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MANIPALCIGNA PROHEALTH PRIME

(PROSPECTUS)
Active Plan

I. What are the Key Highlights of the Policy?

Basic Covers

1. In-patient Hospitalization
2. Pre-hospitalization
3. Post-hospitalization
4. Day Care Treatment
5. Domiciliary Hospitalization
6. Road Ambulance
7. Donor Expenses
8. Restoration
9. AYUSH Treatment
10. Convalescence Benefit
11. Daily Cash for Shared Accommodation
12. Home Treatment

Value Added Covers

1. Domestic Second Opinion
2. Tele Consultation
3. Cumulative Bonus
4. Wellness Program
5. Discount from Network Providers
6. Premium Waiver Benefit

Optional Covers

1. Non-Medical Items
2. Waiver of Mandatory Co-payment
3. Worldwide Emergency Hospitalization Cover
4. Health Check Up
5. Waiver of Disease Specific Sublimit
6. Cumulative Bonus
7. Modification of Pre & Post Hospitalization Days

Add-on Covers

1. ManipalCigna Prime Plus

II. What are the Basic covers?

1. In-patient Hospitalization

We will indemnify Medical Expenses of an Insured Person up to the Sum Insured in the event of Medically Necessary Hospitalization arising from a Disease/ Illness or Injury provided such Medically Necessary Hospitalization is 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 operation theatre charges, fees of medical Practitioner/ Surgeon, anaesthetist, qualified nurses, specialists, cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner and that are used intra operatively during a surgical procedure.

Under the Active Plan coverage for room rent is available upto 1% of Sum Insured per day for ₹3 Lacs of Sum Insured. The ICU expenses are covered up to Sum Insured.

For Sum Insured of ₹5 Lacs and above, coverage for room rent is available up to a Single Private AC Room. The ICU expenses are covered up to Sum Insured.

Proportionate Deduction Clause

If you choose a hospital room that is higher than your eligible room category, you will need to pay a proportionate share of the associated medical expenses. This will be calculated based on the difference between your eligible room rent and the actual room rent charged by the hospital.

The proportionate deduction will apply to accommodation charges and associated medical expenses

Associated Medical Expenses shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.

Understanding proportionate deduction with a simple example

Mr. Raj was hospitalized for **4 days** in a **Deluxe Room** at XYZ Hospital. However, as per his policy, he was eligible for the most economical **Single Private AC Room**.
Since he chose a higher room category than what his policy allowed, proportionate deduction will apply. This means the claim amount will be calculated based on the ratio between his eligible room rent and the actual room rent charged by the hospital.

Item	Details
Actual Room Rent Expense (Deluxe Room) [A]	₹ 10,000 per day * 4 days= ₹ 40,000
Eligible Room Rent expense (Single Private AC room) [B]	₹ 6,000 per day * 4 days = ₹ 24,000
Proportionate Ratio [B/A]	Eligible Room Rent ÷ Actual Room Rent = 6,000 ÷ 10,000 = **0.6**
Actual Associated Medical Expenses (AME) (includes Nursing charges, OT charges, consultation fees etc.) **[C]**	₹ 42,000
Eligible AME after Proportionate deduction [D]	₹ 25,200 (C*0.6)
Pharmacy & consumables, diagnostic tests, implants, medical devices ***(not subject to proportionate deduction)*** **[E]**	₹ 10,000
Total Bill Amount at actuals (F = A + C + E)	₹ 92,000
Amount Paid by Insurer after Proportionate deduction (G = B + D + E)	₹ 59,200
Amount Payable by Policyholder/Insured Person (F – G)	₹ 32,800

Sub-limits for Listed Treatment/Procedure

We will indemnify the Medical Expenses incurred by an Insured Person in respect of the ailments/procedures specified in the table below, up to the limit applicable to each ailment/procedure as per the opted Base Sum Insured. The specified limit shall be the maximum amount payable per Policy Year

Base Sum Insured (in ₹)	₹3 Lacs	₹5 Lacs	₹7.5 and ₹10 Lacs	>₹10 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	₹80,000	NA
Treatment of Cataract (Per Eye)	₹20,000	₹30,000	₹30,000	NA
Treatment of Total Knee replacement (Per knee)	₹80,000	₹1,00,000	₹1,20,000	NA
Treatment for breakage of bones	₹2,00,000	₹2,50,000	₹3,00,000	NA

Wherever the above mentioned Sub-limits are applied, the Mandatory Co-payment shall not be applicable however co-payment for the treatment taken at higher zone as mentioned under section V.vii will continue to apply.

Coverage for Advanced/Modern Treatment procedures

The following procedures will be covered (wherever medically indicated) either as inpatient or as part of Day
Care Treatment in a up to 50% the Sum Insured, 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. Bronchical Thermoplasty
j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Coverage for HIV/AIDS

Indemnification of Medical Expenses upto the Sum Insured incurred for the Medically Necessary Treatment of the Insured Person for In-patient Hospitalization arising from 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), will be covered up to the Sum Insured as specified in the Policy Schedule during the Policy Year. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time. The necessity of the Hospitalization is to be certified by an authorized Medical Practitioner.

Coverage for Mental Illness

Indemnification of Medical Expenses upto the Sum Insured incurred for the Medically Necessary treatment of the Insured Person for in-patient Hospitalization arising from or associated with a Mental illness or a medical condition impacting mental health will be covered up to 50% of the Sum Insured as specified in the Policy Schedule during the Policy Year. This coverage is provided in accordance with The Mental Health Care Act, 2017 as amended from time to time. 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 Pre-Hospitalization Medical Expenses of an Insured Person incurred due to a Disease/ Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalization up to limits specified under the plan opted, provided that a Claim has been admitted under Section II.1 In-patient Hospitalization or Section II.4 Day Care Treatment and expenses are related to the same illness/condition.

