PART B

Tata AIA Vitality Protect 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) **"Age"** means age as on the last birthday; i.e. the age of the Life Insured in completed years as on Date of Commencement of Policy and is as shown in the Policy Schedule.
2) **"Annualized Premium"** means the Rider Premium payable in a year chosen by the Policyholder, excluding the taxes, underwriting extra premiums and loadings for modal Rider Premium, if any, as specified in the Schedule.
3) **"Base Plan"** means the insurance policy to which this Rider is being attached.
4) **"Claimant"** means the person entitled to receive the Policy benefits and includes the Policyholder, the nominee, the assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be;
5) **"Coverage Term"** means the term in respect of the chosen Benefit Option as specified in the Schedule;
6) **"Insured Amount"** shall be –
   a) **Combination of Lump sum and Income:** Highest of:
   - 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.
   - 105% of Total Premiums Paid (Excluding loading for modal Rider Premiums) up to the date of occurrence of the insured event.
   - Sum Assured under Benefit Option.

   b) **Partner Care:** Equal to the Sum Assured under Benefit Option as specified in the Schedule.

   c) **Waiver of Future Premium Benefit –** The outstanding future Premium under the Base Plan, Rider/s and any attached Benefit Option/s, if any, at the inception of the Benefit Option. In case the payout under Waiver of Future Premium Benefit is triggered, the Premiums waived shall be added to the Premiums paid by You for the calculation of the Insured amount for that condition.
7) **"IRDAI/Authority"** means the Insurance Regulatory and Development Authority of India;
8) **"Life Insured"** shall mean the person insured under the respective Benefit Option as specified in the Schedule;
9) **"Maturity/Expiry Date"** means the date specified in the Schedule, on which the Coverage Term expires;
10) **"Policy/Base Plan"** means the base policy to which this Rider is attached;
11) **"Rider"** means this rider contract containing these terms and conditions;
12) **"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;
13) **"Rider Sum Assured"** is the maximum of all "Sum Assured under Benefit Option" for the respective Benefit Options chosen by the Policyholder.
14) **"Sum Assured"** refers to the sum assured under respective Benefit Option as specified in the Schedule.
15) **"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;
16) **"Survival Period"** in respect of a chosen Benefit Option shall be:

Benefit Option	Survival Period (from the date of diagnosis of illness/actual undergoing of procedure)
CritiCare Plus	30 days

17) **"Total Premium Paid"** means total of all the premium paid under base product, excluding any extra premium and taxes, if collected explicitly;
18) **"Underwriting Policy"** means an underwriting policy approved by Our board of directors;
19) "**We**", "**Us**", "**Our**" or **"Company"** means Tata AIA Life Insurance Company Limited; and
20) "**You**", "**Your**" or "**Policyholder**" means the policyholder as named in the Schedule, who is the policyholder under the Base Plan and Rider.

Interpretation:

Whenever the context requires, the masculine form shall apply to feminine and singular terms shall include the plural.

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

PART C

1. BENEFITS

The Benefits shall depend on the Benefit Option/s chosen by You, which cannot be changed once chosen. Subject to insurable interest between the Policyholder and the Life Insured, and as per the Underwriting Policy, You may propose to avail additional Benefit Option/s under the Rider on one or more lives (may or may not include coverage on self), except in 'Accelerated CritiCare ', where the Life Insured under the Benefit Option must be the same as Life Insured under the Base Plan. Such Benefit Option can be added:

- In case of Single Pay: at the inception or any policy anniversary of the Base Plan, post premium payment term of the Base Plan provided the Base Plan is fully paid-up.
- In case of Non-Single Pay: at the inception or any policy anniversary of the Base Plan during the premium payment term of the Base Plan.

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. TERM BOOSTER

In the case of death or Diagnosis of Terminal Illness (as detailed in Annexure A) of the Life Insured, the Insured Amount shall be payable.

This benefit is payable only once during the Coverage Term and shall terminate upon death or Diagnosis of Terminal Illness of the Life Insured or expiry of the Coverage Term, whichever is earlier.

II. ACCIDENTAL DEATH

In the event of the death of the Life Insured due to an Accident (as detailed in Annexure A) during the Coverage Term, We shall pay the Insured Amount, provided the death occurs within 180 days from the date of that Accident.

The benefit shall be payable even if the Accident takes place within the Coverage Term and the death occurs beyond the Coverage Term, provided the date of death is within 180 days of the Accident.

DOUBLE BENEFIT

We shall pay twice the amount of this benefit if the death 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.

This benefit is payable only once during the Coverage Term and shall terminate upon death of the Life Insured or expiry of the Coverage Term, whichever earlier.

III. ACCIDENTAL TOTAL AND PERMANENT DISABILITY

In the event of the Total and Permanent Disability (as detailed in Annexure A) of the Life Insured due to an Accident within the Coverage Term, the Insured Amount shall be payable, provided the Total and Permanent Disability occurs within 180 days from the date of that Accident.

