or conditions, You have the option to return the Rider for cancellation, stating the reasons for objection and be entitled to a refund of the premiums paid without interest after deduction of proportionate risk premium, stamp duty and medical examination cost along with applicable taxes and cesses or levies, if any.

4.2. LOANS

You are not entitled to any loans under this Rider.

4.3. NON-FORFEITURE PROVISIONS

At any time during the Rider Term, if the Premiums are not paid within the Grace Period and the Rider has not acquired surrender value, the Rider will lapse. No benefits are payable under a lapsed benefit option.

4.4. SURRENDER / UNEXPIRED RISK PREMIUM BENEFIT

Surrender Benefit shall be payable under the following scenarios:

Premium Paying options	Conditions for acquiring Surrender Value	Guaranteed Surrender Value	Unexpired Risk Premium Value
Single Pay	Immediately on receiving the premium	Not available	75% * (sum of premiums paid excluding any premium discounts availed under Wellness Program (if opted as per Clause 3.3.2) as premium cashback or premium discount) * (1-premium paying term / benefit option term) * (Balance benefit option term / benefit option term) less any claims paid/payable
Limited Pay	If at least 2 full years' premiums have been paid	Not available	75% * (sum of premiums paid excluding the first years' premium excluding any premium discounts availed under Wellness Program (if opted as per Clause 3.3.2) as premium cashback or premium discount) * (1-premium paying term / benefit option term) * (Balance benefit option term / benefit option term) less any claims paid/payable

Any individual benefit option under the Rider may be surrendered / discontinued separately or it gets surrendered / discontinued if the Base Plan is surrendered / discontinued or made paid-up.

No surrender benefit is payable if the total claim/s value paid exceeds the Total Rider Premiums Paid. The surrender benefit payable will be the surrender value calculated less any claims paid under this Rider.

4.5. REDUCED PAID-UP

If You have opted for a Return of Balance Premium option, the Reduced Paid-up Benefit shall apply to all regular/limited-premium paying benefit options (if chosen), as specified below-

Premium Paying options	Cover Continuance	
	Before 2 years' premium paid	After 2 years' premium paid
Regular Pay	Cover cease to exist	Cover cease to exist
Limited pay	Cover cease to exist	Cover cease to exist

Maturity Benefit – As per 'MATURITY BENEFIT' provisions under Part C 'BENEFITS' of this Rider.

4.6. REVIVAL OF THE RIDER

a) The lapsed benefit option may be revived (along with the Base Plan) on the payment of all due Premiums within Revival Period as applicable under the Base Plan, by paying interest.

If there is default in Premium beyond the Grace Period (as applicable under the Base Plan) and subject to the Rider not having been surrendered, it may be revived, in accordance with Underwriting Policy within Revival Period (as applicable under the Base Plan) but before the Maturity/Expiry Date of benefit option, subject to:

- Your written application for revival;
- Production of Insured's current health certificate and other evidence of insurability satisfactory to Us; and
- Payment of all overdue premiums with interest.

b) If the Rider/Benefit Option is not revived along with the Base Plan, the Rider/Benefit Option shall be terminated by paying any residual Surrender Value (if any) as on the date of revival of the Base Plan and revival of such terminated Rider/Benefit Option will not be allowed at a later stage.

c) The applicable interest rate for revival shall be the same as Base Plan.

d) Any revival shall cover insured events which occur after the date of revival, subject to the Waiting Period for the Benefit Option (as applicable). Upon revival, the benefits option shall be restored with effect from the date of revival, subject to the Waiting Period as may be applicable for the respective Benefit Option.

e) The benefit option cannot be revived independently and can only be revived along with the revival of the Base Plan.

4.7. PAYMENT OF RIDER BENEFITS

As per base Policy.

4.8. TERMINATION OF THE RIDER/BENEFIT OPTION

The benefit option shall terminate upon the happening of the first of the following events:

a) on the expiry of Coverage Term;
b) on payment of surrender value of the benefit option;
c) on the date on which We receive free look cancellation request for the benefit option within requisite period;
d) on the payment of the benefit as per the terms of the benefit option or commencement of income benefit payment or the date of intimation of repudiation of the claim by Us;
e) on the expiry of the Revival Period, if the lapsed benefit option has not been revived;
f) on termination of Base Plan, except where the Rider coverage is opted on a Life Insured other than or in addition to the Life Insured under the Base Plan, in case of death of Base Plan Life Insured, the Rider coverage shall continue for the surviving Life Insureds under the Rider.

g) on the Maturity/Expiry Date or the date on which the Base Plan is surrendered cancelled for any reason;
h) on our acceptance of the receipt of Your written request for cancellation of the Benefit Option, after the completion of the free look period;
i) on cancellation/ termination of this Rider/benefit option by Us on grounds of misrepresentation, fraud or non- disclosure established in terms of Section 45 of the Insurance Act, 1938 as amended from time to time.

5. PART E
FEES / CHARGES

This Rider is a Non-Linked Rider; therefore, Part E is not applicable to this Rider.

6. PART F: GENERAL PROVISIONS

6.1. TAXES

All Premiums, Charges and interest payable under the benefit option are exclusive of applicable taxes, cesses or levies, if any, which will be entirely borne/paid by You, in addition to the payment of such Premium, charges or interest. We shall have the right to claim, deduct, adjust, recover the amount of any applicable tax or imposition, levied by any statutory or administrative body from the benefits payable under the benefit option.
Tax benefits and liabilities under the benefit option are subject to prevailing tax laws. Tax laws and the benefits arising thereunder are subject to change. You are advised to seek an opinion of Your tax advisor in relation to the tax benefits and liabilities applicable to You.