3. **Post - hospitalization**

We will reimburse Medical Expenses of an Insured Person incurred due to a Disease/ Illness or Injury that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital up to limits specified under the plan opted, provided that a Claim has been admitted under II.1 In-patient Hospitalization or Section II.4 Day Care Treatment and expenses are related to the same illness/condition.

4. **Day Care Treatment**

We will reimburse Post-Hospitalization Medical Expenses up to Sum Insured, of an Insured Person in case of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of 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, up to the Sum Insured as specified in the Policy Schedule, provided that:

a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.
c. We will not cover any Out-Patient Treatment (OPD) Treatment and Diagnostic Services under this benefit.
d. Coverage under this benefit shall also include pre-post hospitalization expenses as per the limits applicable and specified in Policy Schedule.

5. Domiciliary Hospitalization

We will cover Medical Expenses of an Insured Person up to the limits specified in the Policy Schedule, 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 the attending Medical Practitioner. We will also cover the Claims for Pre-hospitalization and Post-hospitalization Medical Expenses 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:

- Asthma, bronchitis, tonsillitis and upper & lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
- Arthritis, gout and rheumatism, including the rheumatism of bones, joints and also rheumatic heart disease,
- Chronic nephritis and nephritic syndrome,
- All types of Diarrhoea and dysenteries, including gastroenteritis,
- Diabetes mellitus and Diabetes insipidus,
- Epilepsy / Seizure disorder,
- Hypertension,
- Pyrexia of unknown origin.

6. Road Ambulance

We will reimburse the reasonable and customary expenses incurred up to the Sum Insured that are incurred towards road transportation of an Insured Person by a registered Healthcare or Ambulance Service Provider to a nearest Hospital for treatment of an Illness or Injury covered under the Policy In case of an emergency, necessitating the Insured Person's admission to a Hospital. The necessity of use of an Ambulance must be certified by the attending Medical Practitioner.

Reasonable and Customary expenses shall include:

a. To transport you from the incident site to the nearest hospital and/or
b. To transport you from one hospital to another nearest hospital if the current hospital doesn't have the required medical treatment facility you need and/or
c. To transport you from a hospital to a nearby diagnostic center and back, for diagnostic tests advised by your doctor, that aren't available at your current hospital

7. **Donor Expenses**

We will indemnify In-patient Hospitalization Medical Expenses towards the donor for harvesting the organ, up to the Sum Insured, 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 as per Medical Advice and a claim has been admitted under In-patient Hospitalization.

However, Pre and/or 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**

Under restoration benefit, we will provide 100% restoration of the opted Base Sum Insured unlimited times in a Policy Year

Specific Conditions applicable to Restoration

a. The Base Sum Insured and earned Cumulative Bonus (if any) should be insufficient as a result of previous claims in that Policy Year.
b. The Restored amount shall not be available for claims towards an Illness/Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person.
c. The Restored amount will will not apply to the first admissible claim in the Policy Year. The Restored amount can only be used for future claims that may arise during the remainder of the Policy Year.
d. The restored amount can only be used to pay claims admissible under the below benefits:
   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'
   IV.1 'Non-Medical Items'.
e. The Restored amount will not be considered while calculating the Cumulative Bonus.
f. The Restored amount will be available unlimited times, during a Policy Year to each insured in case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
g. Any Restored amount which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year.
h. For any single claim during a Policy Year the maximum claim amount payable shall be sum of:
   i. The Base Sum Insured
   ii. Cumulative Bonus (if opted or earned)
   iii. Restored amount

9. **AYUSH Treatment**

We will indemnify the Medical Expenses incurred during the Policy Year, up to the Sum Insured, in case of Medically Necessary Treatment taken during In-patient Hospitalization/Day Care Treatment 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/AYUSH Day Care Centre.

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. Convalescence Benefit

We will pay a lump sum amount as per the Sum Insured opted, if the Insured Person has been Hospitalized for at least 10 consecutive days for Anyone illness or Accident, provided that, the Hospitalization is only for In-patient care for the Insured Person. The benefits payable under this cover are for each Hospitalization exceeding the number of days as specified and the limits payable under this cover are over and above the Sum Insured.

11. 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, We have accepted claim under In-patient Hospitalization during the Policy Year and the Insured Person has occupied a shared room accommodation during such Hospitalization.

The Insured Person needs to be admitted in a Hospital for a minimum period of 48 hours continuously in order to be eligible for a claim under this benefit.

This benefit is available for Base Sum Insured of ₹5 lacs and above.

We will not pay any amount if the Insured Person stays in an Intensive Care Unit or High Dependency Units/ wards.

12. Home Treatment

Coverage for eligible treatments, even when care comes home.

What we cover

If you need treatment at home for the conditions listed below, we'll cover the medical expenses, provided the treatment is recommended in writing by your treating Medical Practitioner and approved by us in advance.

Key Service Terms

1. The treatment at home must be for a condition that would otherwise require hospitalization.
2. Your treating Medical Practitioner must continuously monitor your health throughout the treatment period.
3. A continuous and active line of treatment must be followed during the entire home treatment period.
4. The duration of medically necessary treatment must be certified in writing by your treating medical practitioner.
5. A day-wise treatment record must be maintained and signed by the treating Medical Practitioner.
6. Home Treatment will be covered for up to 60 days per policy year at the policy level. This may be extended only with our explicit prior approval.
7. Under this benefit, we only cover cost related to the medical treatment. Any other ancillary expenses such as expenses related to modification in residence, rental/purchase for medical equipment etc. shall not be covered.
8. Claims under this benefit will be payable only for the duration that is medically necessary.
9. Kindly note that you must pre-inform us before starting the treatment. The request will be valid only after we approve it. If the treatment is taken without our prior approval, the claim will not be payable. Also, home treatment may not be accessible in every location. This benefit will therefore be available subject to service availability in your area.