The benefit shall be payable even if the Accident takes place within the Coverage Term and the Total and Permanent Disability occurs beyond the Coverage Term, provided the date of death is within 180 days of the Accident.

This benefit is payable only once during the Coverage Term and shall terminate upon payment of benefit or expiry of the Coverage Term, whichever earlier.

DOUBLE BENEFIT

If you have not chosen Waiver of Future Premium Benefit, 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.

IV. ACCELERATED CRITICARE

It accelerates the payout of death benefit under the Base Plan upon first Diagnosis of or actual undergoing of any of the below listed illnesses or procedure (as explained in Annexure A):

No	Illness / Procedure	No	Illness / Procedure
	Cancer:	20	Major Head Trauma
1	Cancer of Specified Severity	21	Major Organ (less heart)/ Bone Marrow Transplant
	Cardiac Conditions:	22	Permanent Paralysis of Limbs
2	Myocardial Infarction (First Heart Attack of specified severity)	23	Loss of limbs
3	Open Chest CABG (Coronary Artery Bypass Graft)	24	Fulminant Viral Hepatitis
4	Open Heart Replacement or Repair of Heart Valves	25	Alzheimer's Disease
5	Major surgery of Aorta	26	Aplastic Anaemia
6	Heart transplant	27	Deafness
7	Cardiomyopathy (of specified severity)	28	Loss of Speech
8	Stroke resulting into permanent symptoms	29	Medullary Cystic Kidney Disease
9	Primary (Idiopathic) Pulmonary Hypertension	30	Motor Neuron Disease with Permanent Symptoms
	Critical Illness:	31	Multiple Sclerosis with Persisting Symptoms
10	Apallic Syndrome	32	Muscular Dystrophy
11	Benign Brain Tumor	33	Parkinson's Disease
12	Blindness	34	Progressive Scleroderma
13	Severe Rheumatoid Arthritis	35	SLE with Renal Involvement
14	End Stage Lung Failure	36	Bacterial Meningitis
15	Coma of Specified Severity	37	Chronic Recurrent Pancreatitis
16	End Stage Liver Failure	38	Loss of Independent Existence
17	Kidney Failure requiring Regular Dialysis	39	Poliomyelitis
18	Encephalitis	40	Creutzfeldt-Jacob disease
19	Third Degree Burns	-	-

This benefit is payable only once during the Coverage Term and the cover shall terminate upon payout of the benefit. The Base Plan shall continue for the balance Sum Assured on Death.

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

V. CRITICARE PLUS

The Insured Amount under the Benefit Option shall be paid upon first Diagnosis of or actual undergoing of any of the below listed illnesses or procedure (as explained in Annexure A), provided the Life Insured survives during the Survival Period:

No	Illness / Procedure	No	Illness / Procedure
	Cancer:	20	Major Head Trauma
1	Cancer of Specified Severity	21	Major Organ (less heart)/ Bone Marrow Transplant
	Cardiac Conditions:	22	Permanent Paralysis of Limbs
2	Myocardial Infarction (First Heart Attack of specified severity)	23	Loss of limbs
3	Open Chest CABG (Coronary Artery Bypass Graft)	24	Fulminant Viral Hepatitis
4	Open Heart Replacement or Repair of Heart Valves	25	Alzheimer's Disease
5	Major surgery of Aorta	26	Aplastic Anaemia
6	Heart transplant	27	Deafness
7	Cardiomyopathy (of specified severity)	28	Loss of Speech
8	Stroke resulting into permanent symptoms	29	Medullary Cystic Kidney Disease
9	Primary (Idiopathic) Pulmonary Hypertension	30	Motor Neuron Disease with Permanent Symptoms
	Critical Illness:	31	Multiple Sclerosis with Persisting Symptoms
10	Apallic Syndrome	32	Muscular Dystrophy
11	Benign Brain Tumor	33	Parkinson's Disease
12	Blindness	34	Progressive Scleroderma

13	Severe Rheumatoid Arthritis	35	SLE with Renal Involvement
14	End Stage Lung Failure	36	Bacterial Meningitis
15	Coma of Specified Severity	37	Chronic Recurrent Pancreatitis
16	End Stage Liver Failure	38	Loss of Independent Existence
17	Kidney Failure requiring Regular Dialysis	39	Poliomyelitis
18	Encephalitis	40	Creutzfeldt-Jacob disease
19	Third Degree Burns	-	-

This benefit is payable only once during the Coverage Term and shall terminate upon payout of the benefit.