6.2. CLAIM PROCEDURE

For processing the claim request under this policy, we will require the following documents:

Type of Claim	Requirement
Death (all causes of death other than the Accidental Death)	a) Claim Forms Part I: Application Form for Death Claim (Claimant's Statement) along with NEFT form Part II: Physician's Statement - to be filled by last attending physician
	b) Death Certificate issued by a local government body like Municipal Corporation
	c) Medical Records (Admission Notes, Discharge/Death Summary, Indoor Case Papers, Test Reports etc.)
	d) Claimant's Photo ID with age proof & relationship with the Insured along with Address proof of the claimant and Cancelled cheque with name and account number printed or cancelled cheque with copy of Bank Passbook / Bank Statement If no nomination - Proof of legal title to the claim proceeds (e.g. legal succession paper)
In case of an unnatural death (to be submitted in addition to the above)	• Copy of the First Information Report (FIR) or Panchanama/ Police complaint/ Inquest# • Copy of Post-Mortem report (PMR)/ Autopsy and Viscera report# • Copy of the Final Police Investigation report (FPIR)/ Charge sheet#

Type of Claim	Requirement
Disability and Dismemb-erment Claim (If opted)	a) Claim Forms - Part I: Application Form for Disability / Dismemberment Claim (Claimant's Statement) along with NEFT form - Part II: Confidential Medical Report - to be filled by attending physician
	b) Attested True Copy of Indoor Case Papers of the Hospital
	c) Discharge Summary of Present and Past Hospitalizations
	d) Insured's PAN Card OR Form 60, Insured's Address proof
	e) Bank Details of the Insured – Cancelled cheque (with printed name and account number)/bank passbook
	f) Disability Certificate by attending Physician / Institute for disabled
	g) Rehabilitation Certificate - if applicable
	h) Employer's written confirmation / statement - for Disability claim
	i) All related Medical Examination Reports, e.g. Laboratory test reports X-Ray / CT Scan / MRI Reports & Plates, Ultrasonography Report Clinical / Hospital Reports
	j) Clinical Photographs showing the injured areas - if available
In case of an unnatural death (to be submitted in addition to the above)	• Copy of the First Information Report (FIR) or Panchanama/ Police complaint/ Inquest# • Copy of Post-Mortem report (PMR)/ Autopsy and Viscera report# • Copy of the Final Police Investigation report (FPIR)/ Charge sheet#

#Medical records shall be required if Life Assured was in hospital at the time of death or any time prior to the date of death. Please submit copies certified/attested by the issuing or competent authority. Original Seen Verified (OSV) by Branch Personnel will also be accepted.

Copies of the other documents to be submitted by self-attestation of the claimant

Maturity Claim Requirements

To ensure processing the maturity payout on or before the Maturity Date, We shall consider the bank account details available in Your Policy record. If there is any change, please submit below documents sufficiently in advance, to enable us release the maturity payout on or before the Maturity Date:

- NEFT Form;
- a cancelled cheque or copy of passbook with pre-printed name and bank account number, for payout through NEFT, and
- a self-attested photo ID proof.

Note-
In case the claim warrants any additional requirement, We reserve the right to call for the same.
Notification of claim & submission of the claim requirements does not mean admission of the claim liability by the Company.
No agent is authorized to admit any liabilities on behalf of the Company, nor to alter this list of documents or any claims requirements called for by the Company.

To process the claims of senior citizens, the Company shall ensure preferential treatment to the senior citizen and a speedy disposal of the claims.

6.3. MISTATEMENT OF AGE

As per base Policy.

6.4. FRAUD AND NON-DISCLOSURE

As per base Policy.

6.5. CURRENCY AND PLACE OF PAYMENT

As per base Policy.

6.6. FREEDOM FROM RESTRICTIONS

There are no restrictions on travel or occupation under this Rider.

6.7. NOMINEE

As per Base Plan.

6.8. ASSIGNMENT

As per Base Plan.

6.9. CHANGE IN ADDRESS

In order to provide better service, We request you to intimate us in the event of any change in the address of the Policyholder or the nominee.

6.10. AMENDMENT

As per base Policy.

6.11. REGULATORY AND JUDICIAL INTERVENTION

As per base Policy.

6.12. COMMUNICATION AND NOTICES

As per base Policy.

6.13. GOVERNING LAW AND JURISDICTION

As per base Policy.

7. PART G: POLICY SERVICING AND GRIEVANCE HANDLING MECHANISM

As per base Policy.

To handle the grievances of senior citizens, the Company shall ensure preferential treatment to the senior citizen and a speedy disposal of the grievances.

Annexure A (Definitions and Exclusions)

Definitions of Conditions covered
(as applicable under the respective benefit)

A. Accidental Disability Care

1. Accidental Permanent Partial Disability:

Accidental Permanent Partial Disability is defined as a disability of the Life Assured as a result of bodily injury caused by an accident solely, directly and independently of any other cause within 180 days of the accident and must result in one of the following:

Description of Disability	Amount of Benefit (% of Insured Amount under the Benefit Option)
Permanent loss of	
- each arm at the shoulder joint	60%
- each arm to a point above elbow joint	55%
- each arm below elbow joint	50%
- each hand at the wrist	50%
- each thumb	20%
- each index finger	10%
- each finger other than the thumb or index finger	5%
- each leg above center of the femur	60%
- each leg up to a point below the femur	55%
- each leg to a point below the knee	50%
- each foot at the ankle	40%
- each big toe	5%
- each toe other than the big toe	2%
Loss of Sight in each eye*	50%
Loss of Hearing in each ear*	30%

The disability has to be certified by a Registered Medical Practitioner to be permanent in nature.

If the disability is due to amputation/dismemberment, the loss of hand will mean amputation/dismemberment above wrist, the loss of arm will mean amputation/ dismemberment above elbow, the loss of feet will mean amputation/dismemberment above ankle and the loss of leg will mean amputation/dismemberment above knee. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. If the disability is not due to amputation/dismemberment, the loss will mean loss of usage of both limbs and the limbs should have motor power grade 0/5, 1/5 or 2/5 only.

Loss of a Limb resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded. The loss of use of the particular limb must be certified by a relevant Medical Practitioner and documented for an uninterrupted period of at least six months.

**Loss of hearing* - Total and irreversible loss of hearing as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in ears.

**The total Loss of Sight* in one eye means total, permanent and irreversible loss of all vision in an eye as a result of accident evidenced by:

i. corrected visual acuity being 3/60 or less in one eye or;
ii. the field of vision being less than 10 degrees in one eye

The diagnosis of Loss of sight in one eye must be certified by an ophthalmologist to be permanent in nature and must not be correctable by aids or surgical procedure.

