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MANIPALCIGNA PROHEALTH PRIME

Plans: Protect | Advantage
(PROSPECTUS)

I. What are the Key Highlights of the Policy?

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- Post-hospitalization
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- Domiciliary Hospitalization
- Road Ambulance
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- Restoration of Sum Insured
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- Outpatient Expenses
- Daily Cash for Shared Accommodation

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- Domestic Second opinion
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- Enhance
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- ManipalCigna Prime Plus

II. What are the Basic covers?

1. In-patient Hospitalization

We will cover medical expenses in case of medically necessary hospitalization of an Insured person incurred due to Disease, Illness or injury when the Insured person is admitted as an In-patient for more than 24 consecutive hours provided that the admission date of the Hospitalization due to Illness or Injury is within the Policy Year. The coverage will include reasonable and customary charges towards room rent for accommodation in a hospital, up to limits specified under the eligible Room Category under the Plan opted, charges for accommodation in Intensive Care Unit and operation theatre charges, fees of medical practitioner, anaesthetist, qualified nurses, specialists, the cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner that are used intra operatively during a surgical procedure.

Room category coverage under each plan will be covered up to Single Private AC Room or as specified in the Policy Schedule, subject to maximum of Sum Insured Opted. For ICU accommodation, we will cover up to Sum Insured opted or as specified in the Policy Schedule.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the Plan opted, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category to the room rent actually incurred.

Under In-patient Hospitalization expenses, when availed under In-patient care, we will cover the expenses towards artificial life maintenance, including life support machine use, even where such treatment will not result in recovery or restoration of the previous state of health under any circumstances unless in a vegetative state, as certified by the treating Medical Practitioner.

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of day care treatment in a hospital up to the limit as per the plan and sum insured opted in a Policy Year.:

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchical Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person for Hospitalization due to a condition caused by or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, sexually transmitted diseases (STD) in respect of an Insured Person will be covered up to the Sum Insured opted in a Policy Year. The necessity of the Hospitalization is to be certified by an authorised Medical Practitioner.

Medical Expenses incurred towards Medically Necessary treatment taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to a Mental illness, or a medical condition impacting mental health will be covered up sum insured opted in a Policy Year. For the below mentioned ICD Codes, the Insured Person should have been continuously covered under this Policy for at least 24 months before availing this benefit.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F10	Alcohol related disorders
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

2. Pre - hospitalization

We will reimburse medical expenses of an Insured person due to a disease or injury or illness that occurs during the Policy Year incurred immediately prior to hospitalization, up to the limits specified under the plan opted by the Insured subject to a claim being admissible under In-patient Hospitalization and expenses are related to the same illness/condition.

3. Post - hospitalization

We will reimburse medical expenses of an Insured person incurred post hospitalization due to a disease or injury or illness that occurs during the Policy Year up to the limits specified under the plan opted by the Insured subject to a claim being admissible under In-patient Hospitalization and expenses are related to the same illness/condition.

4. Day Care Treatment

We will cover payment of medical expenses of an Insured Person in case of medically necessary day care treatment or surgery that requires less than 24 hours hospitalization due to advancement in technology and which is undertaken in a Hospital/ Nursing Home/ Day Care Centre on the recommendation of a medical practitioner. Any treatment in an outpatient department (OPD) is not covered. Coverage will also include pre-post hospitalization expenses as available under the Plan opted.

5. Domiciliary Treatment

We will cover medical expenses, up to 10% of the Sum Insured opted as per plan, of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalization or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable. This is provided that the condition would otherwise have been covered for hospitalization under the Policy and for which treatment is required continues for at least 3 days and is on the advice of a medical practitioner. Claims for pre-hospitalization expenses, post-hospitalization up to 30 days each. We shall not be liable under this policy for any claim in connection with or in respect of the following:

i. Asthma, COPD, bronchitis, tonsillitis and upper and lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
ii. Arthritis, gout and rheumatism including the rheumatism of bones, joints and also rheumatic heart disease,
iii. Chronic nephritis and nephritic syndrome,
iv. All types of Diarrhea and dysenteries, including gastroenteritis,
v. Diabetes mellitus and Diabetes Insipidus,
vi. Epilepsy / Seizure disorder,
vii. Hypertension,
viii. Pyrexia of unknown origin.

6. Road Ambulance

We will cover the reasonable and customary expenses incurred for transportation of an Insured person by an ambulance service provider to the hospital for treatment covered under the Policy following an emergency, requiring the Insured Person's admission to a Hospital. The coverage will be up to the Sum Insured under the plan opted by the Insured. This benefit will be applicable per Hospitalization and necessity must be certified by the attending Medical Practitioner.

7. Donor Expenses

We will cover in-patient hospitalization medical expenses towards the donor for harvesting the organ in case of major organ transplant if it is in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules. The organ donated is for the use of the Insured person per Medical Advice and a claim has been admitted under in patient hospitalization.

However, Pre-Post hospitalization expenses towards the donor, cost towards donor screening, cost associated to the acquisition of the organ or any other medical treatment for the donor consequent on the harvesting will not be covered.

8. Restoration of Sum Insured

In case the Sum Insured inclusive of earned cumulative bonus (if any) or Cumulative Bonus Booster (if opted & earned) is insufficient due to claims paid or accepted as payable during the policy year, then we will restore 100% of the Sum Insured for any number of times in a policy year. This restored amount can be used for all future claims whether the illness/condition is unrelated or same for which a claim has been made in the particular policy year for the same Insured Person. Restoration will not trigger on the first claim.

Restoration of the Sum Insured will only be provided for coverage under II.1. 'In-patient Hospitalization', II.2.'Pre-Hospitalization', II.3. 'Post-Hospitalization', II.4. 'Day Care Treatment', II.6. 'Road Ambulance', II.7 'Donor Expenses', II.9. 'AYUSH Treatment (In-patient Hospitalization)' and V.1 'Non-Medical Items'.

In case the Restored Sum Insured is not utilised in a policy year, it shall not be carried forward to subsequent policy year. Any restored Sum Insured will not be used to calculate the Cumulative Bonus or Cumulative Bonus Booster. For Individual policies restored Sum Insured will be available on individual basis whereas in case of a floater it will be available on floater basis.

For any single Claim during a Policy Year the maximum Claim amount payable shall be sum of:

a. The Sum Insured
b. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
c. Restored Sum Insured

9. AYUSH Treatment (In-patient Hospitalization)

We will pay the Medical Expenses incurred during the Policy Year in case of Medically Necessary Treatment taken during In-patient Hospitalization for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

The Insured Person has undergone treatment in an AYUSH Hospital where AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:

i). Central or State Government AYUSH Hospital; or
ii). Teaching hospitals attached to AYUSH College recognized by Central Government / Central Council of Indian Medicine and Central Council of Homeopathy; or
iii). AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   a). Having at least five In-patient beds;
   b). Having qualified AYUSH Medical Practitioner in charge round the clock;
   c). Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   d). Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

   The following exclusions will be applicable in addition to the other Policy exclusions:

   Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation

10. Air Ambulance Cover

We will reimburse the Reasonable and Customary expenses incurred towards transportation of an Insured Person, to the nearest Hospital or to move the Insured Person to and from healthcare facilities within India, by an Air Ambulance, provided that:

i. Air Ambulance is used in case of an Emergency life threatening health condition of the Insured Person which requires immediate and rapid ambulance transportation to the hospital or a medical centre which ground transportation cannot provide;
ii. The Illness/ Injury, causing Emergency, is covered under the Section II.1 In-patient Hospitalization;
iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment to monitor vitals and treat the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;
iv. Restoration of Sum Insured shall not be available under this benefit.
v. Air Ambulance service is offered by a Registered Ambulance service provider;
vi. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the Insured Person's requirement for Air Ambulance;
vii. Payment under this cover is subject to a claim being admissible under Section II.1 'In-patient Hospitalization' or under Section II.4 Day Care Treatment', for the same Illness/Injury;

Benefit under this cover is payable upto the limits as specified in the Policy Schedule subject to maximum up to ₹10 Lacs in a policy year and this is over and above the Sum Insured.

What is not covered: Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.

11. Bariatric Surgery Cover

We will cover the Medical Expenses incurred towards Medically Necessary Hospitalization of the Insured Person for Bariatric Surgery and its complications, up to Sum Insured, subject to maximum of ₹5 Lacs.

The cover is available subject to below conditions:

i. Surgery is Medically Necessary and is certified by an authorized Medical Practitioner;
ii. Hospitalization is within the Policy Year.

iii. The Insured Person satisfies following criteria as devised by NIH (National Institute of Health):
   a. The BMI should be greater than 37.5 without any co-morbidity; or greater than 32 with co-morbidity and
   b. Is unable to lose weight through traditional methods like diet and exercise.

iv. This cover is available after a Waiting Period of 36 months from the inception of this Policy with Us, with respect to the Insured Person.

v. Restoration of Sum Insured shall not be available under this benefit

12. Outpatient Expenses

We will cover the Reasonable and Customary Charges for below mentioned expenses incurred by the Insured Person as an Outpatient when treatment is taken from a Network Medical Practitioner to the extent of the Outpatient Sum Insured opted and as specified in Policy Schedule for this benefit.

i. Consultation and Diagnostic tests including Dental and Vision consultations and diagnostics, wherever prescribed by the Network Medical Practitioner, up to the Outpatient Sum Insured.

ii. Expenses incurred on drugs and medicines prescribed by the Network Medical Practitioner up to 20% of the Outpatient Sum Insured.

Overall payout in a Policy Year should not exceed 100% of the applicable Outpatient Sum Insured.

Any unutilized amount under this benefit shall not be carried forward to subsequent Policy Year.

Any medical aids such as spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt shall not be covered under this benefit.

We shall not cover any treatment and/or procedure under this benefit related to Dental and Vision.

This benefit shall be available only on Cashless basis from the MCHI Network. All Diagnostics and Pharmacy requirements would need to be prescribed by the Network Medical Practitioner in order to make them eligible under this benefit.

Restoration of Sum Insured shall not be available under this benefit.