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

2. MATURITY BENEFIT (applicable for Term Booster, Accidental Death and Accidental Total and Permanent Disability)

If You have chosen Return of Balance Premium option at the inception of the Rider, on survival till end of the Coverage Term provided the Rider/Benefit Option is not terminated, the Total Premiums Paid (Excluding loading for modal Rider Premiums) towards the respective Benefit Option shall be returned, after deduction of any Premium discounts or Premium cashback availed under the Wellness Program (if opted as per Clause 3.2 below).

In case the payout under Return of Premium option is triggered, the Premiums waived (if any) shall be added to the Total Premiums Paid by the Policyholder for the calculation of the Return of Balance Premium for the respective Benefit Option.

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

3. SERVICE FEATURE

3.1. Health Management Services:

Life Insureds of TATA AIA Vitality Protect, 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:

a) the availability of a suitable service provider/s;
b) primary diagnosis (wherever applicable) has been done by a registered medical practitioner as may be authorized by a competent statutory authority;
c) Health Management Service is available to be utilised throughout the policy term, subject to prevailing eligibility conditions;
d) the eligibility conditions of the Life Insured will be determined as per the Company's extant Underwriting Policy;
e) the eligibility will be reviewed periodically and changes shall apply without any discrimination to all existing and new customers of the product.
f) 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 (Call charges apply), before using the services;
g) 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
h) The current eligibility is of a minimum total Sum Assured of Rs. 30 Lakhs [under base plan and rider/s (if any)].

Note:

i) These services are aimed at improving Policyholder engagement.
j) These Value-added Services are completely optional for the eligible Life Insured to avail.
k) For Life Insured availing such services, they are offered at no additional cost.
l) The Premiums charged shall not depend on whether such a service(s) is offered or availed.
m) The Life Insured may exercise his/her own discretion to avail the services.
n) These services shall be directly provided by the service provider(s).
o) The services can be availed only where the Policy / rider is in-force.
p) All the supporting medical records should be available to avail the service.
q) We reserve the right to change the service provider(s) at any time.
r) The services are being provided by third party service provider(s) and We will not be liable for any liability.

3.2. 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 Life 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 Life Insured opts to enroll for the Wellness Program, an up-front reward equivalent to 5% of Annualized Premium for AD & ATPD 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 and shall apply to prospective Policyholders only.

- **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)	AD & ATPD	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 AD & ATPD 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 Term Booster = (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.

You 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. You need 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: You will be able to offset the premium payable towards the rider against the Rewards.
- Premium Cashback: You 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 Life 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 year. 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 Term Booster policy with premium payment term of five years, if the Wellness Status maintained throughout premium payment term is Platinum. The policyholder has accumulated Total Rewards of 18%. The accumulated cover booster at the end of premium payment term is equivalent to 18%.

  Example 2 – For a single pay Term Booster 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	AD & ATPD	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 Term Booster 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.

The customer 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.

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.

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 we propose 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 Life 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 in a Policy Year, upon completion of the Health Screening.

Wellness Status – Points

The Wellness Status is driven by an objective criterion where the Life assured 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.)
Assessments	Health Review	1,000
	Nutrition Assessment	1,000
	Mental Wellbeing	900
	Declaration: Smoker / Non-Smoker	1,000

Remarks: Assessment are available for all Life Insured irrespective of Wellness Status. Points are allocated to all Life Insured who have completed the assessment.

Health Screening – Annual

Details	Points for doing the health screening	Additional Points if the results are within the clinically accepted range
BMI	1,500	1,500
Blood Pressure	1,500	1,500
Cholesterol	1,500	1,500
Glucose	1,500	1,500

Remarks: All Life Insured are eligible for Annual Health Screening and points are allocated to Life Assured basis health screenings conducted and also if the results of the test being in line with WHO recommended clinical range.

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 assured get equal opportunity for participating in Wellness Program and all similarly placed life assured (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 Underwriting Policy (as amended from time to time). Any such change in the reward point structure will be communicated to the life assured with a notice of minimum 30 days in advance.

The communication with respect to Wellness Benefit shall be notified to You before the Policy Anniversary on Your registered email id or contact number.

4. 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

5. MODE OF PAYOUT

For 'Accelerated CritiCare', the only payout option available is "Combination of Lump Sum and Income", and for 'Accidental Death', the payout options available shall be "Combination of Lump Sum and Income" or "Partner Care".

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

a) Combination of Lump sum and Income: You may choose to receive the payout as either:

- Lump sum benefit OR
- Income for the income period chosen OR
- Combination of lump sum and income for the income period chosen.

If 'Combination of lump sum and income for the income period chosen' has been opted, You shall have the flexibility to choose payout in the form of lump-sum and/or income for the chosen income period. Along with the lump sum amount, the Claimant shall also receive regular income in arrears for chosen income period as per the chosen frequency which can be Annual / Half Yearly / Quarterly / Monthly, from the date of occurrence of insured event. The payment frequency cannot be changed once the regular income commences. Any accrued income, due before intimation, will be paid along with first payout under this option.