2. Accidental Total and Permanent Disability:

Accidental Total and Permanent Disability means disability as a result of bodily injury caused by an accident and such injury shall within 180 days of its occurrence solely, directly and independently of any other cause, result in the Member's disability which must be total and permanent, and must result in at least one of the following:

i. Loss of sight in both eyes
ii. Loss of both arms or both hands;
iii. Loss of one arm and one leg;
iv. Loss of one arm and one foot;
v. Loss of one hand and one foot;
vi. Loss of one hand and one leg;
vii. Loss of both legs;
viii. Loss of both feet;
ix. Removal of the entire lower jaw
x. Loss of one hand and loss of sight in one eye
xi. Loss of one foot and loss of sight in one eye

If the disability is due to amputation/dismemberment, the loss of hand will mean amputation/dismemberment above wrist, the loss of arm will mean amputation/ dismemberment above elbow, the loss of feet will mean amputation/dismemberment above ankle and the loss of leg will mean amputation/dismemberment above knee. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. If the disability is not due to amputation/dismemberment, the loss will mean loss of usage of both limbs and the limbs should have motor power grade 0/5, 1/5 or 2/5 only.

Loss of a limb resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded. The loss of use of the particular limb must be certified by a relevant Medical Practitioner and documented for an uninterrupted period of at least six months.

The total *Loss of Sight in one eye* means total, permanent and irreversible loss of all vision in an eye as a result of accident, evidenced by:

i. corrected visual acuity being 3/60 or less in one eye or;
ii. the field of vision being less than 10 degrees in one eye

The diagnosis of loss of sight in one eye must be certified by an ophthalmologist to be permanent in nature and must not be correctable by aids or surgical procedure.

Loss of Sight in both eyes - Total, permanent and irreversible loss of all vision in both eyes as a result of accident, evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;
ii. the field of vision being less than 10 degrees in both eyes

The diagnosis of Loss of Sight in both eyes must be certified by an Ophthalmologist to be permanent in nature and must not be correctable by aids or surgical procedure.

B. Cancer Care

1. Cancer of specified severity:

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. 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 leukemia 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;

Reconstructive Breast Surgery (Only For Female Life) If the life assured is diagnosed as suffering from breast cancer as defined above under "**Major stage**

cancer of specified severity", and the same is intimated to the company within 30 days of diagnosis, an additional benefit amount of 30% (thirty percentage) of the Insured Amount under the Benefit Option will be payable to her for Reconstructive breast surgery. This payment will be made on the actual undergoing of Reconstructive Breast Surgery on the diagnosis of the breast cancer and it being confirmed by an oncologist supported by surgical, clinical, radiological, histological and laboratory evidence acceptable to the Company.

2. Carcinoma in-situ

Carcinoma-in-situ means the presence of malignant cancer cells that remain within the cell group from which they arose. It must involve the full thickness of the epithelium but does not cross basement membranes and it does not invade the surrounding tissue or organ. The diagnosis of which must be positively established by microscopic examination of fixed tissues supported by biopsy result. The diagnosis must be established by histological evidence and be confirmed by an independent Medical Practitioner who is an Oncologist. Clinical diagnosis does not meet this standard.

The following are specifically excluded from all minor cancer benefits:

- All tumors which are histologically described as benign, borderline malignant, or low malignant potential
- Dysplasia, intra-epithelial neoplasia or squamous intra-epithelial lesions
- Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, and CIN II. In the case of the cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS.
- Carcinoma in-situ of skin and Melanoma in-situ
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond
- Malignant melanoma that has not caused invasion beyond the epidermis

3. Early Stage Cancer

It shall mean the presence of one of the following malignant conditions. The Diagnosis must be based on histopathological features and confirmed by an independent Medical Practitioner who is an Oncologist. Pre-malignant lesions and conditions, unless listed below, are excluded.

- *Prostate Cancer – Minor Stage:* Minor Prostate Cancer that is histologically described using the TNM classification as T1a, T1b & T1c with a Gleason Score 2 (two) to 6(six).
- *Thyroid Cancer – Minor Stage:* All thyroid cancers that are less than 2.0 cm and histologically classified as T1N0M0 according to TNM classification.
- *Bladder Cancer – Minor Stage:* All tumors of the urinary bladder histologically classified as T1N0M0 according to TNM classification.
- *Chronic Lymphocytic Leukaemia – Minor Stage:* Chronic Lymphocytic Leukaemia categorized as stage 1(one) to 2 (two) as per the Rai classification.

The following are specifically excluded from all minor cancer benefits:

- All tumors which are histologically described as benign, borderline malignant, or low malignant potential
- Dysplasia, intra-epithelial neoplasia or squamous intra-epithelial lesions
- Carcinoma in-situ of skin and Melanoma in-situ

C. Cardiac Care

1. Angioplasty:

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

Note: A lower of INR 5 lakhs or 25% of Cardiac Insured Amount shall be made in case the Life Assured undergoes Angioplasty; Cardiac Care Benefit shall continue with the balance Insured Amount, if any; for the remaining insured cardiac ailments.

2. Balloon Valvotomy or Valvuloplasty:

The actual undergoing of percutaneous intravascular Valvotomy or percutaneous intravascular Valvuloplasty not involving the deployment of any device or prosthesis necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available.

The following are excluded:

- All other surgical corrective methods will be excluded from this benefit.
- Procedures done for treatment of Congenital Heart Disease.

3. Cardiomyopathy (of specified severity):

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class III or Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

- Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure
- Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced and Echocardiography findings confirming presence of cardiomyopathy and Left Ventricular Ejection Fraction (LVEF %) of 40% or less.

The following are excluded:

- Cardiomyopathy directly related to alcohol or drug abuse.

4. Pulmonary Artery Graft:

The undergoing of surgery requiring median sternotomy for disease to the pulmonary artery with excision and surgical replacement of a portion of the diseased pulmonary artery with a graft.

For the above definition, the following are not covered:

- Any other surgical procedure for example the insertion of stents or endovascular repairs

5. Carotid Artery Surgery:

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

(a) Either:

- Actual undergoing of endarterectomy to alleviate the symptoms; or
- Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

(b) The Diagnosis and medical necessity of the treatment must be confirmed by a Registered Medical Practitioner who is a specialist in the relevant field.

6. Heart Transplant:

The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner. Stem Cell transplants are excluded.

7. Implantable Cardioverter Defibrillator:

Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

- Cardiac arrest secondary to alcohol or drug misuse will be excluded.

8. Implantation of Pacemaker of Heart:

Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a Cardiologist. Cardiac arrhythmias to be evidenced by 24 Holter monitoring report or any such other established diagnostic reports. The insertion of any other type of temporary cardiac pacemaker is specifically excluded. Cardiac arrest secondary to alcohol or drug misuse will be excluded.