13. Daily Cash for Shared Accommodation

We will pay a daily cash amount as specified in the Policy Schedule for the Insured Person for each continuous and completed period of 24 hours of Hospitalization provided that,

a. We have accepted claim under Section II.1 In-patient Hospitalization during the Policy Year

b. The Insured Person has occupied a shared room accommodation during such Hospitalization

c. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

What is not covered:

This benefit will not be payable if the Insured Person stays in an Intensive Care Unit or High Dependency Units / wards.

III. What are the Value Added Covers?

1. Health Check Up

(a) If the Insured Person, covered as adult (excluding dependent children in floater Policy) and has completed 18 years of age, the Insured Person may avail a comprehensive health check-up with Our Network Provider as per the eligibility details mentioned in the table below.

(b) In case of individual policy where more than 1 member are covered under the same Individual Policy, upon attainment of 18 years of age, the Insured member shall be eligible for health check-up with Our Network Provider as per the eligibility details mentioned in the table below.

(c) Health Check Ups will be arranged by Us and conducted at Our Network Providers. Alternatively, the Insured member may choose to undergo Health Check Ups as per Insured member's choice on Cashless basis with Our Network Provider, subject to the maximum limits as specified against the applicable Sum Insured.

(d) This benefit is available once in a policy year including the first policy year. And all the tests must have been done on the same date.

(e) Original Copies of all reports will be provided to You.

(f) We shall cover Health Check Up only on cashless basis.

(g) All eligible Insured members under the Policy shall either follow "Basis A" or "Basis B" while availing Health Check Up cover, within MCHI Network.

<table>
<tr><th colspan="6">Health Check Up</th></tr>
<tr><th rowspan="3">Package</th><th rowspan="3">Sum Insured</th><th rowspan="3">Age group</th><th colspan="2">Basis - A</th><th>Basis - B</th></tr>
<tr><th colspan="2">List of tests</th><th rowspan="2">Limits for tests of Insured member's choice on Cashless basis</th></tr>
<tr><th>Compulsory Tests</th><th>Optional Tests (Any one)</th></tr>
<tr><td rowspan="2">1</td><td rowspan="2">₹3 Lacs, ₹4 Lacs, ₹5 Lacs</td><td>Upto 40 Years</td><td>CBC-ESR, FBS, Lipid Profile, Sr. Creatinine</td><td>B1 - Heart monitoring – ECG or
B2 - Liver screening - SGOT and SGPT</td><td rowspan="2">₹1,000 per adult Insured member</td></tr>
<tr><td>Above 40 years</td><td>CBC-ESR, FBS, Lipid Profile, Sr. Creatinine</td><td>B1 - Heart monitoring – ECG or
B2 - Liver screening - SGOT and SGPT or
B3 - Thyroid Screening - Thyroid profile
B4 - Diabetes screening - HbA1c</td></tr>
<tr><td rowspan="2">2</td><td rowspan="2">₹7.5 Lacs, ₹10 Lacs,</td><td>Upto 40 Years</td><td colspan="2">ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, USG - Abdomen & pelvis</td><td rowspan="2">₹2,500 per adult Insured member</td></tr>
<tr><td>Above 40 years</td><td colspan="2">ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, HbA1c, USG Abdomen & Pelvis, PSA (for Males), Mammogram/ PAP Smear (for females)</td></tr>
</table>

3	> ₹10 Lacs	Upto 40 Years	FBS, Kidney Profile, ECG, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, USG Abdomen & Pelvis, Vitamin D3, Vitamin B12	₹5,000 per adult Insured member
		Above 40 years	FBS, ECG, HbA1C, Kidney Profile, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, PSA (for Males)/ Mammogram/ PAP Smear (for females), USG Abdomen & Pelvis, Vitamin D3, Vitamin B12	

Full explanation of Tests is provided here: FBS – Fasting Blood Sugar, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, Sr. Creatinine – Serum Creatinine, HbA1c – Glycosylated Hemoglobin, SGOT – Serum Glutamate oxaloacetate transaminase, SGPT – Serum Glutamate Pyruvate Transaminase, GGT – Gamma Glutamyl Transferase, TMT – Tread Mill Test, PSA – Prostate Specific Antigen, USG – Ultrasound Sonography, TSH – Thyroid Stimulating Hormone, CBC – Complete Blood Count

(h) This cover is available up to the limits as per Sum Insured opted.

(i) This benefit shall be over and above the Sum Insured.

(j) Restoration of Sum Insured shall not be available under this benefit

2. Domestic Second Opinion

You may choose to secure a second opinion from Our Network of Medical Practitioners in India, if an Insured Person is diagnosed with/ advised a treatment listed and defined under Critical Illness during the Policy Year. The expert opinion would be directly sent to the Insured Person.

You understand and agree that You can exercise the option to secure an expert opinion, provided:

(a) We have received a request from You to exercise this option.

(b) That the expert opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner

(c) This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

(d) The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

(e) We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

(f) The expert opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medico legal purposes.

(g) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(h) This benefit can be availed by each Insured Person only once during a Policy Year for one Critical Illness. However, one can avail this benefit for multiple critical illnesses in a year.

(i) Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus or Cumulative Bonus Booster.

For the purpose of this benefit covered Critical Illnesses shall include –

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specific Severty)
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure Requiring Regular Dialysis
7. Stroke Resulting in Permanent Symptoms
8. Major Organ/Bone Marrow Transplant
9. Permanent Paralysis of Limbs
10. Motor Neuron Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms
12. Primary (Idiopathic) Pulmonary Hypertension
13. Aorta Graft Surgery
14. Deafness
15. Blindness
16. Aplastic Anemia
17. Coronary Artery Disease
18. End Stage Lung Failure
19. End Stage Liver Failure
20. Third Degree Burns
21. Fulminant Hepatitis
22. Alzheimer's Disease
23. Bacterial Meningitis
24. Benign Brain Tumor
25. Apallic Syndrome
26. Parkinson's Disease
27. Medullary Cystic Disease
28. Muscular Dystrophy
29. Loss of Speech
30. Systemic Lupus Erythematous
31. Loss of Limbs
32. Major Head Trauma
33. Brain Surgery
34. Cardiomyopathy
35. Creutzfeldt-Jacob Disease (CJD)
36. Terminal Illness

3. Tele-Consultation

Insured Person may avail tele-consultations with our Medical Practitioner (s) through our network in India. These consultations would be available through tele/chat mode.

Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus or Cumulative Bonus Booster (if opted).

4. Cumulative Bonus

a) On Sum Insured

We will increase the Sum Insured as specified under the Plan opted, at the end of the policy year if the policy is renewed with us. The applicable percentage of Cumulative Bonus is set out under Section IX Table of Benefits:

a) No Cumulative Bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.

b) The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us under any circumstances.

c) Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of that Policy Year if the policy is renewed with us within grace period and will be available for any claims made in the subsequent Policy Year.

d) Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last policy year amongst all the expiring polices being

merged.

e) Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

f) Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.

g) Increase in Sum Insured: If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

h) Cumulative bonus shall not be available for claims made under Value added cover (Section III) and also for IV.A.1 Maternity & New Born Hospitalization Expenses, IV.C.1 Maternity & New Born Hospitalization Expenses, IV.A.3 Health Maintenance Benefit, II.10 Air Ambulance Cover, II.12 Outpatient Expenses, II.13 Daily Cash for Shared Accommodation and V.3 Infertility Treatment.

i) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under SectionF.I.6 under Policy Terms and Condition

5. Switch Off Benefit

In the event of your travel outside India after the first policy year, you may switch off your insurance cover for a maximum continuous period of 30 days in a policy year and earn a premium discount in the form of pro-rated premium, based on the total number of days up to which the cover has been switched off. Such pro-rated premium can be utilized in the form of premium discount at the time of policy renewal.

When the insurance cover is in Switch Off mode, only the following cover (s) if opted in the policy, shall remain active:

I. Section V.4. Personal Accident Cover and

II. Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover under Freedom optional package

III. Section V.6 Critical Illness Add On Cover

a. Premium discount shall be calculated on a pro-rata basis the number of days the policy has been switched off on a per day basis and this discount shall be adjusted in the renewal premium falling due immediately after the expiring Policy Period.

b. In a Floater Policy, Switch Off Benefit can be availed only if all the Insured Persons travel outside India. However, in case of an Multi-Individual Policy if any one or more Insured Person (s) travel outside India, You can avail this benefit and the premium discount shall be calculated based on the applicable premium for that/those particular individual (s).

c. This benefit shall not be available in the first Policy Year.

d. This benefit cannot be availed in the last 90 days of the Policy Year.

e. During the Switch-off period, Your cover will be limited only to Section V.4 Personal Accident Cover, Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover and Section V.6 Critical Illness Add-on, if opted. Any claim under the floater policy, arising during the switch off period other than claim under Section V.4 Personal Accident Cover, Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover and Section V.6 Critical Illness Add-on, shall not be payable. In case of Multi-Individual policies where members are covered on individual basis, the switch off period shall apply only to the respective member for which the request to switch off the coverage is placed with the Insurer. The coverage shall start once the cover is switched on either upon the expiry of the Switch Off period or 30 days from the Switch Off date, whichever is earlier.

f. The date of travel to abroad for all the Insured Members should be same in case of a floater policy in order to be eligible to utilize this cover.

g. In a Floater Policy, Switch Off Benefit can be availed only if all the Insured Persons travel outside India at the same time. The date of travel to abroad and return to India for all the Insured Members should be same to be eligible to utilize this cover.

h. In case of a Multi-Individual Policy, You can Switch Off the Policy for one or more members provided that the date of travel to abroad and return to India for those Insured Members is same to be eligible to utilize this cover.

i. This benefit can be utilized only once in a Policy Year irrespective of Policy type (Floater or Individual/ Multi-Individual).

j. You need to intimate Us at least 72 hours prior to the date of travel to switch off the policy. We would require the following details:

a. Date and time of leaving India

b. Date and time of your return to India

k. In case You arrive back to India earlier than the date informed to Us, then You need to intimate us at least 24 hours prior to the return travel to India in order to Switch On the Policy. If out of all members who travelled, only one or few members return to India earlier than the date informed to Us, then the Policy shall be switched on from the earliest date of return to India for all the members.