The income chosen will be paid as per the frequency chosen for the income period (A period up to 30 years as chosen).

You can choose between the following payout options:

- Level Income Payout – Fixed income payout throughout the chosen income period
- Increasing Income Payout – income increases year-on-year based on chosen simple interest rate (up to 15%) throughout the chosen income period

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

In case of a Reduced Paid-up Rider, the regular income payable shall be based on the adjusted Yearly Income defined as:

*(Number of premiums paid under Benefit Option / Number of premiums payable under Benefit Option) * Yearly Income applicable at the time of Reduced Paid-Up*

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.

The Claimant also has 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%).

b) **Partner Care**: Upon occurrence of the insured event, Insured Amount shall be paid to the chosen dependent partner/s as a regular income. The mode of payout shall be annual, quarterly, half yearly or monthly from the occurrence of the insured event, as may be chosen by You at the inception of the Benefit Option. The payout frequency can't be changed once the regular income commences. Any accrued income, due before intimation of the insured event, shall be paid with the first payout under this option.

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

The income streams are payable as per the payout frequency chosen and shall continue,

- till the partner dies or reaches age 100 (last birthday), whichever happens first, if one dependent partner is chosen to receive income;
- till the last surviving partner dies or reaches age 100 (last birthday), whichever happens first, if two dependent partners are chosen to receive income.

You shall have the option to choose from the following options at inception of the Rider -

Payout Option	With Return of Lumpsum	With Return of Premium
Basic	No	No
Basic Plus	No	Yes
Advance	Yes	No
Advance Plus	Yes	Yes

Where -

Return of Lumpsum Option - If You opt for Advance or Advance Plus option, Lumpsum benefit shall be payable upon the death of the partner or last surviving partner in case of two dependents (given the regular income stream is already triggered). The lumpsum benefit shall be equal to Discounted Value of income stream (derived basis younger life in case of two dependents) till age of 100 discounted at 6% p.a. If the policyholder opts for Basic or Basic Plus option, no return of lumpsum is applicable.

Return of Premium – If You opt for Basic Plus or Advanced Plus option, the premiums paid for Partner Care will be returned provided the death of the partner (last surviving partner in case of two dependent) occurs prior to the death of the Life Assured, during policy term. The Partner Care benefit will terminate thereafter. If You opt for Basic and Advance option, no return of premium shall be applicable.

In case of a Reduced Paid-up Rider, the regular income payout shall be based on the adjusted Yearly Income defined as: *(Number of Premiums paid under Benefit Option / Number of Premiums payable under Benefit Option) * Yearly Income applicable at the time of Reduced Paid-Up.*

c) **Waiver of Future Premium Benefit:** Under this mode, payout is available as a Regular Pay without Return of Balance of Premium option. Under this mode of payout, the future Premium under the Base Plan, Rider/s and any attached Benefit Option/s, if any, shall be waived off throughout the remaining Premium Payment Term of the Base Plan/Rider or until the termination of the Base Plan/Rider, whichever is earlier. The 'Waiver of Future Premium Benefit' opted shall not be applicable for Benefit Options availed subsequent to the selection of 'Waiver of Future Premium Benefit' option and You may opt for 'Waiver of Future Premium Benefit' additionally in respect of such Benefit Options chosen subsequently. Where Waiver of Future Premium Benefit is opted under multiple Benefit Options, Benefit of waiver under this mode of payment shall terminate all the Waiver of Premium Benefits under the Rider.

6. 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; and
- the Benefit Option shall terminate, and no future Premiums and benefits shall be payable.

Waiting Period as per the chosen Benefit Option shall be as under:

Benefit Option	Waiting Period applicable^
Accelerated CritiCare CritiCare Plus	A waiting period of 90 days is applicable on the first Diagnosis of any of the 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' shall not be applicable if the insured event occurs as a result of an Accident (e.g.: Major Head Trauma due to an Accident)

7. 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, the coverage under the chosen Benefit Option shall lapse or be converted to a reduced paid-up policy 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.

At renewability, the policyholder shall be offered a grace period of 30 days. The insurance coverage shall cease to exist till the date of receipt of renewal premium during the grace period.

8. RENEWABILITY OPTION AT MATURITY (available with Accelerated CritiCare and CritiCare Plus benefit option and any add-on benefits applicable to these benefit options)

At maturity, the policyholder can choose to extend the term of respective coverage option. The Policyholder 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:

a) You will be eligible for extension provided the Policy is in force and all due premiums till date have been paid.
b) You can select policy term and Premium payment term of another 5 year as per other minimum/maximum limits under the Rider.
c) Benefit(s) (including add-on benefits) shall continue as per the outstanding coverage applicable at the time of extension of the Policy term.
d) You will not be able to extend the Policy term in case any claim has already been made.

e) Death, Maturity and Surrender benefits, if any will be applicable as per the original terms.
f) 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, premium payment term opted (SP/LP/RP) and the premium rate applicable at the time of extension.
g) The additional Premium will be based on outstanding coverage at the date of extension.
h) No policy alteration (except change in Policy term/premium payment term) shall be allowed at the time of extension.