9. Infective Endocarditis:

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

- Positive result of the blood culture proving presence of the infectious organism(s)
- Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) attributable to Infective Endocarditis; and
- The diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

10. Major Surgery of Aorta:

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches (including aortofemoral or aortoiliac bypass grafts). The surgery must be determined to be medically necessary by a Consultant Cardiologist / Surgeon and supported by imaging findings. The following are excluded:

- Surgery performed using only minimally invasive or intra-arterial techniques.
- Procedures done for treatment of Congenital Heart Disease.

11. Minimally Invasive Surgery of Aorta:

The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

The following are excluded:

- Procedures done for treatment of Congenital Heart Disease.

12. Myocardial Infarction (First Heart Attack of specified severity):

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.

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.

13. Open Chest CABG (Coronary Artery Bypass Graft):

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. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

14. Open Heart Replacement or Repair of Heart Valves:

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

15. Percutaneous Procedures for Heart Valve Surgery:

The actual undergoing of surgery to replace existing heart valve by the deployment of a new replacement valve by percutaneous intravascular techniques not involving a thoracotomy. Percutaneous or transcatheter based repair procedures not involving replacement with a new valve are excluded.

The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.

16. Pericardiectomy:

The undergoing of a pericardiectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist. The following are excluded:

- Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

17. Primary (Idiopathic) Pulmonary Hypertension:

A. 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 (NYHA) of cardiac impairment.

B. The NYHA Classification of Cardiac Impairment are as follows:
   a) Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   b) Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

C. 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

18. Pulmonary Thromboembolism:

Acute Pulmonary Thromboembolism: means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and requiring medical or surgical treatment on an inpatient basis.

19. Renal Angioplasty:

Means the actual undergoing for the first time of Renal Artery Angioplasty or the insertion of a stent to correct the stenosis, of one or more renal arteries as shown by Angiographic or appropriate imaging evidence. The revascularization must be considered medically necessary by an appropriate specialist.

Intra Arterial investigative procedures and Diagnostic Angiography are excluded.

20. Stroke resulting into permanent symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extra cranial 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.The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

21. Surgery for Cardiac Arrhythmia:

Procedures like Maze surgery, RF Ablation therapy necessitated by a cardiologist to treat life threatening arrhythmias. Diagnosis must be evidenced by Electrophysiological Study, monitoring through a Holter monitor, event monitor or loop recorder and should be confirmed by a consultant cardiologist. Ablation procedures should ideally immediately follow the diagnostic electrophysiology study.

The following are excluded:

- Cardio version and any other form of non-surgical treatments
- Procedures done for treatment of Congenital Heart Disease

22. Surgery to Place Ventricular Assist Devices or Total Artificial Hearts:

The actual undergoing of open heart surgery to place a Ventricular Assist Device or Total Artificial Heart medically necessitated by severe ventricular dysfunction or severe heart failure, with cardiac echocardiographic evidence of reduced left ventricular ejection fraction of less than 30%. The following are excluded: Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse is excluded.

D. Multistage CritiCare

1. Apallic Syndrome:

A persistent vegetative state in which patients with severe brain damage (universal necrosis of the brain cortex with the brainstem remaining intact), are in a state of partial arousal rather than true awareness. The Diagnosis must be confirmed by a Specialist Medical Practitioner (Neurologist) acceptable to the Company and condition must be documented for at least 30 days.

2. Aplastic Anaemia:

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

(a) Regular Blood product transfusion;

(b) Marrow stimulating agents;

(c) Immunosuppressive agents; or

(d) Bone marrow transplantation.

The Diagnosis and suggested line of treatment of aplastic anaemia must be confirmed by a Haematologist acceptable to the Company using relevant laboratory investigations including 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.

Temporary or reversible aplastic anaemia is excluded

3. Alzheimer's Disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" (defined in 'Generic Definitions' section below) for a continuous period of at least 3 months. The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Alcohol-related brain damage.

4. Bacterial Meningitis:

A definite diagnosis of bacterial meningitis resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by growth of pathogenic bacteria from cerebrospinal fluid culture.

For the above definition, the following are not covered:

- Aseptic, viral, parasitic or non-infectious meningitis

5. Benign Brain Tumor

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.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor

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.

6. Blindness:

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:

- corrected visual acuity being 3/60 or less in both eyes or;
- the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

7. Brain Surgery:

The actual undergoing of surgery to the brain, under general anaesthesia during which a Craniotomy is performed. Burr hole and brain surgery as a result of an Accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

This requirement of surgery must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques and certified by a neurosurgeon or qualified medical doctor of relevant specialty.

8. Coma of Specified Severity:

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:

- No response to external stimuli continuously for at least 96 hours;
- Life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting from alcohol or drug abuse is excluded.

9. Chronic Recurrent Pancreatitis:

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

10. Cirrhosis of the Liver:

Chronic hepatitis due to hepatitis virus infection having progressed to liver cirrhosis. At time of claim all of below must be fulfilled:

1. clinical evidence of chronic viral hepatitis in the form of serology and other laboratory tests.
2. unequivocal diagnosis of liver cirrhosis caused by viral hepatitis must be made based on liver tissue histopathology, clinical findings and medical history by gastroenterologist in a hospital recognized by the insurer.
3. histopathological report shows stage F4 by Metavir grading[8] or a Knodell fibrosis score[9] of 4.

Liver disease caused by alcohol or drug abuse is excluded.

11. Creutzfeldt-Jacob disease:

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective permanent neurological abnormalities persisting for more than 180 days along with severe progressive dementia.

12. Deafness:

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

13. Encephalitis:

Severe inflammation of the brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit for a min period of 60 days. This diagnosis must be certified by a consultant neurologist and the permanent neurological deficit must result in an inability to perform at least three of the Activities of Daily Living (defined in 'Generic

Definitions' section below) either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.

14. End Stage Liver Failure:

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

- permanent jaundice; and
- ascites; and
- hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

15. End Stage Lung Failure:

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

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 < 55$ mmHg); and
- Dyspnea at rest.

16. Fulminant Viral Hepatitis:

A definite diagnosis of fulminant viral hepatitis evidenced by all of the following:

- Typical serological course of acute viral hepatitis
- Development of hepatic encephalopathy
- Decrease in liver size
- Increase in bilirubin levels
- Coagulopathy with an international normalized ratio (INR) greater than 1.5
- Development of liver failure within 7 days of onset of symptoms
- No known history of liver disease

The diagnosis must be confirmed by a Consultant Gastroenterologist. For the above definition, the following are not covered:

- All other non-viral causes of acute liver failure (including but not limited to paracetamol or aflatoxin intoxication)
- Fulminant viral hepatitis associated with intravenous drug use

17. Kidney Failure Requiring Dialysis:

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

18. Loss of Independent Existence:

Confirmation by a consultant physician acceptable to the Company of the loss of independent existence due to illness or trauma, which has lasted for a minimum period of 6 months and results in a permanent inability to perform at least three (3) of the 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 hope of recovery with current medical knowledge and technology. The "Activities of Daily Living" have been defined in 'Generic Definitions' section below.