l. Your coverage shall be switched off and reactivated as per the details provided in clause (j) above subject to a maximum switch off period of 30 days. If the return to India is later than 30 days from the date of Switch off, the coverage shall be reactivated immediately after 30 days irrespective of your return.

m. We may require the following documents to record the date of your travel in order to Switch-Off and Switch-on the policy for You

a. Flight tickets of the Insured members travelling to abroad

b. Flight tickets of the Insured members travelling back to India

n. Your Policy coverage will be automatically activated based on the information pertaining to date of return provided to us or 30 days from the Switch Off date, whichever is earlier. In case of policy term of 2 years and 3 years, you can avail this benefit each year and the discount shall be accumulated during the policy period which can be redeemed at the time of policy renewal as per the below

a. If the policy is renewed with the same policy term or higher, then 100% of the earned discount shall be adjusted in the renewal premium as 'Discount in renewal premium'.

b. If the policy is renewed with a reduced policy term, then the earned discount shall be adjusted on a proportionate basis in the ratio as specified below:

$$\text{Discount to be Adjusted} = \text{Earned Discount} \times \frac{\text{Renewal Policy Term}}{\text{Previous Policy Term}}$$

Illustration: Previous Policy Term = 3 years; Switch Off Discount Earned over 3 years = ₹1,800

If Renewed Policy Term is	Renewal Premium (Excluding optional covers, Rider and taxes)	Switch Off discount utilized	Renewal Premium Payable after adjusting Switch Off discount

1 Year	13,000	600 (1,800*1/3 as Insured is renewing from 3 Year Policy Term to 1 Year Policy Term)	12,400
2 Years	27,000	1,200 (1,800*2/3 as Insured is renewing from 3 Year Policy Term to 2 Year Policy Term)	25,800
3 Years	42,000	1,800 (Insured is renewing with the same Policy Term of 3 years)	40,200

Illustration 2: Switch Off Period

Travel Period	From: 15/ 01/ 2022 Time: 16:00 hrs.	To: 20/ 01/ 2022 Time: 15:00 hrs.
Requested Date of Switch Off	15/ 01/ 2022	
Requested Date of Switch On	20/ 01/ 2022	
In this case, Switch Off shall happen on 15/01/2022 at 23:59:59 hrs. and Switch On shall happen on 20/01/2022 at 00:00:00 hrs.		

For the purpose of this benefit,

Switch Off - means to deactivate all the covers in the Policy, except coverage under Section V.4 Personal Accident Cover and Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover Section V.6 Critical Illness Add-on, from the requested Switch Off date.

6. Wellness Program

You can earn reward points by opting for Our Healthy Life Management Program wherein you need to complete number of steps per day as per the table given below, that will help You in improving Your well-being.

Healthy Life Management Program - Rewards Structure				
No. of days	**No. of steps**			
	10,000 steps and above per day	8,000 - 9,999 steps per day	6,000 - 7,999 steps per day	Less than 6,000 steps per day
240 days and above	20%	15%	10%	Nil
180 - 239 days	15%	10%	5%	Nil
120 - 179 days	10%	5%	Nil	Nil

Conditions under this benefit:

i. The number of days specified in the table above should fall under the first 9 (nine) months of every Policy Year. The activities undertaken towards this benefit during the last 3 (three) months of the Policy Year shall not be considered for reward calculation.

ii. This wellness program is available only for the adult members with age 18 years and above. However, in a Floater policy, this program shall be available only to the independent adult members and shall not be available to dependent children.

iii. In an Individual Policy with one or more members, earning of reward points will be at member level wherein each member can earn up to 20% of his/her respective expiring base premium as per the applicable terms and conditions but in a floater policy, earning of reward points will be at policy level wherein all eligible members cumulatively can earn a maximum up to 20% of the expiring base premium. as per the applicable terms and conditions.

iv. In a floater policy the above reward percentage would be divided as per the number of eligible Adult Insured members as per the below illustration.

In a floater policy, the reward percentage would be divided as per the number of eligible Adults covered.
For Example
In a 2A+2C policy, the Healthy Life Management Program shall be applicable for 2A only. Assuming Adult 1 attains a score of 10,000 steps per day for a period of 240 days and Adult 2 attains a score of 6000 steps per day for a period of 240 days.
The reward points shall be calculated as per the below:
Adult 1: 20% / 2 = 10%
Adult 2: 10% / 2 = 5%
Hence, the total earned reward points would be 10% + 5% = 15% of the existing Policy premium (Excluding optional cover/ Rider and taxes).

v. No reward points will be allocated for any count of steps per day, for a period of less than 120 days.

vi. Maximum reward points that can be earned in a single Policy Year will be limited to 20% of the premium paid (excluding premium for Optional covers, Riders and taxes) in the existing Policy. In case of 2 or 3 year policies, maximum reward points that can be earned shall not exceed 20% of the total premium paid (excluding premium for Optional covers, Riders and taxes) for 2 years or 3 years asapplicable.

vii. Each earned reward point will be valued at 1 Rupee. Accrued rewards can be redeemed against payable premium (excluding premium for Optional covers, Riders and Taxes) from 1st Renewal of the Policy.

viii. The earned reward points can be utilized as Discount in the renewal premium falling due immediately after the accrual. Carry forward of earned reward points shall not be allowed.

ix. Redemption against renewal premium will be available only at the time such renewal is due. Any earned rewards will lapse at the end of the grace period if the policy is not renewed with us.

Refer Annexure- A below on the Illustration of Reward Points.

Annexure – A – Illustration of Healthy Life Management Program Rewards

Reduction of Renewal Policy Year

Policy Term - 3 years
(Premium indicated here is just for illustration purposes in case of 1 Adult policy and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee

Year	Premium (Excluding optional covers/ Rider and taxes)	Activity	No. of Days	Reward %	Reward Points Earned
Year 1	10000	10,000 and above steps/day	240 days and above	20%	2000
Year 2	11000	8,000 - 9,999 steps/day	240 days and above	15%	1650
Year 3	12000	6,000 - 7,999 steps/day	240 days and above	10%	1200
Total	33000				4850

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium
Renewal of Policy as per below table

If Renewed Policy Term is	Renewal Premium (Excluding optional covers, Rider and taxes)	Reward discount utilized	Renewal Premium Payable after adjusting Reward discount
1 Year Policy	13000	1617 (4850*1/3 as Insured is renewing 3 Year policy to 1 Year Policy)	11383
2 Years Policy	27000	3233 (4850*2/3 as Insured renewing 3 Year policy to 2 Year Policy)	23767
3 Years Policy	42000	4850 (Insured renewing to the same policy tenure of 3 years)	37150

Increase of Renewal Policy Year

Policy Term - 1 year
(Premium indicated here is just for illustration purposes and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee

Year	Premium paid (Excluding optional cover, Rider and taxes)	Activity	No. of Days	Rewards %	Points Earned
Year 1	10000	6,000 - 7,999 steps / day	180 - 239 days	5%	500
Total	10000				500

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium

Renewal of Policy as per below table

If Renewed Policy Term is	Renewal Premium (Excluding optional cover, Rider and taxes)	Rewards discount utilized	Renewal Premium Payable after adjusting Rewards discount
1 Year Policy	11000	500 (as Insured is renewing 1 Year policy to 1 Year Policy)	10500
2 Year Policy	21000	500 (as Insured is renewing 1 Year policy to 2 Year Policy)	20500
3 Year Policy	33000	500 (as Insured is renewing 1 Year policy to 3 Year Policy)	32500

The notifications related to wellness program will be communicated via SMS, email and the program specific phone/ web application Details about reward points will be available on the program app (if any) or would be shared through SMS and/or Renewal Notice which would be sent to customers.

7. Discount from Network Providers

The Insured Person can avail discounts on Diagnostics, Pharmacy and Health Supplements offered through our Network Providers.

8. Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers Death due to an injury caused by an Accident within 365 days from the date of the event or he/she is diagnosed with a Critical Illness, listed under this section, We will pay the next one full Policy Year's Renewal Premium (including premium for Optional covers, Riders and Taxes) of the Policy, for a policy tenure of 1 year.

The premium shall be paid towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.

In case of any change in Policy benefits, complete premium will be paid by the Policyholder.

The cover is available subject to below conditions:

- If only one person is covered under the Policy, policy will not be renewed in case of death of the Policyholder.
- The Policyholder is not added in the Policy in the middle of the Policy Year. There is no change in covers, Sum Insured, benefit structure, limits and conditions applicable under the Policy, at the time of renewal.
- No new member is being added under the renewed Policy.
- In case of a policy with existing tenure of 2 or 3 years, it will be renewed only for one year, provided all the terms and conditions, benefits and policy limits remain same.

For the purpose of this benefit, Critical Illnesses shall include –

a) Cancer of Specified Severity

b) Myocardial Infarction (First Heart Attack of Specific Severity)
c) Open Chest CABG
d) Open Heart Replacement or Repair of Heart Valves
e) Coma of Specified Severity
f) Kidney Failure Requiring Regular Dialysis
g) Stroke Resulting in Permanent Symptoms
h) Major Organ/Bone Marrow Transplant
i) Permanent Paralysis of Limbs
j) Motor Neuron Disease with Permanent Symptoms
k) Multiple Sclerosis with Persisting Symptoms

Once a claim has been accepted and paid under this benefit, this cover will automatically terminate in respect of that Insured Person.

IV. What are the Optional Packages?

These optional packages shall be available to all eligible Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only.

The limits specified under below optional package shall override the applicable limits mentioned as part of base cover for the respective coverages.

The Insured Person can opt for any one of the below packages.

A. Enhance Plus (Applicable for Protect Plan)

1. Maternity and New Born Hospitalization Expenses

a. Maternity Expenses

We cover Maternity Expenses for the delivery of a child and/or maternity expenses incurred during the Policy Year related to medically necessary and lawful termination of pregnancy limited to maximum 2 deliveries during the lifetime of an Insured person, subject up to Maternity Sum insured and as per Plan opted.

The female adult Insured person should have been continuously covered under this policy for at least 36 months before availing this benefit.