Treatments covered under Home Treatment

This benefit is available only for the treatments specifically listed below. Any treatment not listed here will not be covered.

1. **Infectious Diseases**
   Treatment for infectious diseases

2. **Injectable Chemotherapy at Home**
   Injectable chemotherapy at home will be covered only under strict protocols.

3. **Dialysis**
   Peritoneal dialysis and home haemodialysis are covered.

4. **Post-operative Care and Wound Management**
   We'll cover post-operative care of the operated site and wound management for a severe wound at the operated site. This does not include laparoscopic surgery.

5. **Brain and Spinal Injury Care After Discharge**
   We'll cover an active line of treatment for brain injury and spinal injury cases after discharge from the hospital.

6. **Palliative Care**
   Palliative care may be covered for the following conditions:

   a. **End-stage oncology conditions**

      ii. Advanced or metastatic cancers, such as Stage IV or refractory cancers, where the treating oncologist has confirmed that the treatment is not intended to cure the condition.

      iii. ECOG (Eastern Cooperative Oncology Group) performance status 3–4.

   b. **End-stage organ failure**

      i. End-stage renal disease - CKD Stage 5, where dialysis is not being pursued or has been discontinued.

      iv. End-stage liver failure or cirrhosis with refractory complications.

      v. Advanced heart failure - NYHA Class III or IV.

      vi. End-stage COPD or respiratory failure requiring long-term oxygen support with no curative option.

   c. **Progressive infections or systemic conditions**

      i. Refractory septic shock or multi-organ failure where further escalation of care is considered futile.

      ii. End-stage HIV/AIDS with failing ART and recurrent opportunistic infection.

What is included under Home Treatment

1. Doctor-prescribed treatment with written medical advice and supervision.
2. Medicines, drugs, and IV therapies related to the covered condition.
3. Medical consumables such as syringes, dressings, and IV sets.
4. Diagnostic tests required to monitor the home treatment.

What's not covered under Home Treatment

1. Non-medical expenses mentioned in List I of Annexure 2
2. Non-medical care, such as caretakers or attendants.
3. Rental or purchase of equipment such as hospital beds or oxygen concentrators.
4. Any kind of AYUSH Treatment under this benefit.
5. Oral Chemotherapy
6. Any ancillary expenses - such as home modifications, rental or purchase of medical equipment, or similar ancillary costs.

III. What are the Value Added Covers?

1. **Domestic Second Opinion:**
   The Insured Person may choose to secure a second opinion from Our Network of Medical Practitioners in India, if he/she 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.

   Conditions applicable for this benefit.

   a. We have received a request from the Insured Person 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.

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

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
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

2. Tele Consultation

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

3. Cumulative Bonus

On completion of each Policy Year with Us, Insured Persons shall be granted Cumulative Bonus irrespective of any claims made during the expiring Policy Year

Special Conditions for Cumulative Bonus

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period.

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

c) Bonus shall be provided irrespective of claims made in the expiring policy year

d) Any accumulated Cumulative bonus shall be carried forward to subsequent policy years.

e) Claims made during a policy year under Cumulative bonus shall reduce the balance bonus amount available for the remainder of such Policy Year.

f) Cumulative Bonus can be accumulated upto a maximum of 100% of your Base Sum Insured under the current Policy.

g) Reduction in Base Sum Insured: If the Base Sum Insured is reduced at Renewal, the applicable Cumulative Bonus will also be reduced in the same proportion .

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

i) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, 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 among all the Insured Persons.

j) 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 opted Base Sum Insured in to two or more Family Floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

k) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section F.I.6

4. Wellness Program

If the Insured Person has been suffering from one or more of the following conditions such as Asthma, Diabetes, Hypertension, Dyslipidaemia, Obesity and the same has been declared/identified at the time of buying the policy or subsequently in any policy year, the Insured Person can be a part of Wellness Program based on the covered conditions as per the applicability of the opted plan and earn rewards based on adherence to program metrics.

The details of the Wellness Programs are as below:

Plan Type	Active Plan
Wellness Program	Condition Management Program
Conducted By	ManipalCigna along with its Network Partners
Program Components	- Health Risk Assessment - Baseline assessment (Medical test) - Coaching by experts - Improvement assessment (Medical test)
Medical Tests	
Diabetes	HbA1c + Lipid profile + Serum creatinine + Microalbuminuria + MER + Ophthalmologist Consultation + ECG
Hypertension	Lipid profile + Serum creatinine + Microalbuminuria + Uric acid + MER + ECG
Obesity	Lipid profile + Serum creatinine + Thyroid Profile + HbA1c + MER
Dyslipidaemia	Lipid profile + Serum creatinine + HbA1c + MER
Asthma	MER + Spirometry
More than 1 disease	Combination of tests pertaining to each condition (No repetition of tests)
Program Metric	- Health Risk Assessment completion - Medical tests undertaken at the beginning of the program in the policy year - Coaching completion - Improvements achieved at the end of the program in the policy year
Reward Accrual - 1 year Policy Tenure (Refer Annexure A for illustration, provided as part of the benefit)	Maximum reward points which could be accrued is upto 15% of the existing base premium (**excluding Premium for optional cover(s), Rider(s) and taxes as applicable)** applicable for the respective insured

In order to be eligible for the rewards, the Insured Person shall adhere to all the components of the programs as specified under program metric, as per the applicability of opted plan.