The following is excluded:

- Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.

19. Loss of Limbs:

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. Loss of Speech:

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

21. Major Head Trauma:

Accidental head injury resulting in permanent Neurological deficit 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.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living (defined in 'Generic Definitions' section below) 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.

The following are excluded:

- Spinal cord injury

22. Major Organ (less heart)/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs: lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- Other stem-cell transplants
- Where only Islets of Langerhans are transplanted

23. Medullary Cystic Kidney Disease:

Medullary Cystic Disease is a disease where the following criteria are met:

- The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- Clinical manifestations of anaemia, polyuria and progressive deterioration in kidney function; and
- The diagnosis of medullary cystic disease is confirmed by renal biopsy.
- Isolated or benign kidney cysts are specifically excluded from this benefit.

24. Motor Neuron Disease with Permanent Symptoms:

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

25. Multiple Sclerosis with Persisting Symptoms:

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Neurological damage due to SLE is excluded.

26. Muscular Dystrophy:

Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of muscular dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence. The disease must result in the permanent inability of the insured to perform (whether aided or unaided) at least three (3) of the six (6) "Activities of Daily Living" (defined in 'Generic Definitions' section below).

27. Nephrectomy/Removal of One Kidney:

The actual undergoing of a complete nephrectomy due to illness, disease or Accident. Nephrectomy for the purpose of organ donation is specifically excluded.

The requirement of surgery has to be confirmed by a specialist medical practitioner.

28. Parkinson's Disease:

Unequivocal Diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) by a Registered Medical Practitioner who is a neurologist where the condition:

- cannot be controlled with medication; and
- shows objective signs of progressive impairment; and
- Activities of Daily Living assessment confirms the inability of the Member to perform at least 3 of the Activities of Daily Living as defined in "Generic Definitions" section below, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons, for a continuous period of six months:
  - Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinson's Disease are excluded.

29. Permanent Paralysis of Limbs:

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

30. Portal Vein Thrombosis:

Portal vein thrombosis is blockage or narrowing of the portal vein (the blood vessel that brings blood to the liver from the intestines) by a blood clot. It should be characterized by the following:

i. Bleeding from varicose veins in the esophagus or stomach and/or
ii. An enlarged spleen

Doppler ultrasonography /magnetic resonance imaging (MRI) or computed tomography (CT) and a Gastroenterologists report is necessary.

31. Progressive Scleroderma:

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The systemic involvement should be evidenced by any two of the following findings-

- Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted
- Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterization
- Chronic kidney disease with a GFR of less than 60 ml/min (MDRD-formula)
- Echocardiographic findings suggestive of Grade III and above left ventricular diastolic dysfunction

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist. The following conditions are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fascitis; and
- CREST syndrome

32. Pneumonectomy:

The actual undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung for any physical injury or disease.

33. Poliomyelitis:

The first occurrence of poliomyelitis where the following conditions are met:

i. Poliovirus is identified as the cause and is provided by stool analysis
ii. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months

34. Severe Osteoporosis:

A certified medical consultant must make the definite diagnosis of osteoporosis that follows the WHO definition where there is testing evidence of bone density reading with a T-score of less than –2.5 (2.5 standard deviation below the peak bone density of a normal 25-30 year old adult). The osteoporosis must have caused multiple fractures resulting in the Insured's permanent inability to perform at least 3 of 5 Activities of Daily Living (ADLs).

Activities of Daily Living are defined as:

(a) *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;
(b) *Dressing:* The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
(c) *Transferring:* The ability to move from a bed to an upright chair or wheelchair and vice versa;
(d) *Toileting:* The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
(e) *Feeding:* The ability to feed oneself once food has been prepared and made available.

WHO Definition of Osteoporosis: Bone density reading with a T-score of less than –2.5 (i.e. 2.5 standard deviation below the peak bone density of a normal 25- 30 year old adult).

35. Severe Rheumatoid Arthritis:

Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

(a) Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis and has been diagnosed by a Rheumatologist;
(b) Permanent inability to perform at least three (3) of the six (6) Activities of Daily Living (defined in 'Generic Definitions' section below);
(c) Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet confirmed by clinical and radiological evidence; and
(d) The foregoing conditions have been present for at least six (6) months.

For the above definition, the following are not covered:

- Reactive arthritis, psoriatic arthritis and activated osteoarthritis

36. Small Bowel Transplant:

Certified by a gastroenterologist that the surgery is necessary in case of person has a small intestinal failure (serious malfunctioning bowel), and has developed complications from total parenteral nutrition or are unable to tolerate this form of feeding. Payout will be based on the actual undergoing of surgery. Drug or alcohol abuse leading to intestinal failure is excluded.

37. Systemic Lupus Erythematosus (SLE) with Renal Involvement:

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

Class VI - Advanced sclerosing lupus nephritis

The final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

38. Third Degree Burns:

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

39. Ulcerative Colitis:

Ulcerative Colitis is a chronic inflammation of the large intestine, not caused by bacteria, which results in ulceration and bleeding. The diagnosis must be confirmed by a Gastro-Enterologist and the disease must be treated with either steroids or immunomodulatory medication for a period of at least six months. It should be supported with Endoscopy and histopathological report.

Generic Definitions

Accident: An Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Activities of Daily Living: 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.

Adventurous Pursuits or Hobbies: Adventurous Pursuits or Hobbies include but are not limited to any kind martial arts, racing (other than on foot or swimming); potholing, rock climbing (except on man-made walls), hunting, mountaineering or climbing requiring the use of ropes or guides, any underwater activities involving the use of underwater breathing apparatus including deep sea diving, sky diving, cliff diving, bungee jumping, paragliding, hand gliding and parachuting.

Biological attack: Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Chemical attack: 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.