Maternity Sum Insured will be limited to per event and in addition to Sum Insured opted under the Policy, however any restored amount will not be available for coverage under this section.

Applicable Deductible under the plan shall also apply to this benefit.

The following expenses are not covered under maternity benefit:

a. Medical expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.
b. Medical expenses for ectopic pregnancy. However, these expenses will be covered under the In-patient hospitalization.

b. New Born Baby Expenses

We cover medical expenses towards treatment of the Insured person's new born baby while the Insured Person is hospitalized as an In-patient for delivery, subject to a valid claim being accepted under maternity expenses.

This would include In-patient hospitalization expenses incurred on the new born baby during and post birth including any complications up to a period of 90 days from the date of birth and within the limits specified under Maternity Expenses cover under the plan opted by You.

Any restored Sum Insured will not be available for coverage under this section Subject to the underwriting and to the terms and conditions of the Policy, We would cover the baby beyond 90 days on payment of requisite premium subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier.

Applicable Deductible or Co-pay under the plan shall also apply to this benefit.

c. First Year Vaccinations

We will cover Reasonable and Customary charges for vaccination expenses for the New Born Baby as per National Immunization Scheme (India) listed below, till the baby completes 1 year (12 months) within the limits under Maternity Expenses without payment of any additional premium. In case the Policy ends before the New Born Baby has completed 1 year (12 months), the coverage under this benefit shall continue subject to the Policy being renewed in the subsequent year. Any restored Sum Insured will not be available for coverage under this section

The reasonable and customary charges for standard vaccinations will be covered as per below schedule:

Time Interval	Vaccinations to be done (Age)	Frequency
0 – 3months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
3 – 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

2. Room Accommodation Upgrade

We will upgrade the Room category coverage under Section II.1 In-patient hospitalization up to 'Any Room Category' subject to maximum of Sum Insured Opted and as specified in the Policy Schedule.

3. Health Maintenance Benefit

We will cover, up to limits specified in the Policy Schedule, by way of reimbursement of the Reasonable and Customary Charges for below mentioned expenses incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on an Out Patient basis.

i. Consultation with Medical Practitioner, Diagnostic tests, preventive tests, drugs, prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), prescribed by the specialist Medical Practitioner up to the limits specified in the Policy Schedule.

ii. Towards Dental Treatments and AYUSH forms of Medicines wherever prescribed by a Medical Practitioner.

Insured can use Our application or contact Us for scheduling an appointment for availing services covered under this benefit at our Network provider.

Any unutilised Health Maintenance Benefit limit shall lapse at the end of the Policy Year. Fresh limits will be available as specified in the Policy Schedule for the new Policy Year.

All Waiting Periods and Permanent Exclusions including Co-pay's applicable on the Policy under Section VII shall not apply to this section.

B. Assure

(Applicable for Sum Insured ₹3 Lacs, ₹4 Lacs and ₹5 Lacs under Protect Plan)

1. Room Accommodation Limit

We will limit the Room category coverage under Section II.1 In-patient hospitalization up to 1% of the opted Sum Insured per day and as specified in the Policy Schedule. For ICU accommodation, we will cover up to 2% of the opted Sum Insured per day and as specified in the Policy Schedule.

If the Insured Person is admitted in a room category/ limit that is higher than the one that is specified in the Policy Schedule, then the Policyholder/ Insured Person shall bear a ratable proportion of the total Associated Medical Expenses (including surcharge or taxes there on) in the proportion of the difference between the room rent of the entitled room category to the room rent actually incurred.

2. Disease Specific Sub-limits

We will indemnify the Medical Expenses under Section II.1 In-patient hospitalization incurred by an Insured Person in respect of the below listed ailments / procedures (refer the table below) up to the limits specified against each and every ailment / procedure for the applicable Sum Insured options:

Sum Insured (in ₹)	**₹3 & ₹4 Lacs**	**₹5 Lacs**
Treatment for each Ailment / Procedure mentioned below: 1. Surgery for treatment of all types of Hernia 2. Hysterectomy 3. Surgeries for benign Prostate Hypertrophy 4. Surgical treatment of stones of renal system	₹50,000	₹65,000
Treatment of Cataract (Per Eye)	₹20,000	₹30,000
Treatment of Total Knee replacement (Per knee)	₹80,000	₹1,00,000
Treatment for breakage of bones	₹2,00,00	₹2,50,000

3. Modern and Advanced Treatments

We will cover the following procedures (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a hospital up to 10% of the Sum Insured as specified in the Policy Schedule, during the Policy Year:

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchial Thermoplasty
j. Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

C. Enhance (Applicable for Advantage Plan)

1. Maternity and New Born Hospitalization Expenses

a. Maternity Expenses

We cover Maternity Expenses for the delivery of a child and/or maternity expenses incurred during the Policy Year related to medically necessary and lawful termination of pregnancy limited to maximum 2 deliveries during the lifetime of an Insured person, subject up to Maternity Sum insured and as per Plan opted.

The female adult Insured person should have been continuously covered under this policy for at least 36 months before availing this benefit.

Maternity Sum Insured will be limited to per event and in addition to Sum Insured opted under the Policy, however any restored amount will not be available for coverage under this section.

Applicable Deductible under the plan shall also apply to this benefit.

The following expenses are not covered under maternity benefit:

a. Medical expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.

b. Medical expenses for ectopic pregnancy. However, these expenses will be covered under the In-patient hospitalization.

b. New Born Baby Expenses

We cover medical expenses towards treatment of the Insured person's new born baby while the Insured Person is hospitalized as an In-patient for delivery, subject to a valid claim being accepted under maternity expenses.

This would include In-patient hospitalization expenses incurred on the new born baby during and post birth including any complications up to a period of 90 days from the date of birth and within the limits specified under Maternity Expenses cover under the plan opted by You.

Any restored Sum Insured will not be available for coverage under this section

Subject to the underwriting and to the terms and conditions of the Policy, We would cover the baby beyond 90 days on payment of requisite premium subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier.

Applicable Deductible or Co-pay under the plan shall also apply to this benefit.

c. First Year Vaccinations

We will cover Reasonable and Customary charges for vaccination expenses for the New Born Baby as per National Immunization Scheme (India) listed below, till the baby completes 1 year (12 months) within the limits under Maternity Expenses without payment of any additional premium. In case the Policy ends before the New Born Baby has completed 1 year (12 months), the coverage under this benefit shall continue subject to the Policy being renewed in the subsequent year. Any restored Sum Insured will not be available for coverage under this section.

The reasonable and customary charges for standard vaccinations will be covered as per below schedule:

Time Interval	Vaccinations to be done (Age)	Frequency
0 – 3months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
3 – 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

2. Room Accommodation Upgrade

We will upgrade the Room category coverage under Section II.1 In-patient hospitalization up to 'Any Room Category' subject to maximum of Sum Insured Opted and as specified in the Policy Schedule.

D. Freedom

(Applicable for Protect and Advantage Plans)

This package is available to all Insured Persons provided they are Indian resident at inception of the Policy and at subsequent renewals of this policy.

1. Room Accommodation Upgrade

We will upgrade the Room category coverage under Section II.1 In-patient hospitalization up to 'Any Room Category' subject to maximum of Sum Insured Opted and as specified in the Policy Schedule.

2. Worldwide Emergency Hospitalization with Outpatient Cover

We will cover Medical Expenses incurred during the Policy Year, for Emergency In-patient Hospitalization Treatments or Emergency Outpatient Treatment of the Insured Person incurred outside India, covered up to Sum Insured, provided that:

(a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India and is payable under Section II.1 'In-patient Hospitalization' and/or II.12 'Outpatient Expenses' of the Policy.

(b) The Medical Expenses payable shall be limited to Emergency In-patient Hospitalization and Emergency Outpatient only.

(c) Any payment under this benefit will only be made in India, in Indian rupees on a re-imbursement basis and subject to maximum of Sum Insured. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance. In case where Cumulative Bonus accumulated is used for payment of claim under this benefit, the maximum liability under a single Policy year shall not exceed the Opted Sum Insured including Cumulative Bonus or Cumulative Bonus Booster as applicable.

(d) The payment of any claim under this benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

(e) You have given Us, intimation of such hospitalization within 48 hours of admission.

(g) Any claim payable under this benefit is over and above the Sum Insured.

(h) Restoration of Sum Insured shall not be available under this benefit.

V. What are the Optional Covers?

The following optional covers shall be available under the Policy and shall apply to all Insured Persons under a single policy without any individual selection.

1. Non-Medical Items

We will cover the cost of Non-Medical items, listed under Annexure III List 1 of the Policy Terms and Condition, incurred towards Medically Necessary Hospitalization of the insured person, arising out of Disease/ Illness or Injury.

The cover is available subject to the claim being admissible under Section II.1 'In-patient Hospitalization' and/ or Section II.4 Day Care Treatment cover under this policy and the expenses on Non-medical items are related to the same Illness/ Injury.

Any claim made under this optional benefit will reduce the Sum Insured.

2. Deductible

You can opt for a Deductible of ₹10,000 or ₹25,000 in the Policy. Wherever a Deductible is selected such amount will be applied for each Policy Year on the aggregate of all Claims in that Policy Year other than for claims under fixed benefit covers and Health Check Ups.

Deductible shall apply to all sections other than V.4 Personal Accident Cover, II.13 Daily Cash for Shared Accommodation, II.12 Outpatient Expenses, Section III. Value added covers and Add On Riders if opted.

For Deductible of ₹10,000, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal

For Deductible of ₹25,000, the cover can be opted either at inception or at the time of Policy Renewal. However once opted, the Insured Person can remove the Deductible of ₹25,000 only at the time of renewal falling immediately due after 4 continuous Policy Years or any subsequent renewals thereon, from the year of opting ₹25,000 Deductible.

This benefit shall not be available if IV.B Assure optional package is opted.

All other terms, conditions, waiting periods and exclusions shall apply.