At the end of the policy year, 'Health Scores' shall be calculated based on the final test values and improvement in health parameters (wherever applicable). Thereafter, 'Weighted Health Score' shall be calculated provided there was no hospitalization during the Policy Period for the covered conditions and/or its complications.

Reward Accrual Methodology under Active Plan:

Disease-wise Health Score for Active Plan:

Final Test Values and Improvement will be considered for health score allocation.

Diabetes:

Diabetes (HbA1c Final Test Value)	< or = 6.5 %	Final value	< or = 6.5		
		Health Score	100		
	>6.5 %	Final Value Reduced by (improvement by)	0.50%	0.51% to 1%	>1 %
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in HbA1C values only.
2. No rewards will be allocated for increase in HbA1c value or reduction <0.5% (for HbA1c >6.5).
3. Eligible for rewards provided there is no hospitalization for diabetes or its complications.

Hypertension:

Hypertension (SBP/DBP Final Test Value)	**SBP < or = 140 mm Hg and DBP < or= 90 mm Hg (AND)**	Final value	SBP < or = 140 and DBP < or= 90		
		Health Score	100		
	SBP > 140 mm Hg and /or DBP > 90 mm Hg (AND / OR)	Final Value Reduced by (improvement by)	5 mm Hg	6 to 10 mm Hg	>10 mm Hg
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in BP values only.
2. Increase in any one marker (SBP/DBP) will disqualify the rewards.
3. No rewards will be allocated for improvement in BP values <5 mm Hg (for SBP >140 mm Hg and/ or DBP > 90 mm Hg).
4. Eligible for rewards provided there is no hospitalization for hypertension or its complications.

Obesity:

Obesity (BMI)	**Final BMI upto 29**	**Final value**	**BMI upto 29**		
		Health Score	100		
	Final BMI above 29	Final Value Reduced by (improvement by)	1	>1 to 2	>2
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in BMI values only
2. No rewards will be allocated for increase in BMI value and reduction in BMI <1 (for Final BMI above 29)
3. Eligible for rewards provided there is no hospitalization for obesity or its complications

Dyslipidaemia:

Dyslipidaemia Total Cholesterol (TC) and Triglycerides (TG)	**TC upto 200 and TG upto 150**	Final value	TC upto 200 and TG upto 150		
		Health Score	100		
	TC > 200 and/or TG > 150	Final Value Reduced by (improvement by)	20	21 to 40	>40
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in both TC and TG value only.
2. Increase in any one marker (TC / TG) will disqualify the rewards.
3. No rewards will be allocated for increase in TC and TG and reduction in TC and /or TG values < 20 mg/dl (for TC > 200 and/or TG > 150).
4. Eligible for rewards provided there is no hospitalization for Dyslipidaemia or its complications.

Asthma:

Asthma	**Treatment type**	Final Value	On oral medications except steroids/ immunodilators	On Inhalers	Not on treatment
		Health Score	50	75	100

Reward Principle:

1. Reward points will be allocated for improvement or status quo in type of treatment only.
2. No rewards will be allocated for change in line of treatment to a higher category.
3. Hierarchy for type of treatment: Category 1: Not on treatment; Category 2: On Inhalers; Category 3: On oral medications; Category 4: On steroids/ immunomodilators.
4. Eligible for rewards provided there is no hospitalization for asthma or its complications.

Health Score and Reward Allocation:

a. Health Score will be allocated against the final value of each ailment.

b. In case of more than one ailment, a weighted average of all health scores will be calculated. The weights will be assigned for ailments in decreasing order as follows: Diabetes, Hypertension, Obesity, Dyslipidaemia, Asthma.

Reward Allocation Grid:

Weighted Health Score	<25	>25 to 50	>50 to 75	>75
Rewards - % of premium paid (Excluding Optional Covers/Rider and taxes as applicable) in the existing Policy	0%	5%	10%	15%

Conditions under this benefit:

i. The reward points earned will be at eligible member level.

ii. Maximum reward points that can be earned in a single Policy Year will be limited to 15% of premium paid (excluding Optional covers, Riders and taxes as applicable**)** in the existing Policy. In case of 2 or 3 year policies, maximum reward points that can be earned shall not exceed 15% of the total premium paid (excluding Optional covers, Riders and taxes as applicable) for 2 years or 3 years as applicable.

iii. 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 as applicable) from 1st Renewal of the Policy.

iv. 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.

v. 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 illustration of Reward Points.

Annexure – A – Illustration of Reward Points

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 (Excluding Optional Cover, Rider and taxes as applicable)	Weighted Health Score	Rewards %	Points Earned
Year 1	10000	40	5%	500
Total	10000			500

The notifications related to wellness programs 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.

5. Discount from Network Providers

The Insured Person can avail discount on Diagnostic, Pharmacy and Health Supplements offered through Our Network Providers. You may avail the requisite discount by calling our call centre or through our mobile application.

6. 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 Optional covers, Riders and Taxes as applicable) 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, Base 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 as below -

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specific Severity)
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

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 Covers/Add-on Covers?

The following optional covers shall apply under the Policy for an Insured Person if specifically mentioned on the Policy Schedule and shall apply to all Insured Persons under a single policy without any individual selection

1. Non-Medical Items

We will indemnify the cost of Non-Medical items, listed under Annexure III List 1 of the Policy Terms and Conditions, 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 In-patient Hospitalization and/ or 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. Waiver of Mandatory Co-payment

The Policyholder shall have an option to remove the Mandatory Co-payment which is applicable for all insured persons available on payment of additional premium.