Congenital Anomaly: Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) *Internal Congenital Anomaly:* Congenital anomaly which is not in the visible and accessible parts of the body.
b) *External Congenital Anomaly:* Congenital anomaly which is in the visible and accessible parts of the body

Cooling Off Period: In case of multiple minor stage claims under the same category (Critical illness, Cancer or Cardiac as applicable), the acceptance of the claims shall be subject to a Cooling Off Period. Cooling off Period shall apply after each occurrence of the condition/procedure, provided such occurrence resulted into a valid minor stage claim.

- For multiple minor stage claims, there needs to be a period of at least 180 days between the date of occurrence of a minor stage condition and date of occurrence of a subsequent minor stage condition. No minor claims shall be payable in this period for the aforementioned scenario.
- Date of occurrence is the date of diagnosis of a covered illness or the date of undergoing of any procedure covered under minor conditions
- However, this requirement of 180 days is not applicable in case of diagnosis of a major stage condition following a minor stage claim.
- A particular minor condition can be claimed only once during the Benefit Option Term.

Hospital: A Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56(1) and the said Act or, complies with all minimum criteria as under:

- Has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- Has qualified nursing staff under its employment round the clock;
- Has qualified medical practitioner(s) in charge round the clock;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out; and
- Maintains daily records of patients and makes these accessible to the Tata AIA's authorized personnel.

Hospitalization: Hospitalization means admission in hospital for minimum period of 24 consecutive 'In patient care' hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Illness: An Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    2. it needs ongoing or long-term control or relief of symptoms
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4. it continues indefinitely
    5. it recurs or is likely to recur

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

Intensive Care Unit: Intensive Care Unit (ICU) means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Medical Practitioner: A Medical Practitioner means person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

The person must be qualified in allopathic system of medicine and shall not be

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

Medically Necessary Treatment: Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a medical practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Pre-Existing disease: Pre-Existing condition means any condition, ailment, injury or disease:

- That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the Company or its revival
- For which medical advice or treatment was recommended by, or received from, a Physician within 36 months prior to the effective date of the policy issued by the Company or its revival

Surgery / Surgical Procedure: Surgery / Surgical Procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Symptom is a physical or mental feature which is regarded as indicating presence of a disease, particularly such a feature is apparent to an individual and will result in a medical consultation and/or further investigations to confirm the cause.

Exclusions

Details of the Exclusions applicable under the various 'Health Benefit options' are given below:

Event	Exclusion
Accidental Disability Care	Accidental Disability Care Benefit shall be not payable for any losses caused directly or indirectly, wholly or partly, by any one of the following occurrences: • Injury occurred before the risk commencement date • If the Disability occurs after 180 days from the date of the accident • If the Disability has not persisted for at least 180 days and is not in the opinion of a medical practitioner, deemed to be permanent. • Attempted suicide, attempted self-destruction or self-inflicted injury, irrespective of mental condition. • No benefits will be payable for any condition(s) which is a direct or indirect result of any pre-existing conditions unless Life Assured has disclosed the same at the time of proposal or date of revival whichever is later and the Company has accepted the same. Wherever the proximate cause is accident which has occurred after the rider inception date, this exclusion shall not apply. • Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner. • War, invasion, act of foreign enemy, hostilities (whether war is declared or not), terrorism, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power or taking part in any riot, strikes, industrial disputes or civil commotion • Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. • Taking part in any naval, military or air force operation during peace time. • Engaging or Taking part in or practicing for any professional sport(s) or any adventurous pursuits or hazardous sports / pastimes including but not limited to taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off pastel skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport, bungee jumping, hand gliding etc. • Taking part in any act of a criminal or illegal nature or committing any breach of law with criminal intent. • Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature and any kind of biological and chemical contamination. • Disability as a result of any disease or infection
HospiCare (HC)	The Life Insured will not be entitled to any benefits if the surgery or hospitalization is directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following: • Any pre-existing condition (disease, illness or injury) and its complications which manifested itself prior to the effective date of the Benefit Option or its latest revival date, whichever is later. Wherever the proximate cause is accident which has occurred after the rider inception date, this exclusion shall not apply. • Any investigation or treatment for any Illness, disorder, complication or ailment arising out of or connected with the pre-existing Illness shall be considered part of that pre-existing illness. • Attempted suicide, attempted self-destruction or self-inflicted injury, irrespective of mental condition. • Complications of Sexually Transmitted Diseases or Veneral Disease • Any covered condition which is diagnosed and/or received medical advice/treatment within the waiting period. • Engaging or Taking part in or practicing for any professional sport(s) or any adventurous pursuits or hazardous sports / pastimes including but not limited to taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off pastel skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport, bungee jumping, hand gliding etc. • A Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. • Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner. • War, invasion, act of foreign enemy, hostilities (whether war is declared or not), terrorism, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power or taking part in any riot, strikes, industrial disputes or civil commotion. • Taking part in any act of a criminal or illegal nature or committing any breach of law with criminal intent. • Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature and any kind of biological and chemical contamination. • Taking part in any naval, military or air force operation during peace time. • Admission, Diagnosis or Treatment taken outside India • Circumcision, any cosmetic procedures or plastic surgery • Pregnancy, childbirth or their complications, abortion, medical termination of pregnancy, infertility including IVF surrogate or vicarious pregnancy or services including complications arising due to supplying services or Assisted Reproductive Technology or sex change operation • Organ donation (as a donor) • External and known congenital conditions or birth defects • Dental treatment except if arising from an accident • Any form of Non-Allopathic treatment • Purely investigative procedure not resulting in any treatment or elective procedures • All preventive care, vaccinations including inoculation and immunizations • Study and treatment of sleep disorder or sleep apnea • Any hospitalization/surgery performed within 90 days from the start of coverage or the revival date. • Treatment for developmental problems including learning difficulties e.g. Dyslexia, behavioral problems • Any treatment received in convalescent homes, convalescent hospitals, nature cure clinics, rest care, rehabilitation, or similar establishments • Charges incurred in connection with cost of external aids, spectacles and contact lenses, hearing aids, laser surgery for correction of refractive errors other than for focal error of +/-7 or more and medically necessary. • Routine eye examinations and ear examinations, cochlear implants, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, hair fall treatment & products, and all other similar external