3. Infertility Treatment

We will cover the Medical Expenses of the eligible Insured Person if hospitalized on the advice of the Medical Practitioner for Infertility Treatments up to maximum of ₹2.5 lacs as per Sum Insured opted provided that,

a. IV.A 'Enhance Plus' or IV.C 'Enhance' Optional Package is opted and Sum Insured opted under the Policy is ₹7.5 lacs and above.
b. This cover is limited to IVF and/or IUI treatments.
c. The Insured Person should have been continuously covered under this Policy for at least 36 months before availing this benefit.
d. The benefit shall be restricted to two successful procedures leading to conception during the lifetime of the eligible Insured Person and the coverage shall terminate thereafter
e. Sum Insured available under this section will be in addition to Maternity Sum Insured under Section IV.A.1 Maternity & New Born Hospitalization Expenses or IV.C.1 Maternity & New Born Hospitalization Expenses
f. Restoration of Sum Insured shall not be available under this benefit.
g. The cover shall automatically cease upon the eligible Insured Person attaining 60 years of age.

4. Personal Accident Cover:

We will pay two times of the Sum Insured opted subject to maximum of ₹50 Lacs in case the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Insured Person's Death or Permanent Total Disablement which is of the nature specified below within 365 days of the Accident.

Table of Benefits	Percentage of the Sum Insured payable
a. Type of Permanent Total Disablement	
i) Total and irrecoverable loss of sight of both eyes	100%
ii) Loss by physical separation or total and permanent loss of use of both hands or both feet	100%
iii) Loss by physical separation or total and permanent loss of use of one hand and one foot	100%
iv) Total and irrecoverable loss of sight of one eye and loss of a Limb	100%
v) Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye	100%
vi) Total and irrecoverable loss of hearing of both ears and loss of speech	100%
vii) Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye	100%
viii) Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in "Loss of Independent Living"	100%

For the purpose of this benefit,

- **Limb** means a hand at or above the wrist or a foot above the ankle;
- **Physical separation of one hand** or **foot** means separation at or above wrist and/or at or above ankle, respectively.

The benefits as specified above will be payable provided that:

a. The Permanent Total Disablement is proved to Our satisfaction; and a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and
b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement of the Permanent Total Disablement; provided that We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.
c. If We have admitted a claim for Permanent Total Disablement in accordance with this benefit, then We shall not be liable to make any payment

under this benefit on the death of the Insured Person, if the Insured Person subsequently dies.

d. Once a claim has been accepted and paid under this benefit in case of Death then cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

e. Restoration of Sum Insured shall not be available under this benefit.

5. Cumulative Bonus Booster

We will provide an option to increase the Sum Insured by 50% for each policy year up to a maximum of 200% of Sum Insured provided that the Policy is renewed with Us without a break.

a. No cumulative bonus will be added if the Policy is not renewed with Us by the end of the grace period. The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us.

b. Any earned Cumulative Bonus will not be reduced for claims made in the future, wherever the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year.

c. In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.4 shall not be available, however all terms and conditions of the said section shall apply.

d. This Cumulative bonus shall not be available for claims made for Value added cover (Section III) and also for IV.A.1 Maternity & New Born Hospitalization Expenses, or IV.C.1 Maternity & New Born Hospitalization Expenses, IV.A.3 Health Maintenance Benefit, II.10 Air Ambulance Cover, II.12 Outpatient Expenses, II.13 Daily Cash for Shared Accommodation and V.3 Infertility Treatment.

6. Add on -

Critical Illness Rider

Along with this Product You can also avail the ManipalCigna Critical Illness Add On Cover (UIN: MCIHLIP21128V022021 or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider including medical check-up requirement will apply.

For the purpose of this Benefit, Critical Illness will be as listed under the ManipalCigna Critical Illness Add on Cover Policy documents.

ManipalCigna Prime Plus

Along with this Product You can also avail the ManipalCigna Prime Plus (UIN: MCIHLIA25005V012425) - Add On Cover or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase.

All waiting periods, exclusions and terms and conditions of the applicable rider including medical check-up requirement will apply.

Room Rent Modification:

The Insured Person shall be eligible to modify the room type category eligibility under the Policy as follows:

Option 1: Any room; ICU Up to Sum Insured

Option 2: Twin Sharing AC room; ICU Up to Sum Insured

Surplus Benefit:

Additional 100% of Sum Insured, available from day 1 for 1st claim only, in each policy year.

Supreme Bonus:

Guaranteed Cumulative Bonus of 100% of Base Sum Insured each policy year; subject to a maximum of 800% of the Base Sum Insured.

Premium Management Cover:

Once opted below benefits shall not be available in Base product

1. Air Ambulance Cover
2. Bariatric Surgery Cover
3. Daily Cash for Shared Accommodation
4. Health Check Up
5. Domestic Second Opinion
6. Tele Consultation
7. Premium Waiver Benefit

Women Care:

Coverage for Mammography, Cervical Cancer screening and PCOS/PCOD diagnostic tests on cashless basis from MCHI network for women aged 18 years and above. The limit for the same is ₹10,000 per female insured.

Deductible:

Option to opt from ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 and ₹5,00,000 on aggregate basis.

Vi. What are Features of the Policy?

i). Eligibility

The minimum entry age under this policy is 91 days for children and 18 years for adults. There is no limit for entry under this policy.

Coverage for children:

a. Children from 91 days to 18 years will only be covered if one of the parents is the proposer.

b. Children up to 25 years can be covered under the floater

c. Children beyond 25 years can be covered under an individual policy.

Renewals will be available for lifetime.

ii). Individual and Family Floater

The policy can be purchased on an Individual/ Multi-Individual basis or a Family floater basis.

a. In case of an Individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, lawfully wedded spouse, children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, uncle, aunty, nephew & niece.

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, lawfully wedded spouse, children up to the age of 25 years or parents. A floater cover can cover a maximum of 2 adults and 3 children under a single policy.

iii). Policy Period option

You can buy the policy for one, two or three continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the inception date of the policy.

iv). Plan & Sum Insured Options

You have the option to choose from a wide range of Sum Insured's available under different plans.

Plan Name	Sum Insured (Lacs)
Protect Plan	₹3 Lacs, ₹4 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs, ₹100 Lacs
Advantage Plan	₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs, ₹100 Lacs

v). Discounts under the Policy

You can avail of the following discounts on the premium on Your policy.

i. **Lifetime Discounts**

a. **Employee Discount**: 10% discount on the premium

b. **Standing Instruction Discount:** 3% discount on the renewal premium, if the renewal premium is received through standing instruction.

c. **Long Term policy discount** - Long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy. This discount is available only with 'Single' Premium Payment mode

d. **Family discount:** (Applicable only with cover on individual basis) 20% discount on the premium is applicable for covering 2 or more members under the same individual Policy on Multi-Individual basis.

ii. **Short Term Discounts**

a. **ManipalCigna Existing Customer Discount:** 5% discount will be applicable to customers of ManipalCigna Insurance who are already covered under Group / Retail Products. Discount would be applicable once, only at inception and shall not be offered to Portability/Migration related proposals.

b. **Worksite Marketing Discount** - A discount of 10% will be available on polices which are sourced through worksite marketing channel. Discount would be applicable once only at inception of the Policy.

Discount under VI.v.i (d) is applicable only to individual policies. All other discounts mentioned above are available to both individual as well as floater policies. Maximum discount in a single policy shall not exceed 40%.

Family Discount, Long Term Discount and Worksite Marketing Discount is applied on the total Policy premium which is sum total of individual premium for Family policies.

vi). Underwriting Loading & Special Conditions

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levis & taxes) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal (s). There will be no loadings based on individual claims experience.

We may apply a specific sub-limit on a medical condition/ailment depending on Your medical history and declarations or additional waiting periods (a maximum of 36 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.

We will inform You about the applicable risk loading or special condition through a counter offer letter or through an electronic mode, as the case may be and We will only issue the Policy once We receive your consent and applicable additional premium (if any) within the duration specified in the counter offer letter.

In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

vii).Premiums

The Premium charged on the Policy will depend on the Plan, Sum Insured, Policy Tenure, Age, Policy Type, Gender, Zone of Cover, Optional Covers and Add On Benefits opted. Additionally, the health status of the individual will also be considered.

For premium calculation of floater policies, age of eldest member would be considered

Premium towards Section IV.A.1 Maternity Expenses & New born Hospitalization Expenses or IV.C.1 Maternity & New Born Hospitalization Expenses and Section V.3 Infertility Treatment shall be applied to female Insured Members covered as adult in the Policy.

For detailed premium chart please refer Annexure "Rate Chart" attached along with this document.

Operational cost for Section III.6 Wellness Program is 0.05% of Premium.

For the purpose of calculating premium, the country has been divided into 3 Zones. Identification of Zone will be based on the City-Location of the correspondence address of the proposed Insured persons and premiums will be calculated accordingly.

Zone Classification

Zone I: Mumbai, Thane & Navi Mumbai, Gujarat and Delhi & NCR

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Pune

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the City of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any co-pay.

(b) Persons paying Zone II premium
   i) Can avail treatment in Zone II and Zone III without any co-pay.
   ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

(c) Person paying Zone III premium
   i) Can avail treatment in Zone III, without any co-pay
   ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
   iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

Option to select Zone 1 if the actual Zone is Zone 2 or Zone 3, and would be available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalization due to an Accident.

viii). Premium payment mode

The premium should always be paid in advance for a full Policy Year. However, for your convenience, we may allow you other modes of payment of premium. Premium can be paid on Single, Yearly, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy.

In case of premium payment modes other than Single and Yearly, a loading will be applied on the premium.

Loading grid applicable for Half yearly, Quarterly and Monthly payment mode.

Premium payment mode	% Loading on premium
Monthly	5.50
Quarterly	3.50
Half yearly	2.50

If we receive any amount in excess of the required premium, we will refund the excess with out paying any interest on the excess amount.

If we receive any amount lesser than the required premium, the same shall not be adjusted towards the premium and no interest shall be paid on the amount. You will not be entitled to any benefits or claims under the policy unless you pay the full premiums in time.