3. Worldwide Accidental Emergency Hospitalization Cover:

We will indemnify all eligible Medical Expenses incurred during the Policy Year, for Emergency In-patient Hospitalization Treatments of the Insured Person, due to an Injury arising out of an Accident, incurred outside India, covered up to the Sum Insured and as specified in the Policy Schedule, 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 of the Policy. Our maximum liability under this benefit, in a single Policy Year shall not exceed the limit available under this coverage and as specified in the Policy Schedule.

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

(c) Any payment under this benefit will only be made in India, in Indian rupees on a re-imbursement basis and subject to availability of limits under this coverage. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance.

(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) The Insured Person has given Us, intimation of such hospitalization within 48 hours of admission.

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

(g) This benefit is available once in a Policy Year for each Insured Person.

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

(i) This cover is available to all Insured Persons provided they are Indian resident at inception of the Policy and at subsequent renewals of this Policy.

4. Health Check Up

(a) Health Check Up benefit can be availed only in case where the Wellness Benefit is not chosen by the Insured person.

(b) If the Insured Person 18 years or above at the start of Policy Year , the Insured Person may avail a comprehensive health check-up with Our Network Provider as per the eligibility details mentioned in the table below. Health Check Ups will be arranged by Us and conducted at Our Network Providers.

(c) This benefit is available once every third policy year. And all the tests must have been done on the same date.

(d) Copies of all reports will be provided to the Insured Person.

Health Check-Up				
Sr no.	**Base Sum Insured**	**Age**	**Package Name**	**Tests**
1	**For All Base Sum Insureds**	**Up to 40**	Health Screening Package	CBC-ESR, FBS, BUN, Lipid Profile, TSH, Liver Function Test, Kidney Function Test
2		**Above 40 for males**	Health Screening Package - Males	CBC-ESR, FBS, BUN, Lipid Profile, TSH, HbA1c, Liver Function Test, Kidney Function Test, PSA
		Above 40 for females	Health Screening Package 1 - Females	CBC-ESR, FBS, BUN, Lipid Profile, TSH, HbA1c, Liver Function Test, Kidney Function Test, Serum Calcium

Full explanation of Tests is provided here: FBS – Fasting Blood Sugar, CBC- ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, HbA1c – Glycosylated Hemoglobin, SGOT – Serum Glutamate oxaloacetate transaminase, SGPT – Serum Glutamate Pyruvate Transaminase, GGT – Gamma Glutamyl Transferase, PSA – Prostate Specific Antigen, TSH – Thyroid Stimulating Hormone, CBC – Complete Blood Count, BUN – Blood Urea Nitrogen

(e) This benefit shall be over and above the sum insured.

(f) Opting this cover shall mean that the coverage under Wellness Program shall not be applicable for the Insured members for the lifetime of the Policy. The Insured members shall not be able to participate in any of the wellness programs and shall not be able to earn any rewards under \the coverage Wellness Program.

(g) We shall cover Health Check Up only on cashless basis within MCHI Network.

(h) This benefit shall only be opted at the time of renewal of the Policy. or at inception and once opted, cannot be removed.

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

5. Waiver of Disease Specific Sublimit

The Policyholder shall have an option, to remove the Disease Specific Sublimit which is applicable for listed ailments/procedures as specified under Section II.1 In-patient Hospitalization and available on payment of additional premium.

6. Cumulative Bonus

The Policyholder can select from any one of the options below, and the applicable bonus benefit will be adjusted accordingly:

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

b) A bonus of 25% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

c) A bonus of 50% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

Special conditions applicable to Cumulative Bonus Booster

a) When the Policyholder chooses the Cumulative Bonus Booster at renewal, any Cumulative Bonus already earned under this Policy will be carried forward. From that renewal onwards, the regular Cumulative Bonus under Section II.3 will stop applying, and any future bonus accumulation will happen as per the terms of the Cumulative Bonus Booster benefit.

b) All clause applicable under Cumulative Bonus section II.3 shall apply to this benefit as well

7. Modification of Pre & Post Hospitalization Days

The Policyholder may opt to modify the Pre-Hospitalization and Post-Hospitalization days by selecting any one of the options specified below. We shall reimburse the reasonable and customary Pre-Hospitalization and Post-Hospitalization Medical Expenses incurred by an Insured Person for an Illness or Injury for which a claim has been admitted under the In-patient Hospitalization Benefit (Section II.1) OR Day Care Treatment (Section II.4), provided such expenses are directly related to the same Illness / Injury for which the Hospitalization occurred.

The available options are:

Option	Pre-Hospitalization	Post-Hospitalization
Option A	60 days	90 days
Option B	60 days	180 days

For the selected option:

- **Pre-Hospitalization Medical Expenses** shall mean expenses incurred during the specified period immediately preceding the admission date of Hospitalization.
- **Post-Hospitalization Medical Expenses** shall mean expenses incurred during the specified period immediately following discharge from the Hospitalization.

The limits applicable under this Optional Cover shall be as specified in the Policy Schedule.

8. ManipalCigna Prime Plus (Add-on Cover)

Along with this Product You can also avail the ManipalCigna Prime Plus Add On Cover. 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.

a. **Room Rent Modification:** The Insured Person shall be eligible to modify the room type category eligibility under the Policy as follows:
   i. Option 1: Any room; ICU Up to Sum Insured
   ii. Option 2: Twin Sharing AC room; ICU Up to Sum Insured

b. **Deductible:** Option to opt from ₹10,000 ₹25,000, ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 and ₹5,00,000 on aggregate basis.

V. What are Features of the Policy?

i) Eligibility

The minimum entry age under this Plan is 91 days for children and 18 years for adults.

The maximum entry age under this Plan is 17 years for children and no limit for adults.