	appliances and / or devices whether for diagnosis or treatment. • Any experimental or unproven pharmacological regimens or usage of any unproven treatment devices any Illness or treatment, which is a result or a consequence of undergoing such experimental or unproven treatment. • Any Stem Cell Transplant therapies or hormone replacement therapy • Treatment of obesity or morbid obesity including any complication arising from these treatments or any other weight control programme. • Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health and/ or who has been declared brain dead, as demonstrated by: • Deep coma and unresponsiveness to all forms of stimulation; or • Absent pupillary light reaction; or • Absent oculovestibular and corneal reflexes; or • Complete apnea. • Screening, counseling, treatment or complications related to autoimmune diseases. • Hospitalization only for investigation, evaluation and observation not covered. ***Excluded for first two policy years*** Specific waiting period of 2 years from policy issue date or revival date for conditions/procedures mentioned below will apply for all benefits. • Hernia Repair • Corrective procedure for gall stones • Corrective procedure for kidney or urinary tract stones • Discectomy, Laminectomy • Hemi / Partial Thyroidectomy • Corrective procedure for anal fistula or anal fissure, abscess of anal and pilonidal sinus • Removal of uterus, fallopian tubes and/or ovaries, except for malignancy • Corrective procedure for female genital Prolapse, Endometriosis/ Adenomyosis, Polycystic Ovarian Disease, fibroids, uterine prolapse, or dysfunctional uterine bleeding • Corrective procedures for Hemorrhoids • Cataract & Joint replacement surgeries (other than caused by accidents) • Hyperplasia of Prostate (BPH), Hydrocele, and spermatocele • Knee replacement surgery (other than caused by accidents) • Non-infectious Arthritis, Gout, Rheumatism, Oestoarthritis and Osteoposrosis, Prolapse of Intervertibral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis • Varicose veins and varicose ulcers of lower extremities, • Disease of middle ear and mastoid including Otitis Media (CSOM), Cholesteatoma, Perforation of Tympanic Membrane, any other benign ear, nose and throat disorder or surgery.

	• All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump, • Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract, • Tonsils and Adenoids, Nasal Septum including deviated nasal sinus and Nasal Sinuses, sinusitis and related disorder, • Internal Congenital Anomaly
Cancer Care / Cardiac Care / Multistage CritiCare	In addition to the disease specific exclusions given along with definitions of the respective diseases covered under the Benefit Option, no benefit will be payable if death or the illness covered under the policy is caused or aggravated directly or indirectly by any of the following: • Pre-Existing Diseases are not covered. Any pre-existing disease at the time of inception of the policy. • Any investigation or treatment for any Illness, disorder, complication or ailment arising out of or connected with the pre-existing Illness shall be considered part of that pre-existing illness. • No benefits will be payable for any condition(s) which is a direct or indirect result of any pre-existing conditions unless Life Assured has disclosed the same at the time of proposal or date of revival whichever is later and the Company has accepted the same. • Any covered condition which is diagnosed and/or received medical advice/treatment within the waiting period. • Self-inflicted injuries, attempted suicide, insanity, and deliberate participation of the Life Assured in an illegal or criminal act with criminal intent. • Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a medical practitioner. • Any illness due to an external congenital defect • Engaging in hazardous sports / pastimes, i.e. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off pastel skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport, bungee jumping, hand gliding etc. • Any injury, sickness or disease received as a result of aviation (including parachuting or skydiving), gliding or any form of aerial flight other than as a fare-paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on regular routes and on a scheduled timetable unless agreed by special endorsement. • War, invasion, hostilities (whether war is declared or not), civil war, rebellion, terrorist activity, revolution or taking part in a riot or civil commotion, strikes or industrial action. • Any treatment of a donor for the replacement of an organ • Nuclear reaction due to nuclear accident, Biological, Chemical or Radioactive contamination • Diagnosis and treatment outside India. • Ayurvedic, Homeopathy, Unani, herbalist treatment, any other treatments other than Allopathy / western medicines.

Annexure B - Pricing methodology of Tata AIA Vitality (Wellness Program)

1. Wellness Program Rewards Sample Illustration:

The policyholder may choose to opt for Wellness Program at inception of the policy. The health status attributed to the Insured shall be based on a point-based structure and shall be either Bronze, Silver, Gold, or Platinum.

Provided the Insured opts to enroll for the Wellness Program, an up-front reward equivalent to 5% of annualized premium for accidental rider benefit options and 10% of annualized premium for all other benefit options shall be offered for the first policy year.

The policyholder will receive rewards based on the following:

Table 1

Wellness Status	Annual Rewards Flex		Cover Booster Flex	
	ADC	Other Benefit Options	ADC	Other Benefit Options
Bronze	-2.5%	-5%	-2.5%	-5%
Silver	-1.25%	-2.5%	-1.25%	-2.5%
Gold	0.5%	+1%	0.5%	1%
Platinum	1%	+2%	1%	2%

*Negative reward refers to a reduction in rewards

The rewards are offered on cumulative basis and in any year, the maximum rewards in view of both the Up-front Rewards and Annual Rewards Flex together shall be 15% for ADC and 30% for all other benefit options. Further, the premium payable in any year shall not exceed annual premium at inception without any wellness rewards.

The Cover Boosters are offered on cumulative basis and in any year, the maximum rewards in view of both the Accumulated Cover Booster and Cover Booster Flex together shall be 15% for ADC and 30% for all other benefit options. Further, the total Cover Booster in any year shall not be lower than zero.

Alternatively, during the premium payment term the insured can opt to receive premium discount as premium cashback points in the digital health wallet and post premium payment term the insured can opt to receive the Annual health cashback based on the Wellness Status of the Insured attained each year. The Annual health cashback will be applicable on the Cover Booster as mentioned above.

Example 1:
Benefit Type – Cardiac Care
Age – 35 | Premium Payment Period (PPT) – 5 years | Policy Term (PT) – 5 years
Sum Assured – 10 Lakhs
If Annual Premium = INR 10,000[1]

Rewards During PPT (in INR)
(Premium Discount/ Cashback as per Table 1)

PPT (BOY)	Bronze	Silver	Gold	Platinum
1	1,000	1,000	1,000	1,000
2	500	750	1,100	1,200
3	-	500	1,200	1,400
4	-	250	1,300	1,600
5	-	-	1,400	1,800

Example 2:
Benefit Type – HCB
Age – 35 | Premium Payment Period (PPT) – 3 years | Policy Term (PT) – 5 years
Sum Assured – 10 Lakhs
If Annual Premium = INR 10,000[1]