The premium payment mode can be changed only on a policy anniversary by sending a request at least one month in advance. Change in premium payment mode is subject to:

1. Payment of premium and loading, if any.
2. Minimum premium requirement for the requested premium payment mode, if any.
3. Availability of the requested premium payment mode on the day of implementation of request.
4. Premium rates/ tables applicable for the changed premium payment mode will be the same as the premium rates/ tables applicable on the date of commencement of policy.

ix). Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

a. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d. At the end of the policy period, the policy shall terminate and can be renewed within the grace period of 30/15 days, to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e. No loading shall apply on renewals based on individual claims experience.

I. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. The Policy with Freedom optional package shall be renewed subject to the Insured Person being an Indian resident at the time of renewal.
b. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.
c. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non cooperation by You.
d. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.
e. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.
f. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.
g. Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for change of Sum Insured or addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception, on renewal. The terms and conditions of the existing policy will not be altered.
h. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
i. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 36/ 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.
j. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section VI. (i) to VI (ix) will be applicable considering such Policy Year as the first year of Policy with the Company.

k. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.

l. In case of floater policies, children attaining 26 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the floater cover.

Premium Payment in Instalments: For Policies other than 'Single' Premium payment modes.

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

- Grace Period of 15 days for Monthly mode and 30 days for Half-Yearly & Quarterly mode would be given to pay the instalment premium due for the Policy.
- During such grace period, coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
- The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged if the instalment premium is not paid on due date.
- Wherever premium is not received within the revival period of the policy, the policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the policy. However, we will be liable to pay in respect of all claims where the treatment / admission/ accident has commenced / occurred before the instalment premium due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

You may pay the premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that:

i. NACH/Standing Instruction Mandate form is completely filled & signed by You.

ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

iv. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/ Standing Instruction facility.

v. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy.

x). Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For detailed Guidelines on Portability, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule I of IRDAI (Health Insurance) Regulations 2016 for the Portability norms

xi). Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act 1961. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

xii).Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

xiii).Fre-look Period

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

The insured person shall be allowed a free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

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

a. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or;

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

xiv).Cancellations

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 15 days' notice in writing. We shall refund the premium for the unexpired term as per the short period scale mentioned below.

Premium shall be refunded as per table below if no claim has been registered/ made under the policy and full premium has been received.

Policy Cancelation Within (Days)	Refund Grid as % of Premium		
	Policy Year-1	Policy Year-2	Policy Year-3
0 - 30 Days	85.00%	87.50%	89.00%
31 - 90 Days	75.00%	80.00%	82.50%

91 - 181 Days	50.00%	70.00%	75.00%
182 - 272 Days	30.00%	60.00%	70.00%
273 - 365 Days	0.00%	50.00%	60.00%
366 - 456 Days	NIL	35.00%	55.00%
457 - 547 Days		25.00%	45.00%
548 - 638 Days		15.00%	40.00%
639 - 730 Days		0.00%	30.00%
731 - 821 Days		NIL	25.00%
822 - 912 Days			15.00%
913 - 1003 Days			5.00%
1004 and more Days			0.00%

No refund will be processed for cancellation of policies with Premium Payment Mode as Half-yearly, Quarterly or Monthly.

i. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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

xv).Endorsements

The Policy will allow the following endorsements during the term of the Policy. Any request for endorsement must be made by You in writing.Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later other than for change in Date of Birth or Gender which will be with effect from inception.

a). Non-Financial Endorsements - which do not affect the premium

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not change Zone)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer
- Change in Nominee Details

b). Financial Endorsements- which result in alteration in premium

- Deletion of Insured Member on Death or Separation or Policyholder/Insured Person Leaving the Country only if no claims are paid/outstanding.
- Change in Age/Date Of Birth
- Change of occupation of the insured (if it changes the risk class of insured)
- Addition of Member (New Born Baby or Newly Wedded Spouse)
- Change in Address (resulting in change in Zone)
- Rectification in Gender of the Proposer/ Insured Person
- Disclosure of any illness/ habit
- Change in height & weight of the insured (if it changes the risk class of insured)

All endorsement requests may be assessed by the underwriting team and if required additional information/documents may be requested.

xvi).Redressal of Grievance

In case of a grievance, you can contact us through our website: https://www.manipalcigna.com/grievance-redressal

You can reach us at our Toll Free: 1800-102-4462

For Senior Citizen you can write to us at Seniorcitizensupport@manipalcigna.com

Post/Courier/Walk-in: Any of Our Branch office or corporate office at the addresses available on https://www.manipalcigna.com/locate-us

If in case you are not satisfied with the response then write to us at: headcustomercare@manipalcigna.com

If the channels above have still not met your expectations, you may approach the insurance ombudsman, the office Name and address details applicable for your state can be obtained from the following link https://www.cioins.co.in/Ombudsman on the IRDAI Website

Note: If you are not satisfied with the decision provided by any of the above authorities, you can approach the company within 8 weeks from the date of receipt of response by the insured/policyholder.

You may also approach the Insurance ombudsman if your complaint is open for more than 30 days at any of the above levels

In case of no response within 8 weeks your grievance will stand close.

xvii). Pre-Policy Medical Check-up

We will require You to undergo a medical check-up based on Your age Plan and the Sum Insured opted as provided in the grid below.Wherever any pre-existing disease or any other adverse medical history is declared, We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age/ Sum Insured/Plan opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You.

Wherever required we may request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Full cost of all such tests will be borne by us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer, we will bear the cost for such tests.

Non-Portability:

Without Critical Illness(CI) Rider			
Plan Name	**Sum Insured (Lacs)**	**Age Group (years)**	**Medical Tests**
Protect & Advantage Plans	All SI	Up to 55	No Tests
		>55	Tele / Video Underwriting

With Critical Illness Rider		
CI Sum Insured (Lacs) For Protect & Advantage Plans	**Age (In completed years)**	**Medical Tests**
Up to ₹25 Lacs	18 - 45	No Tests
	46 - 55	SET 2: MER, ECG, Total Cholesterol, Hba1c, Sr Creatinine, CBC-ESR, Urine Routine, SGPT
	>55	SET 8: MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, Urine Routine, SGOT, SGPT, GGT, TMT, Uric acid
₹25 Lacs	18 - 45	Tele/Video Underwriting
	46 - 55	SET 3: MER, CBC-ESR, HbA1c,ECG, Lipid Profile, SGOT, SGPT, GGT,S. Creatinine, Uric acid, Urine Routine
	>55	SET 9: MER, Urine Routine, FBS, CBC - PS, S Creatinine, Lipid Profile, TMT,USG Abdomen & Pelvis, HbA1c, X-Ray Chest, SGOT, SGPT, GGT, HBsAg, Uric acid

Portability:

Without Critical Illness Rider			
Plan Name	**Sum Insured (Lacs)**	**Age Group (years)**	**Medical Tests**
Protect & Advantage Plans	All SI	Up to 55	Tele / Video Underwriting
		>55	Pre Policy Medical Checkups SET 17 (MER, CBC-ESR, FBS, LIPIDS PROFILE, SR. CREATININE, ECG, CEA)

With Critical Illness Rider		
CI Sum Insured (Lacs) For Protect & Advantage Plans	**Age (In completed years)**	**Medical Tests**
Up to ₹25 Lacs	18 - 45	No Tests
	1A 18-45	Tele/Video Underwriting
	46 - 55	SET 2: MER, ECG, Total Cholesterol, Hba1c, Sr Creatinine, CBC-ESR, Urine Routine, SGPT
	>55	SET 8: MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, Urine Routine, SGOT, SGPT, GGT, TMT, Uric acid
₹25 Lacs	18 - 45	Tele/Video Underwriting
	46 - 55	SET 3: MER, CBC-ESR, HbA1c, ECG, Lipid Profile, SGOT, SGPT, GGT,S. Creatinine, Uric acid, Urine Routine
	>55	SET 9: MER, Urine Routine, FBS, CBC - PS, S Creatinine, Lipid Profile, TMT, USG Abdomen & Pelvis, HbA1c, X-Ray Chest, SGOT, SGPT, GGT, HBsAg, Uric acid

Full explanation of Tests is provided here: MER - Medical Examination Report, FBS - Fasting Blood Sugar, RBS - Random Blood Sugar, ECG - Electrocardiogram, CBC-ESR - Complete Blood Count-Erythrocyte Sedimentation Rate, S Creatinine - Serum Creatinine, RUA - Routine Urine Analysis, HbA1c - Glycosylated Hemoglobin, SGOT - Serum Glutamate oxaloacetate transaminase, SGPT - Serum Glutamate Pyruvate Transaminase, GGT - Gamma Glutamyl Transferase, TMT - Tread Mill Test, HBsAg - Hepatitis B Surface Antigen, PSA - Prostate Specific Antigen, LFT - Liver Function Tests, CEA - Carcinoembryonic Antigen,

The list of medical tests covered above are indicative and we may in our sole discretion add, modify or amend this list on approval from the Head of Underwriting.

In addition, basis findings in the proposal form, or Tele/Video underwriting, underwriter may call for additional requirement or trigger Pre Policy Medical Check-ups/additional medical tests to have a complete overview of the risk proposed.

We may in our sole discretion add, modify or amend this grid on approval from the Head of Underwriting in general or for specific type of business or partners.

If a non-disclosure/misrepresentation of material facts is noted post inception either in welcome calling or at claims stage, it will be subjected to

underwriting evaluation and may result in termination of the policy.

xviii).Migration

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

For Detailed Guidelines on Migration, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020.

xix).Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

xx).Moratorium Period:

After completion of 60 continuous months of coverage (including portability and migration) under the policy no look back to be applied. This period of 60 months is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Sum Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

VII. What are the Waiting Period and Exclusions?

We shall not be liable to make any payment for any claim caused by, based on, arising out of or howsoever attributable to any of the following. All waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

i). Pre-existing Disease - Code - Excl. 01

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the applicable waiting period
   a. 24 months of continuous coverage from the date of commencement of coverage for Sum Insured ₹7.5 Lacs and above
   b. 36 months of continuous coverage from the date of commencement of coverage for Sum Insured up to ₹5 Lacs.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of Pre-existing disease waiting period for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

ii. Specified disease/procedure Waiting Period - Code- Excl. 02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI,then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures:
   i. Cataract,
   ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus or myomectomy for fibroids unless necessitated by malignancy,
   iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,
   iv. Varicose Veins and Varicose Ulcers,
   v. Stones in the urinary uro-genital and biliary systems including calculus diseases and complications thereof,
   vi. Benign Prostate Hypertrophy, all types of Hydrocele,
   vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region.
   viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
   ix. gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
   x. Any surgery of the genito-urinary system unless necessitated by malignancy.