3.9 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 applicable or Loyalty Discount.

PART D

POLICY SERVICING

1. FREE LOOK PERIOD

You have a free look period of 30 days from the date of receipt of the Rider document, 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.

2. LOANS

You are not entitled to any loans under this Rider.

3. NON-FORFEITURE PROVISIONS

If any Rider Premium for a non-single pay Benefit Option remains unpaid at the end of the Grace Period, the Benefit Option shall lapse/be converted to a Reduced Paid-up Policy from the due date of the first unpaid Rider Premium. No benefits are payable under a lapsed Benefit Option.

4. SURRENDER / UNEXPIRED RISK PREMIUM BENEFIT

Surrender Benefit shall be the higher of the a) Guaranteed Surrender Value (GSV) or Special Surrender Value (SSV) or b) Unexpired Risk Premium Value (as applicable) payable under the following scenarios:

Premium Paying options		**Conditions for acquiring Surrender Value**	**Guaranteed Surrender Value**	**Special Surrender Value/ Unexpired Risk Premium Value (as applicable)**
Single Pay	Without Return of Balance Premium	Immediately on receiving the Premium	Not available	Special Surrender Value/ Unexpired Risk Premium Value shall be determined by the Company from time-to-time basis changing economic scenario. The Company may revise the same, based on the then prevailing market conditions. Any change in the methodology/ formula shall be subject to IRDAI approval.
	With Return of Balance Premium	Immediately on receiving the Premium	Minimum non-negative surrender value which is equal to (GSV factor x Total Premiums paid (excluding loading for modal premiums and discount)) up to the date of surrender	
Regular Pay	Without Return of Balance Premium	Not available	Not available	Not available
	With Return of Balance Premium	If at least 1 full years' Premium has been paid	Minimum non-negative surrender value which is equal to (GSV factor x Total Premiums paid (excluding loading for modal premiums and discount)) up to the date of surrender	Special Surrender Value/ Unexpired Risk Premium Value shall be determined by the Company from time-to-time basis changing economic scenario. The Company may revise the same, based on the then prevailing market conditions. Any change in the methodology/ formula shall be subject to IRDAI approval.
Limited Pay	Without Return of Balance Premium	If at least 2 full years' Premiums have been paid	Not available	
	With Return of Balance Premium	Payable on completion of one policy year, provided one full years' premium is paid, if at least 1 full years' Premium has been paid	Minimum non-negative surrender value which is equal to (GSV factor x Total Premiums paid (excluding loading for modal premiums and discount)) up to the date of surrender	

Please refer Company's website or visit nearest branch for more details on the applicable GSV or SSV factor.

All or any of the Benefit Options may be surrendered / discontinued separately or it gets surrendered / discontinued if the Base Plan is surrendered / discontinued or made paid-up.

5. REDUCED PAID-UP

If any Rider Premium for a non-single pay Benefit Option remains unpaid at the end of the Grace Period, the Benefit Option shall lapse/be converted to a Reduced Paid-up Rider from the due date of the first unpaid Rider Premium. The following is the treatment under various scenarios:

Premium Paying options		**Cover Continuance**	
		Before 2 years' premium paid (in case of Without Return of Balance Premium Option) or 1 years' (in case of With Return of Balance Premium Option)	**After 2 years' premium paid (in case of Without Return of Balance Premium Option) or 1 years' (in case of With Return of Balance Premium Option)**
Regular Pay	Without Return of	Cover cease to exist	Cover cease to exist

	Balance Premium		
	With Return of Balance Premium	Cover cease to exist	Cover continues with Reduced Paid-Up Sum Assured if the Base Plan is converted to Reduced Paid-up Policy
Limited Pay	Without Return of Balance Premium	Cover cease to exist	Cover cease to exist
	With Return of Balance Premium	Cover cease to exist	Cover continues with Reduced Paid-Up Sum Assured if the Base Plan is converted to Reduced Paid-up Policy

In case a Policy is converted to Reduced Paid-up on Premium discontinuance, the coverage will continue to be in reduced paid-up status with the Insured Amount re-set to the Reduced Paid Up Sum Assured under the Benefit Option less any claims paid/payable.

Under Reduced Paid-up ("RPU") Rider, the RPU Sum Assured shall be as below:

RPU Sum Assured = (Number of Premiums Paid under Benefit Option/ Number of Premiums payable under Benefit Option) x Sum Assured under the Benefit Option

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

6. REVIVAL OF THE RIDER

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 the prevailing 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 reinstatement / revival;
- Production of Insured's current health certificate and other evidence of insurability satisfactory to Us; and
- Payment of all overdue premiums with interest.