[1]This is a dummy number used for demonstration of Vitality Wellness Program

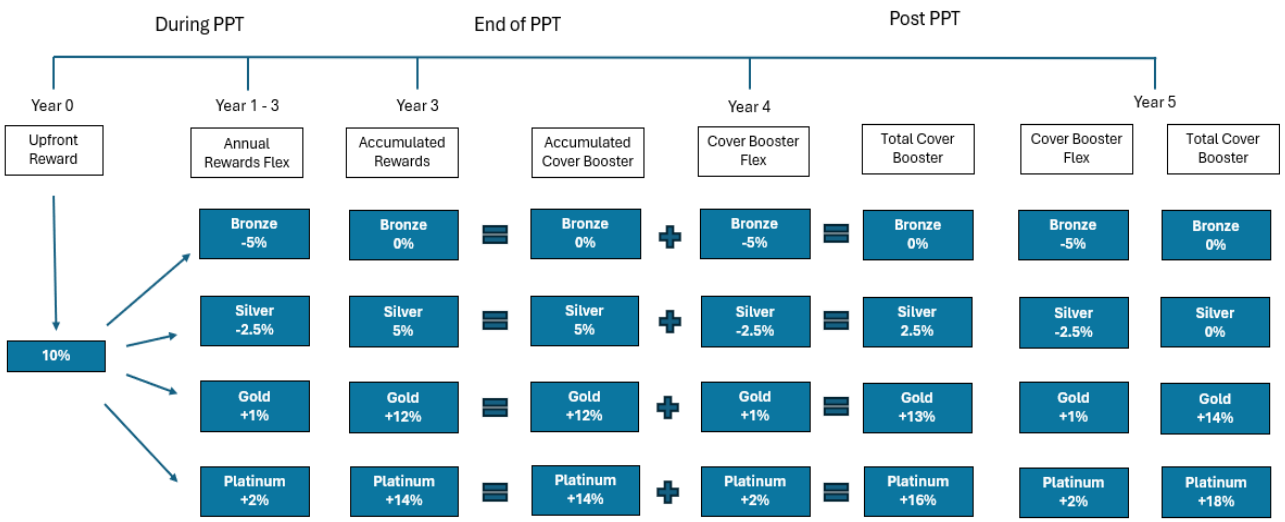
Rewards During PPT (in INR)
(Premium Discount/ Cashback as per Table 1)

PPT (BOY)	Bronze	Silver	Gold	Platinum
1	1,000	1,000	1,000	1,000
2	500	750	1,100	1,200
3	-	500	1,200	1,400
4	-	-	-	-
5	-	-	-	-

Cover Booster post PPT (in INR)

PT (BOY)	Bronze	Silver	Gold	Platinum
1	-	-	-	-
2	-	-	-	-
3	-	-	-	-
4	-	25000	130,000	160,000
5	-	-	140,000	180,000

Below is graphical illustration of wellness reward program for a sample policy (Age 35, PPT = 5 years & PT = 20 years, Benefit Option = Cardiac Care):



2. Justification for status mix assumed in Wellness Program pricing

The status mix of markets with high and low level of Wellness Program engagement has been assumed. Markets where customers are not actively engaged with the Wellness Program are expected to show similar experience as Thailand. The customers in Thailand markets are given Wellness Program at no additional fee. They have no weekly rewards and minimal status-based rewards. Long term normal distribution of Wellness Program engagement has been assumed as a proxy of actively engaged markets. Final assumptions are a weighted average of both by applying 70% weightage to market with low engagement and 30% weightage to highly engaged market.

Status/Mix	Market with high engagement	Market with low engagement	Indian Market Assumption*
Bronze	70%	95%	85%
Silver	20%	3%	10%
Gold	7.5%	1.5%	3%
Platinum	2.5%	0.5%	2%

**The final assumptions are hand polished.*

3. Justification for assumed take-up rate of 10% for annual health screening cost

According to the suggested points structure in the Wellness Program, the policyholders will have to complete annual health screening to attain and maintain Gold & Platinum status. Hence, the take up of annual health screen cost for Gold and Platinum policyholders is assumed to be 100%. Silver status can be obtained with a combination of physical activity & online assessments, hence less than 100% take up rate is assumed. Policyholders in Bronze status are assumed to be not actively engaged in the Wellness Program; hence the take-up is assumed to nil. The portfolio take-up rate of 10% is calculated by applying status-mix to the take-up rates of each status. Our intent is to monitor the experience over time post launch of this proportion and factor in any emerging experience rate through review exercise which we shall carry out at the end of guarantee period.

Description	Bronze	Silver	Gold	Platinum
Health Screen Take-Up	0%	50%	100%	100%
Business Mix	85%	10%	3%	2%

4. Justification for experience improvement factors assumed in the Wellness Program

The experience improvements corresponding to each of Wellness statuses has been considered in line with experience of Wellness Programs in global markets. The experience improvement factors of most common critical illness are observed for global markets. These improvement factors are multiplied by incidence of critical illness in local population. The resultant improvement factors have been smoothed to arrive at multiples below. Accordingly, the following adjustment multiples (expressed as a percentage of rider morbidity assumptions) have been considered while profit testing the model points under various wellness statuses over the policy years:

Wellness Status	Multiple as a % of Base
Bronze	100%
Silver	90%
Gold	83%
Platinum	75%

In our profit testing, for each model point, we have determined the average profitability across each of the possible statuses – Without Wellness Program, Bronze, Silver, Gold and Platinum, taking all the specific wellness feature related assumptions into account.

This approach has been taken to price in the costs and benefits of the wellness and preventive features offered within this product and thereby affirming compliance with clause 1(f) of the Guidelines on Wellness and Preventive Features dated 4th September 2020.

5. Derivation of Annual Health Cashback offered post premium paying term

The Annual Health Cashback post premium paying term is calculated as follows:
*Total Cover Booster applicable at end of each policy year post premium paying term * Annual Health Cashback Rate * Premium Rate applicable for Regular Pay corresponding to Entry Age and Policy Term at inception.*

The Total Cover Booster will be derived as per Wellness Program defined in Part C. The Annual Health Cashback rate is equivalent to annualized level risk premium factor applicable to a policy of same tenure and age at inception for the benefit option chosen. It is calculated as present value of pure risk cost divided by present value of gross office premiums.

Based on sample illustration 2 in Section 1 above, the annual cashback rate at policy duration 5 is calculated as below:
Total Cover Booster = INR 1,80,000
Premium Rate (Regular Pay) = 2.53[2]
Annual Health Cashback Rate = 55.3%
Annual Health Cashback Amount= (2.53 * 55.3%)/1000 * 1,80,000 = INR 251.83

[2]This is a dummy number used for demonstration of Vitality Wellness Program