Coverage for children:

a. Children from 91 days to 17 years will only be covered if one of the parents is the proposer.
   Renewals will be available for lifetime.

ii) Individual and Family (Multi Individual) basis

The Plan can be purchased on an Individual basis or a Family (Multi Individual) basis. There is no Family Floater option available under this Plan.

In case of an Individual / Multi 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.

iii) Policy Period option

You can buy the policy of one year policy tenure.

iv) Plan & Sum Insured Options

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

Plan Name	Base Sum Insured (` in Lacs)
Active Plan	₹3 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs & ₹1 Cr

v) Discounts under the Plan

You can avail of the following discounts on the premium under this Plan.

i. **Lifetime Discounts**

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

b. No Claim Discount – The insured shall be eligible for 1% discount on the renewal premium if no claim has been made during the expiring policy tenure, subject to the following conditions:

i. For the purpose of determining eligibility for No Claim Discount, the utilization of following benefits shall not be considered as a claim:
   a. III.1 - Domestic Second Opinion,
   b. III.2 – Tele Consultation,
   c. III.4 – Wellness Program,
   d. III.5 - Discount from Network Providers, and
   e. IV.4 - Health Check-up

ii. The No Claim Discount shall be applicable on the renewal premium, including premium of all optional covers/riders and any applicable loading.

iii. No Claim Discount shall be applied individually at the insured person level.

ii. Short Term Discounts

a. 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.

Maximum discount in a single policy shall not exceed 40%.

vi) Underwriting Loading & Special Conditions

We may apply a risk loading on the premium payable (excluding Statutory Levis and Taxes as applicable) or Special Conditions on the Policy based upon the health status of the persons proposed for insurance and declarations made in the Proposal Form. These loadings will be applied from inception date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.

We may apply a specific sub-limit on a medical condition/ailment depending on the past 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 shall 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 You would need to revert with consent and premium, within the duration specified in the counter-offer letter.

vii) Premiums

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

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

For the purpose of calculating premium, the country has been divided into 3 Zones. Default zone of cover will be based on Proposer’s city-location pin code as mentioned in KYC document

Zone Classification

Identification of Zone will be based on Proposer’s city-location pin code as mentioned in KYC documents. The residential address provided by You should be true, correct and complete. Any discrepancy or mismatch identified during claim adjudication may lead to delays, disputes or denial of claim settlement. The policyholder is required to promptly inform the company of any changes to the residential address to ensure uninterrupted communication and smooth claim processing.

Zone	Region / District / State
Zone I	Delhi & NCR. Districts in Gujarat: Ahmedabad, Gandhinagar, Surat, Vadodara. Districts in Maharashtra: Mumbai, Thane, Navi Mumbai. Districts in Andhra Pradesh /Telangana: Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal. Districts in Uttar Pradesh: Mathura, Jyotiba Fule Nagar (Amroha), Aligarh. Districts in Punjab: Amritsar, Gurdaspur. Others: Kolkata, Rewari, Jind, Jhunjhunu, Patna
Zone II	Rest of the Bihar State, Districts in Andhra Pradesh / Telangana: Ananthapur, Bapatla, Gadwal, Guntur, Jagtial, Kamareddy, Karimnagar, Kurnool, Mahabubnagar, Mancherial, Medak, Nalgonda, Nellore, Nizamabad, Peddapalli, Rangareddy, Suryapet, Wanaparthy. Districts in Punjab: Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, Mohali, Patiala. Districts in Maharashtra: Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad. Districts in Uttar Pradesh: Banda, Fatehpur, Kanpur. Others: Chennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad.
Zone III	Rest of India excluding the locations mentioned under Zone I & Zone II

(Note - Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts)

(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. The aforesaid Co-payments applicable are in addition to the Mandatory Co-payment under section V.ix) and will be applied in conjunction to section V.ix).

viii) Premium payment mode - Loading grid

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, 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, 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

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) Mandatory Co-payment

A compulsory co-payment of 10% is applicable on all claims for all Insured Persons. Co-pay will be applied on the admissible claim amount. Wherever the claim is processed by applying the sub-limits, the Mandatory co-payment shall not apply.

In addition to the Mandatory Co-payment, based on the Underwriter's discretion, an additional Co-payment up to 50% may be applied as a decision for accepting the proposed risk. This Co-Payment shall be over and above the Mandatory Co-payment as specified above.

For persons who have opted for a Waiver of Mandatory Co-payment, only the 10% Mandatory Co-Payment shall not apply for the respective Insured Persons.

x) Deductible

On underwriting discretion your aggregate deductible of ₹5 Lac and ₹10 Lac may be applied at the time of decision for accepting the proposed risk.

xi) Renewal of Policy

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

a. The Company shall give notice for renewal at least 30 days in advance from the Policy due date.
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 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 Optional cover Worldwide Accidental Emergency Hospitalization Cover shall be renewed subject to the Insured Person being an Indian resident at the time of renewal.
b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days (as applicable) between the previous policy expiry date and current Policy start date. We, however 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, established fraud, non-disclosure of material facts 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.
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 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 45 days prior to date of such revision or modification.
g. Alterations like increase/ decrease in Base Sum Insured or Change in Plan/Product, addition/deletion of members, addition/deletion of optional covers/riders, 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 Base Sum Insured, on renewal. The terms and conditions of the existing policy will not be altered.
h. Any enhanced Base 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 Base Sum Insured is reduced on any Policy Renewals, the waiting periods shall be waived only up to the lowest Base Sum Insured of the last 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.(v) will be applicable considering such Policy Year as the first year of Policy with the Company.
k. Applicable Cumulative Bonus shall be accrued basis each Policy Year, on renewal as per eligibility under the plan opted.