6.1 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.

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

6.3 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.

6.4 The Benefit Option cannot be revived independently and can only be revived along with the revival of the Base Plan.

7. PAYMENT OF RIDER BENEFITS

As per base Policy.

8. TERMINATION OF THE RIDER / BENEFIT OPTION

8.1. The Benefit Option shall terminate upon the happening of the first of the following events:

8.1.1. on the expiry of Coverage Term;

8.1.2. on payment of surrender value of the Benefit Option;

8.1.3. on death of the partner or surviving partner (where 2 partners are chosen) during the Coverage Term before the occurrence of insured event;

8.1.4. on the date on which We receive free look cancellation request for the Benefit Option within requisite period;

8.1.5. on the payment of the benefit under Benefit Option or last instalment of income benefit payment or the date of intimation of repudiation of the claim by Us;

8.1.6. on the expiry of the Revival Period, if the lapsed Benefit Option has not been revived;

8.1.7. on termination of Base Plan, except 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 Base Plan Life Insured.

8.1.8. on the Maturity/Expiry Date or the date on which the Base Plan is surrendered or cancelled for any reason;

8.1.9. on our acceptance of the receipt of Your written request for cancellation of the Benefit Option, after the completion of the free look period;

8.1.10. 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.

PART E: FEES / CHARGES

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

PART F: GENERAL CONDITIONS

1. TAXES

1.1. 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.

1.2. 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.

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)	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 Death Certificate issued by a local government body like Municipal Corporation Medical Records (Admission Notes, Discharge/Death Summary, Indoor Case Papers, Test Reports etc.) 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)	a) Copy of the First Information Report (FIR) or Panchanama/ Police complaint/ Inquest# b) Copy of Post-Mortem report (PMR)/ Autopsy and Viscera report# c) Copy of the Final Police Investigation report (FPIR)/ Charge sheet#

Type of Claim	Requirement
Disability and Dismem-berment Claim (If opted)	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
	I. Attested True Copy of Indoor Case Papers of the Hospital
	II. Discharge Summary of Present and Past Hospitalizations
	III. Insured's PAN Card OR Form 60, Insured's Address proof

	IV.	Bank Details of the Insured – Cancelled cheque (with printed name and account number)/bank passbook
	V.	Disability Certificate by attending Physician / Institute for disabled
	VI.	Rehabilitation Certificate - if applicable
	VII.	Employer's written confirmation / statement - for Disability claim
	VIII.	All related Medical Examination Reports, e.g. Laboratory test reports X-Ray / CT Scan / MRI Reports & Plates, Ultrasonography Report Clinical / Hospital Reports
	IX.	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.

3. MISTATEMENT OF AGE

As per base Policy.

4. FRAUD AND NON-DISCLOSURE

As per base Policy.

5. CURRENCY AND PLACE OF PAYMENT

As per base Policy.

6. FREEDOM FROM RESTRICTIONS

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

7. NOMINEE

As per Base Plan.

8. ASSIGNMENT

As per Base Plan.

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.

10. DUPLICATE RIDER DOCUMENT

If the Rider document is lost or destroyed, then at Your request, the Company will issue a duplicate Rider document. Upon the issuance of the duplicate Rider document, the original Rider document immediately and automatically ceases to have any validity. The Company will charge a fee of Rs. 250/- along with the applicable taxes, cesses or levies, if any, for the issuance of a duplicate Rider document. These charges are subject to revision by the Company from time to time.

11. AMENDMENT

As per base Policy.

12. REGULATORY AND JUDICIAL INTERVENTION

As per base Policy.

13. COMMUNICATION AND NOTICES

As per base Policy.

14. GOVERNING LAW AND JURISDICTION

As per base Policy.

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 1 (Definitions and Exclusions Annexure)

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

• Term Booster:

Terminal Illness: Terminal Illness is defined as an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two (2) independent Medical Practitioners specializing in treatment of such illness, life expectancy is no greater than twelve months from the date of notification of claim. The terminal illness must be diagnosed and confirmed by independent medical practitioners' specializing in treatment of such illness and registered with the Indian Medical Association and the diagnosis of Terminal Illness should be approved by the Company. The Company reserves the right for independent assessment of the Terminal Illness.

• Accidental Death

• Accidental Total and Permanent Disability

Accidental Death: Accidental Death shall mean death which

- is caused by bodily injury resulting from an accident and
- occurs due to the said bodily injury solely, directly and independently of any other causes and
- occurs within 180 days of the occurrence of such accident

The benefit due to accidental death will be payable if the accident occurs within the Benefit Option term even if death occurs beyond the term (however within 180 days of the accident)

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:

- Loss of sight in both eyes
- Loss of both arms or both hands;
- Loss of one arm and one leg;
- Loss of one arm and one foot;
- Loss of one hand and one foot;
- Loss of one hand and one leg;
- Loss of both legs;
- Loss of both feet;
- Removal of the entire lower jaw
- Loss of one hand and loss of sight in one eye
- 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:

1. corrected visual acuity being 3/60 or less in one eye or;
2. 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:

- 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 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.