   If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, the pre-existing waiting periods as mentioned in the Policy Schedule shall apply.

iii) 30-Days Waiting Period - Code- Excl. 03

i. Expenses related to the treatment of any illness within 30 days of continuous coverage from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

iv) Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 36 months of continuous coverage has elapsed for that particular Insured Person since the inception of the first policy with us. However, this exclusion / waiting period will not apply to ectopic pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.

v) Personal Waiting Period

A special waiting period not exceeding 36 months, may be applied to individual Insured persons for the list of acceptable Medical Ailments listed under the Underwriting Manual of the Product, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

vi) 90 day waiting period for Critical Illness Add On Cover (if opted)

Any critical illness contracted and/or the disease incepts or manifests during the first 90 days from the Inception Date of the policy will not be covered under the critical illness benefit wherever opted.

vii) Mental Illness Cover Waiting Period

Any treatment arising out of a condition caused by or associated to a Mental illness or a medical condition under below mentioned ICD Codes impacting mental health, shall not be covered until 24 months of continuous coverage has elapsed for the particular Insured Person since the inception of the first Policy with Us.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F10	Alcohol related disorders
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

viii) Bariatric Surgery Waiting Period

Bariatric Surgery shall not be covered until 36 months of continuous coverage has elapsed for the particular Insured Person since the inception of the first Policy with Us.

ix) Infertility Treatment Waiting Period

Any treatment taken for Infertility Treatment until 36 months of continuous coverage has elapsed for the particular Insured Person since the inception of the first Policy with Us.

x) Permanent Exclusions

We shall not be liable to make any payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless otherwise covered or specified under the Policy or any Cover opted under the Policy.

1. Investigation & Evaluation- Code- Excl 04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. **Rest Cure, rehabilitation and respite care- Code- Excl 05**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. **Obesity/ Weight Control: Code - Excl 06**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1. Surgery to be conducted is upon the advice of the Doctor
   2. The surgery/Procedure conducted should be supported by clinical protocols
   3. The member has to be 18 years of age or older and
   4. Body Mass Index (BMI);
      a. greater than or equal to 40 or
      b. greater than or equal to 35 in conjunction with any of the following severe comorbidities

      Following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

4. **Change-of-Gender treatments: Code - Excl 07**
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or Plastic Surgery: Code - Excl 08**
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. **Hazardous or Adventure sports: Code - Excl 09**
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep -sea diving.

7. **Breach of law: Code - Excl 10**
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers: Code - Excl 11**
   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code - Excl 13**

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

12. **Refractive Error: Code - Excl 15**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13. **Unproven Treatments: Code - Excl 16**
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. **Sterility and Infertility: Code - Excl 17**
    Expenses related to sterility and infertility. This includes:
    (i) Any type of contraception, sterilization
    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,ICSI
    (iii) Gestational Surrogacy
    (iv) Reversal of sterilization

15. **Maternity: Code - Excl 18**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expense towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16. Dental Treatment, orthodontic treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the Policy.

17. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

18. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

19. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

20. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.

21. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.

22. Treatment received outside India other than for coverage under Worldwid Emergency Hospitalization with Outpatient Cover under Freedom optional package if opted.

23. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

24. Any form of Non-Allopathic treatment (except AYUSH In-patient Treatment), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

25. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack or in any other sequence to the loss.

26. All expenses caused by or arising from 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), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

27. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment.

    For complete list of Non-medical expenses, Please refer to the Annexure III List - I "Items for which Coverage is not available in the Policy" of the Policy Term and Conditions.

28. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Policy Schedule.

29. Existing diseases disclosed by the Insured Person ((limited to the extent of the ICD codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

VIII. How can I buy the Policy?

Step 1: The product brochure, policy benefits, exclusions and premium details must be thoroughly understood and discussed with Our advisor/ Company representative, before buying the policy.

Step 2: Once the benefits of the policy are understood, the Proposal Form must be filled, wherein details of the prospective Insured Persons including medical information must be provided as accurately as possible.

Step 3: The proposal form with the required documents have to be submitted along with the premium.

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured and Age band, we would arrange the medical check-ups at Our network of diagnostic centres.

Step 5: Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

We shall process the proposals with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to You within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by Us.

Where a proposal deposit is refundable to a prospect under any circumstances, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

IX. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable

and necessary. The cost of such examination will be borne by Us.

- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy

b) Claim Process

In case of an Illness or an injury please notify Us either at the call centre or in writing:

The following details are to be provided to Us at the time of intimation of Claim:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by Us

For a Cashless Claim -

In case of planned hospitalization - at least 3 days prior to the planned date of admission.

In case of Emergency Hospitalization - within 48 hours of such admission.

Cashless facility is available only at Our Network Hospital. The latest/updated list of network of hospitals will be available on our website. You can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by Us).

For a Reimbursement Claim -

The following claim documents should reach us not later than 15 days from the date of discharge from Hospital –

- Claim Form Duly Signed
- Copy of Photo ID of Patient
- Hospital Discharge summary
- Operation Theatre Notes
- Hospital Main Bill
- Hospital Break up bill
- Investigation reports
- Original investigation reports, X Ray, MRI, CT films, HPE, ECG
- Doctors Reference Slips for Investigaions
- Pharmacy Bills
- MLC/ FIR report, Post Mortem Report if applicable and conducted
- KYC documents (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment
- Payment receipt.

We may call for any additional documents as required based on the circumstances of the claim.

There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You may be required to pay for the treatment and submit the Claim for reimbursement to Us which will be considered subject to the Policy Terms & Conditions.

In case You delay submission of claim documents, then in addition to the documents mentioned above, You are also required to provide Us the reason for such delay in writing. We will accept such requests for delay up to an additional period of 30 days from the stipulated time for such submission. We will condone delay on merit for delayed Claims where the delay has been proved to be for reasons beyond Your/Insured Persons control.

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on our website as also provided to you along with the Policy documents. The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policy holder / Insured Person is required to check the applicable list of Network Hospital on Our's website. Wherever a TPA is used, the TPA will only work to facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

X. What are the Plan wise Benefit Details?

The Plan wise benefit details are as mentioned below:

<table>
<tr><th>Title</th><th colspan="3">Description
Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief</th></tr>
<tr><th>Your Coverage Details:</th><th>Identify your Plan</th><th>Protect</th><th>Advantage</th></tr>
<tr><td rowspan="11">Basic Cover

This section lists the Basic benefits available on your plan</td><td>Identify your Opted Sum Insured (in ₹)</td><td colspan="2">₹3 Lacs, ₹4 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs, ₹100 Lacs</td><td>₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs, ₹100 Lacs</td></tr>
<tr><td>In-patient Hospitalization (When you are hospitalised)</td><td colspan="2">Room Rent: Covered up to Single Private A/C Room
For ICU - Covered up to Sum Insured
This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments:
For Sum Insured < ₹5 Lacs: Up to 50% of Sum Insured
For Sum Insured >= ₹5 Lacs: Up to Sum Insured
b. HIV/AIDS & STD: Up to Sum Insured
c. Mental Illness: Up to Sum Insured
For below mentioned ICD Codes: Waiting Period of 24 months shall apply.
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F10</td><td>Alcohol related disorders</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table></td></tr>
<tr><td>Pre - hospitalization</td><td colspan="2">Medical Expenses Covered up to 60 days before date of hospitalization; Covered upto the Sum Insured</td></tr>
<tr><td>Post - hospitalization</td><td colspan="2">Medical Expenses Covered up to 180 days before date of hospitalization; Covered upto the Sum Insured</td></tr>
<tr><td>Day Care Treatment</td><td colspan="2">Covered up to the Sum Insured</td></tr>
<tr><td>Domiciliary Hospitalization (Treatment at Home)</td><td colspan="2">Covered up to 10% of the Sum Insured
Pre and Post Hospitalization Expenses: 30 days each</td></tr>
<tr><td>Road Ambulance (Reimbursement of Ambulance Expenses)</td><td colspan="2">Covered up to the Sum Insured</td></tr>
<tr><td>Donor Expenses (Hospitalization Expenses of the donor providing the organ)</td><td colspan="2">Covered up to the Sum Insured</td></tr>
</table>