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.
- If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.
- 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 grace period of the policy, the policy will be terminated from the date on which such grace period is over to pay the premium and all claims that fall beyond such grace period 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 expiry of such grace period for the payment of instalment premium.
- 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.

xii) 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 30 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 to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, moratorium period etc. as per IRDAI guidelines on portability.

xiii) Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 126 as per the Income Tax Act 2025. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

xiv) Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the policy including the premium rates. The insured person shall be notified atleast 45 days before the changes are effected

xv) Free-look Period

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

The insured person shall be allowed a free look period of 30 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 refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges. Free look cancellation & refund will be made within 7 days from the date of receipt of request.

In case of any delay in refund, the insurer shall refund such amounts along with interest at the bank rate plus 2 percent on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund.

xvi) Cancellations

i. In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 7 days' notice in writing at any time during the term. We shall refund the premium for the unexpired policy period as mentioned below.

A. Policy Tenure of 1 Year:

1. If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of the cancellation request will be considered as the expiry date of coverage.
2. If a claim has been made during the Policy period, no refund will be given to the Policyholder.

Illustration:

1. Where Policyholder has not made any claim during the Policy Year.

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure (in Year)	1
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	285
Premium Refund	77.87 (100*285/365)

2. Where the Policyholder has made a **claim** during the Policy Year.

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure (in Year)	1
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2024
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	-

No refund would be given to Policyholder as he had made a claim during the Policy Period.

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.

xvii) 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.

xviii) Redressal of Grievance

If you have a grievance that you wish us to redress, you may contact us with the details of the grievance through Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at: seniorcitizensupport@manipalcigna.com

Toll Free: 1800-102-4462

Contact No.: 022-61703600

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at,

'The Grievance Cell, ManipalCigna Health Insurance Company Limited,

401/402, 4th Floor, Raheja Titanium,

Western Express Highway, Goregaon (East),

Mumbai - 400063, Maharashtra, India

or

Email: headcustomercare@manipalcigna.com.

For updated details of grievance officer, kindly refer link: https://www.manipalcigna.com/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

Grievance may also be lodged at IRDAI complaints management system - https://bimabharosa.irdai.gov.in/

You may also approach the Insurance Ombudsman if your complaint is open for more than 30 days from the date of filing the complaint.

The office Name and address details applicable for your state can be obtained from - https://www.cioins.co.in/Ombudsman

xix) Pre-Policy Medical Check-up

Pre-policy medical check-up may be required based on optional cover(s) chosen, Sum Insured, Age and/ or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. Full cost of all such tests will be borne by Us for all accepted proposals.

xx) 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, to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. as per IRDAI guidelines on migration.

xxi) 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.

xxii) 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 sums 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.

xxiii) Revival of policy

If your Policy has passed the stipulated grace period due to non-payment of premium, you may be allowed for revival of your policy, subject to certain specific terms and conditions.

<u>Specific conditions applicable to revival of policy</u>

a. The policy could be revived maximum within 180 days from lapse of the first payment due date
b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):

1. Special conditions,
2. Assessment of current health status or Good health declaration
3. Undergoing medical examinations
4. Payment of all the premium (inclusive of applicable taxes) that was due and unpaid

c. Any claim/medical expense incurred during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.

d. If a ‘Good Health Declaration’ is sought by us and is later proven to be fraudulent, the entire policy shall be cancelled, and no claims shall be payable.

e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

xxiv) Coverage Standards & Protocols

Medicine is an evidence-based science. Clinical diagnosis supported by positive investigation test findings are its founding principles. Treatment in Medicine are given as per well-defined protocols.

Our goal is to deliver care that is appropriate, effective, and safe. Equally important is avoiding treatments that are not medically necessary, as this helps safeguard patient well-being. Insurance, by design, is to support healthcare needs and not to change treatment choices. Furthermore, a key principle in insurance suggests that having coverage should not influence healthcare decisions. Patients naturally consider the benefits of treatment along with its cost and choose care that offers the best value and medical results. This approach supports responsible, value-based care that focuses on what is truly needed for recovery and long-term health.

A. Medical Protocols

We are committed towards supporting safe, effective, and evidence-based medical care. To help bring clarity and consistency, we will be referring to trusted and widely accepted sources such as leading medical textbooks, All India Institutes of Medical Sciences

(AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence **(**NICE).

These guidelines are designed to help explain:

a. When hospitalization is needed, including guidance on the appropriate level of care (for example: admission in an ICU or non-ICU room)

b. What treatments and procedures are considered appropriate, based on the medical condition and its severity, including recommended medicines and procedures

To ensure patient safety and quality of care, coverage under this policy shall be aligned with treatments and medicines that are approved by recognized regulatory authorities such as the Central Drugs Standard Control Organisation (CDSCO), Food and Drug administration (FDA), and other relevant bodies in India. Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India shall not be covered under the policy.

We also follow official guidance provided by manufacturers and regulatory authorities regarding how medicines and procedures should be used, including their approved indications and precautions. Treatments or medications used outside their approved purpose (often called "off-label" or extra usage) shall not be covered under the policy, as these fall outside established approval and safety guidelines.

Our approach is focused on transparency, safety, and supporting care that is medically appropriate and widely accepted, helping customers make informed healthcare decisions with confidence.

B. Position statements

Medicine is constantly evolving, wherein, new technologies and treatment approaches are emerging regularly. While many innovations offer promise, not all deliver outcomes that are meaningfully better when considered alongside their costs and established alternatives.