• Accelerated CritiCare

• CritiCare Plus

• 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 –

- 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.
- 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;
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- 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;

• 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:

A. 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

B. 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.

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.

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:

a) Surgery performed using only minimally invasive or intra-arterial techniques.
b) Procedures done for treatment of Congenital heart disease are excluded.

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:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
b. New characteristic electrocardiogram changes
c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

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

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:

1. Angioplasty and/or any other intra-arterial procedures

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.

Primary (Idiopathic) Pulmonary Hypertension

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

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.

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:

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

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.

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:

- Regular Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- 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

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

Fulminant Viral Hepatitis

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

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

The diagnosis must be confirmed by a Consultant Gastroenterologist.

For the above definition, the following are not covered:

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

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.

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.

- ## 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.

- ## 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.

- ## 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:

a) Spinal cord injury

- ## Major Organ (less heart) / Bone Marrow Transplant:

The actual undergoing of a transplant of:

I. One of the following human organs: lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ, or

II. Human bone marrow using haematopoietic stem cells

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

The following are excluded:

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

- ## 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.

- ## 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.

- ## 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.

- ## 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).

- ## 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:

a) cannot be controlled with medication; and
b) shows objective signs of progressive impairment; and
c) 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.

- ## 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.

- ## Poliomyelitis

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

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

- ## 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

- **Severe Rheumatoid Arthritis**

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

1. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis and has been diagnosed by a Rheumatologist;
2. Permanent inability to perform at least three (3) of the six (6) Activities of Daily Living (defined in 'Generic Definitions' section below);
3. 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
4. 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

- **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.

- **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.

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:

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) Mobility: the ability to move indoors from room to room on level surfaces;

e) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

f) 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:

1. Has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and atleast 15 inpatient beds in all other places;
2. Has qualified nursing staff under its employment round the clock;
3. Has qualified medical practitioner(s) in charge round the clock;
4. Has a fully equipped operation theatre of its own where surgical procedures are carried out; and

5. 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:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
- it continues indefinitely
- 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

a) The Policyholder/ Insured person himself/herself; or

b) An authorized Insurance Intermediary (or related persons) involved with selling or servicing the insurance contract in question; or

c) Employed by or under contractual engagement with the Insurance Company;

d) 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: 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
Term Booster	**Suicide Exclusion:** In case of death due to suicide within 12 months from the date of commencement of risk under the policy or from the date of revival of the policy, as applicable, the nominee or beneficiary of the policyholder shall be entitled to at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided the policy is in force. No other claim would be entertained by the Company except the refund of 80% Total Premiums Paid or the acquired surrender value, as applicable. Apart from Suicide exclusion detailed above, no other exclusion is applicable in the event of death. **Terminal Illness Exclusion:** The Life Insured will not be entitled to any Terminal Illness Benefit if it is caused directly or indirectly due to or occasioned, accelerated or aggravated by intentional self-inflicted injury or attempted suicide, whether medically sane or insane.
Accidental Death (AD)	Accidental Death Benefit shall not be payable for any losses caused directly or indirectly, wholly or partly, by any one of the following occurrences: ● Death as a result of any disease or infection ● Death arising due to any condition other than death solely and directly as a result of an accident ● Any Pre-existing condition or Disability arising out of a Pre-existing Diseases or any complication arising therefrom. Wherever the proximate cause is accident which has occurred after the rider inception date, this exclusion shall not apply. ● Suicide, attempted suicide, intentional self-inflicted injury, acts of self-destruction, irrespective of mental condition. ● Death arising from or caused due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen ● Death arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power. ● Death caused by participation of 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 whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting,

	skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule. ● Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities ● Death arising or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor, or civil commotion with criminal intent. ● Death arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
Accidental Total and Permanent Disability (ATPD)	Accidental Disability Benefit shall be not payable for any losses caused directly or indirectly, wholly or partly, by any one of the following occurrences: ● Disablement as a result of any disease or infection ● Disablement arising due to any condition other than disablement solely and directly as a result of an accident ● Any Pre-existing condition or Disability arising out of a Pre-existing Diseases or any complication arising therefrom. Wherever the proximate cause is accident which has occurred after the rider inception date, this exclusion shall not apply. ● 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, intentional self-inflicted injury, acts of self-destruction irrespective of mental condition. ● Disablement arising from or caused due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen ● Disablement arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power. ● Disablement caused by participation of 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 whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule. ● Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities ● Disablement arising or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor, or civil commotion with criminal intent. ● Disablement arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
Accelerated CritiCare (AC) and CritiCare Plus (CP)	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, Biological, Chemical or Radioactive contamination due to nuclear accident ● 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 Life 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	
	AD & ATPD	Other Benefit Options	AD & ATPD	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 AD & ATPD 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 AD & ATPD 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:
Benefit Type – Term Booster