	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, in addition to the Sum Insured Applicable for below covers only 1. II.1 - In-patient Hospitalization (Except for Bariatric Surgery) 2. II.2 - Pre - hospitalization 3. II.3 - Post - hospitalization 4. II.4 - Day Care Treatment 5. II.6 - Road Ambulance 6. II.7 - Donor Expenses 7. II.9 - AYUSH Treatment 8. V.1 - Non-Medical Items Restoration shall not get triggered for the 1st claim The maximum liability under a single claim shall not be more than Base Sum Insured + Cumulative Bonus + Restored Sum Insured	
	AYUSH Treatment (In-patient Hospitalization)	Covered up to the Sum Insured	
	Air Ambulance cover	Covered up to sum insured subject to maximum of ₹10 Lacs in addition to the Sum Insured for expenses incurred on Air Ambulance	
	Bariatric Surgery cover	Covered up to the Sum Insured opted subject to maximum of ₹5 Lacs Waiting Period of 36 months shall apply for Bariatric Surgery	
	Outpatient Expenses	Not Available	Option to choose from - ₹20,000, ₹30,000, ₹50,000 Per policy Year Can be used to pay for Consultations and Diagnostics including Dental and Vision: Up to 100% of the Sum Insured opted for Outpatient benefit. Up to 20% of the Outpatient Limit can be used for Pharmacy (Drugs and Medicines prescribed by Medical Practitioners). This benefit is available only on cashless basis from the Network providers of ManipalCigna Health Insurance Company Limited. Any unutilized amount under this benefit shall not be carried forward to subsequent Policy Year.
	Daily Cash for Shared Accommodation	Daily Cash benefit for occupying shared accommodation while hospitalized, shall be covered as below:- a. For Sum Insured up to ₹10Lacs: ₹800 per day up to maximum of ₹5,600 b. For Sum Insured above ₹10Lacs: ₹1,000 per day up to maximum of ₹7,000 for each continuous and completed 24 Hours of Hospitalization during the Policy Year This benefit gets triggered post 48 hours of In-patient hospitalization and shall be payable from 1st day onwards.	
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Health Check-Up	Available each policy year (including the first year), to all Adult insured persons who have completed 18 years of Age • For Sum Insured up to ₹5 lacs: Package 1 subject to a maximum of up to ₹1000 per adult member • For Sum Insured above ₹5 lacs and up to ₹10 lacs: Package 2 subject to a maximum of up to ₹2500 per adult member • For Sum Insured above ₹10 lacs: Package 3 subject to maximum of up to ₹5000 per adult member Annually from 1st year onwards The packages shall be offered on cashless basis only. However, the eligible insured may avail any health check from the MCHI Network of Health Check Up Center up to the limit specified	
	Domestic Second Opinion	Available for 36 listed Critical Illnesses	
	Tele-Consultation	Unlimited Tele-consultation during the Policy Year	
	Cumulative Bonus	A guaranteed bonus of 25% of Sum Insured for every completed Policy Year, subject to a maximum accumulation up to 200% of the Sum Insured.	
	Switch Off Benefit	The Policy can be Switched Off, after one year, any time during the Policy Year except for Personal Accident Cover and Worldwide Emergency Hospitalization with Outpatient Cover, under Freedom optional package and Critical Illness Add-On cover, if opted, in case you/ Insured Person travel out of India, for a period maximum up to 30 days. This benefit shall not be available for the last 90 days of the Policy Year. Premium discount shall be calculated on pro-rated basis if Policy is switched off due to Insured Person (in individual policy) or all Insured Persons (under floater policy) travelling out of India and this discount shall be adjusted in the renewal premium falling due immediately after the expiring Policy Period. The Policy will reactivate the cover Switch-On on the requested date of Switch On as intimated to Us by You/ Insured Person. The option to Switch Off the cover shall be available only once in a policy year and up to a maximum of 30 days at a stretch. This shall not deactivate the following cover, if opted: 1. Worldwide Emergency Hospitalization with Outpatient Cover under Freedom optional package 2. Personal Accident Cover 3. Critical Illness Add-on	
	Wellness Program	Rewards can be earned by completing activities specified under Our Healthy Life Management Program up to maximum of 20% of expiring base Premium (excluding Premium for optional covers, Rider and taxes). These earned Reward Points can be used against payable Renewal premium (excluding Premium for optional covers, Rider and taxes) as discount from 1st Renewal of the Policy. Carry forward of earned Reward Points shall not be allowed.	
	Discount from Network Provider	Discount on Pharmacy, Diagnostics and Health Supplements offered by the Network Providers of ManipalCigna Health Insurance Company Limited	
	Premium Waiver Benefit	Waives off one year Policy Premium (including premium for optional covers, rider and taxes) upon occurrence of any of the listed contingencies (Accidental death/ listed Critical Illnesses) to the Policyholder who is also an Insured Person in the Policy	

<table>
<tr>
<td rowspan="2">Optional Packages
This section lists the available optional packages under your plan and the limits under each of these options.
The limits specified under these optional packages shall override the applicable limits mentioned as part of base cover for the respective coverages.</td>
<td>Enhance Plus</td>
<td>
1. Maternity & New Born Hospitalization Expenses
a. Maternity Cover (up to maximum 2 deliveries or terminations) -
Covered up to 10% of Sum Insured Opted subject to a maximum of 1 Lac in addition to the Sum Insured opted
b. New Born Baby -
Coverage for the In-patient hospitalization expenses of a new born up to the limit provided under Maternity Expenses
c. First Year Vaccination
Covered as per national immunization program, up to the limit provided under Maternity Expenses

2. Room Accommodation upgrade
The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to “Any Room Category” in a Hospital.

3. Health Maintenance Benefit
Up to ₹3000 per Policy Year.
Reimbursement of the Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on an Out Patient basis for:
i. Consultation with Medical Practitioner, Diagnostic tests, preventive tests, drugs, prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), prescribed by the specialist Medical Practitioner.
ii. Towards Dental Treatments and AYUSH forms of Medicines wherever prescribed by a Medical Practitioner.
</td>
<td rowspan="2">Not Available</td>
</tr>
<tr>
<td>Assure (Applicable for Sum Insured ₹3 Lacs, ₹4 Lacs and ₹5 Lacs)</td>
<td>
i. Room Accommodation Limit
Room Rent - Up to 1% of Sum Insured per day.
ICU - Up to 2% of Sum Insured per day.

ii. Disease Specific Sub-limits
<table>
<tr><td>Sum Insured</td><td>₹3 and ₹4 Lacs</td><td>₹5 Lacs</td></tr>
<tr><td>Treatment for each Ailment/ Procedure mentioned below:
1. Surgery for treatment of all types of Hernia
2. Hysterectomy
3. Surgeries for benign Prostate Hyper trophy
4. Surgical treatment of stones of renal system</td><td>₹50,000</td><td>₹65,000</td></tr>
<tr><td>Treatment of Cataract (Per Eye)</td><td>₹20,000</td><td>₹30,000</td></tr>
<tr><td>Treatment of Total Knee replacement (Per knee)</td><td>₹80,000</td><td>₹1,00,000</td></tr>
<tr><td>Treatment for breakage of bones</td><td>₹2,00,000</td><td>₹2,50,000</td></tr>
</table>
iii. Modern and Advanced Treatments
Covered Up to 10% of Sum Insured
</td>
</tr>
</table>

	Enhance	Not Available	1. Maternity & New Born Hospitalization Expenses a. Maternity Cover (up to maximum 2 deliveries or terminations) - Covered up to 10% of Sum Insured Opted subject to a maximum of ₹1 Lac in addition to the Sum Insured opted b. New Born Baby - Coverage for the In-patient hospitalization expenses of a new born up to the limit provided under Maternity Expenses c. First Year Vaccination Covered as per national immunization program, up to the limit provided under Maternity Expenses
			2. Room Accommodation upgrade The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to "Any Room Category" in a Hospital.
	Freedom (Applicable to Indian Residents only)	1. Room Accommodation upgrade The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to "Any Room Category" in a Hospital.	
		2. Worldwide Emergency Hospitalization with Outpatient Cover Covered up to Sum Insured opted for Emergency In-patient Hospitalization or Emergency Outpatient outside India. Any claim payable under this benefit is over and above the Sum Insured.	
Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Non-Medical Items	Non-Medical items covered up to Sum Insured opted in case of In-patient Hospitalization and/or Day Care Treatment	
	Deductible	Deductible of ₹10,000 or ₹25,000 can be opted at the inception or during any Renewal of the Policy. For Deductible of ₹10,000, the cover can be removed at the time of Policy Renewal. For Deductible of ₹25,000, the Insured Person can remove the Deductible of ₹25,000 only at the time of renewal falling immediately due after 4 continuous Policy Years or any subsequent renewals thereon, from the year of opting ₹25,000 DeductibleThis benefit will not be available if 'Assure' optional package is opted.	Not Available
	Infertility Treatment	Infertility Cover (Available if IV.A 'Enhance Plus' or IV.C 'Enhance' optional package is opted and for ₹7.5 Lacs and above Sum Insured options) Covered for Infertility Expenses up to ₹2.5 Lacs in addition to Maternity Sum Insured under Maternity Cover. Waiting period of 36 months shall apply for this cover. Maximum upto 2 successful procedures shall be covered during the lifetime of the eligible Insured person and the coverage shall terminate thereafter The cover shall automatically cease upon the eligible Insured Person attaining 60 years of age.	
	Personal Accident Cover	Lump sum benefit equal to two times of Sum Insured subject to a maximum of ₹50 Lacs in case of Accidental Death or Permanent Total Disablement of Insured Member due to accident.	
	Cumulative Bonus booster	A guaranteed bonus of 50% increase in Sum Insured per Policy Year irrespective of claims, subject to a maximum accumulation up to 200% of the Sum Insured. This benefit is applicable for Sum Insured opted for ₹5 lacs and above. Opting for this Benefit will replace the Cumulative Bonus in the Base Cover.	
Add on cover (Rider) This section lists the Add on cover available under your plan	ManipalCigna Critical Illness Add On Cover	Lump sum payment of an additional 100% of Sum Insured Opted.	
ManipalCigna Prime Plus			
Room Rent Modification		The Insured Person shall be eligible to modify the room type category eligibility under the Policy as follows: Option 1: Any room; ICU Up to Sum Insured Option 2: Twin Sharing AC room; ICU Up to Sum Insured	
Surplus Benefit (Applicable for Sum Insured ₹5 Lacs and above)		Additional 100% of Sum Insured, available from day 1 for 1st claim only, in each policy year.	

Supreme Bonus (Applicable for Sum Insured ₹5 Lacs and above up to ₹50 Lacs)	Guaranteed Cumulative Bonus of 100% of Base Sum Insured each policy year; subject to a maximum of 800% of the Base Sum Insured.	
Premium Management Cover	Once opted below benefits shall not be available in Base product 1. Air Ambulance Cover 2. Bariatric Surgery Cover 3. Daily Cash for Shared Accommodation 4. Health Check Up 5. Domestic Second Opinion 6. Tele Consultation 7. Premium Waiver Benefit	
Women Care	Coverage for Mammography, Cervical Cancer screening and PCOS/PCOD diagnostic tests on cashless basis from MCHI network for women aged 18 years and above. The limit for the same is ₹10,000 per female insured.	Not Available
Deductible	Option to opt from ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 and ₹5,00,000 on aggregate basis.	Not Available

Disclaimer:

This is only a summary of the product features. The actual benefits available shall be described in the policy, and will be subject to the policy terms, conditions and exclusions.

For more details on risk factors, terms and conditions read the sales brochure and speak to Your advisor before concluding a sale.

Prohibition of Rebates (under section 41 of Insurance Act, 1938)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation

Annexures:

Benefit Illustration

Rate Charts