Age – 35 | Premium Payment Period (PPT) – 5 years | Policy Term (PT) – 30 years
Sum Assured – 10 Lakhs
Annual Premium – INR 10,000[1]

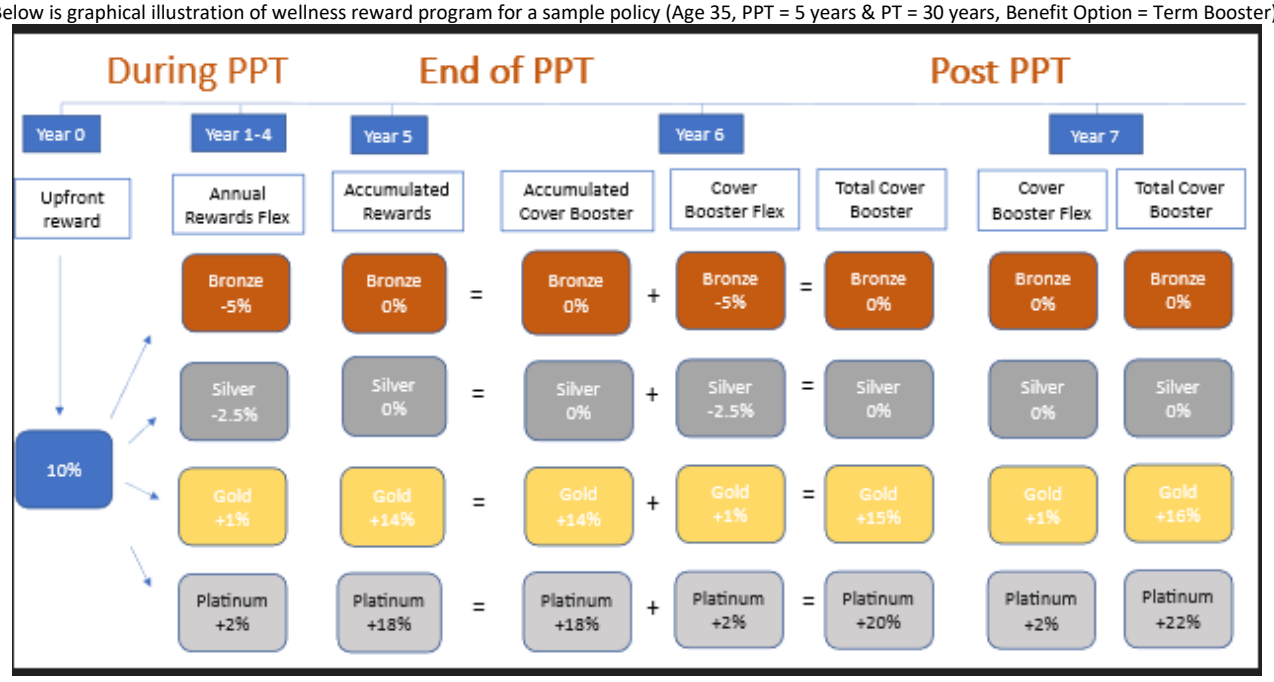
Rewards During PPT (in INR)
(Premium Discount as per Table 1)

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

Cover Booster post PPT (in INR)

PT (BOY)	Bronze	Silver	Gold	Platinum
6	-	-	1,50,000	2,00,000
7	-	-	1,60,000	2,20,000
8	-	-	1,70,000	2,40,000
9	-	-	1,80,000	2,60,000
10	-	-	1,90,000	2,80,000
11	-	-	2,00,000	3,00,000
12	-	-	2,10,000	3,00,000
13	-	-	2,20,000	3,00,000
14	-	-	2,30,000	3,00,000
15	-	-	2,40,000	3,00,000
16	-	-	2,50,000	3,00,000
17	-	-	2,60,000	3,00,000
18	-	-	2,70,000	3,00,000
19	-	-	2,80,000	3,00,000
20	-	-	2,90,000	3,00,000
21 +	-	-	3,00,000	3,00,000

Below is graphical illustration of wellness reward program for a sample policy (Age 35, PPT = 5 years & PT = 30 years, Benefit Option = Term Booster):



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

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 in Section 1 above, the annual cashback rate at policy duration 30 is calculated as below:
Total Cover Booster = INR 3,00,000
Premium Rate (Regular Pay) = 4.5[2]
Annual Health Cashback Rate (standard life) = 31.90%
Annual Health Cashback Amount= (4.5 * 31.90%)/1000 * 3,00,000 = INR 431

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