As a responsible insurer, we believe in being transparent and clear with our customers. Therefore, our decision on the coverage of illnesses or injury shall be basis texts and medical protocols published/recognised by globally trusted establishments like All India Institutes of Medical Sciences (AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence **(**NICE). Our evaluations will be based on comprehensive Health Technology Assessments, health economic evaluations, cost-benefit and cost-efficiency analyses, along with other well-regarded global research published in reputable medical journals. Any research found to have conflicts of interest will be excluded from consideration.

Medical protocols published by these establishments will outline how we assess different medicines, treatments, procedures, investigations, and therapies. Depending on the clinical and scientific evaluation, we may either cover the Reasonable and Customary charge incurred on a treatment wholly or partially or may recommend suitable alternatives or may seek additional review or in some cases may be unable to provide coverage under this product.

Importantly, if our medically-informed assessment results in no coverage or partial coverage for a particular treatment, we will still ensure payment at least up to the cost of the most widely accepted and commonly used alternative treatment currently available for that condition.

C. Prolonged Hospitalization extending beyond 10 days

a. It is important that you inform us in a timely manner. If we do not receive intimation within 10 days from the date of admission, we may apply an additional cumulative co-payment of 10% on the final admissible claim amount.
b. We may request for indoor case papers, treatment sheets, and daily monitoring records to help us understand and support the medical need for the extended stay.
c. If the medical records indicates that the insured's health parameters have stabilized and yet the hospitalization continues, expenses related to the extended period of stay may not be payable under this policy.

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.
b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.
c. For all Kidney, liver and pancreas transplants, a biopsy of the recipient's organ may be required as part of the medical evaluation process.

d. If treatment is taken at a non-network hospital and we do not receive the required intimation or the biopsy report as outlined above, an additional 20% co-payment may be applicable on the admissible claim amount.

xxv) Utilization of Sum Insured

Sequence of utilization of Sum Insured will be as follows:

a. Base Sum Insured (if remaining for that claim)
b. Cumulative Bonus / Cumulative Bonus Booster – if opted (earned and remaining for that claim)
c. Restoration (applicable for that claim)

xxvi) Personal Data and Privacy

Personal and health data will be processed only for policy issuance, servicing and claims, and may include ABDM/ABHA-enabled services where consented; you can withdraw such consent at any time (see Policy T&C).

xxvii) Pre-Policy medical check up

Where a pre-policy medical check-up has been undertaken by the proposed Insured Person(s) and the insurance policy is not issued or the proposal is not taken forward, the entire expenses incurred towards the pre-policy medical check-up shall be payable by the Proposer.

xxviii) Indemnity principle clause

The total amount paid for the same admissible claim, whether under one or more indemnity covers or policies, with us or any other insurer, will not be more than the actual expenses incurred by the Insured Person.

VI. What are the Waiting Periods and 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. All the waiting period 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 24 months of continuous coverage after the date of inception of the first policy with us.

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

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

d. Coverage under the policy after the expiry of 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.

Any condition or illness, complication or ailment as specified in the Policy Schedule out of any of the below mentioned conditions, shall not be considered as part of this waiting period. Wherein, they shall be covered after the first 90 days from the Inception Date of first policy with Us.

a. Asthma
b. Diabetes
c. Dyslipidaemia
d. Obesity
e. Hypertension

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 highest between the Specified disease/procedure Waiting Period or Pre-existing Diseases waiting period 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. 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.

v. 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

vi. 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 are excluded, except for sex reassignment surgery for transgender persons.

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- **Excl13**

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

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 the geographical limits of India other than for coverage under Worldwide Accidental Emergency Cover (if opted).

23. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body subject to conditions mentioned in II.7 'Organ Donor'.

24. Any form of Non-Allopathic treatment (except AYUSH 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, chemicalor 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 Terms and Conditions.

28. Any percentage of admissible claim under co-payment if applicable and as specified in the Policy Schedule.

29. Pre-existing condition disclosed by the Insured Person will be reviewed according to the company's underwriting policy.

30. Expenses related to cataract treatment involving all types of Multi-focal Lenses (including intraocular lenses), Multi-focal Toric Lenses, and Femto Laser-assisted surgeries are not covered.

31. Expenses related to any Modern & Advanced Treatments other than those covered under this Policy shall not be payable.

32. Any kind of Out-Patient Treatment expenses including fractures (not requiring any kind of hospitalization).

33. Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

34. Stem cell harvesting.

35. Vaccination including inoculation and immunizations (except post animal bite treatment).

36. Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.

37. Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.

38. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.

39. Drugs or treatments which are not supported by a prescription.

40. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

41. Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre or AYUSH Hospital.

42. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

43. Expenses incurred towards artificial life maintenance, including life support, after the patient has been certified to be in a vegetative state by the treating medical practitioner shall not be payable

VII. 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.

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured, Age band or any medical declaration, 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 the decision on the proposal thereof, shall be communicated in writing to You within a reasonable period but not exceeding 7 days from the date of receipt of proposals or any requirements called for by Us.

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.

VIII. 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

<u>For a Cashless Claim -</u>

In case of planned hospitalization - at least 48 hours prior to the planned date of admission.

In case of Emergency Hospitalization - within 24 hours of such admission.

Cashless facility is available only at Our Network Hospital or Common empanelment of hospital/healthcare providers as specified by Insurance Council. 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 –

- o Claim form duly signed
- o Copy of photo ID of patient
- o KYC documents (Photo ID proof, address proof, recent passport size photograph)
- o Cancelled cheque for NEFT payment
- o Payment receipt.

Additional claim documents required for below benefits:

S. No.	Name of Benefit	Name of Document
1	In-patient Hospitalization	• Hospital Discharge summary • Operation Theatre notes/ ICP papers • Hospital Main Bill • Hospital Break up bill • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices • Copy of FIR/Panchnama / Police Inquest Report (if conducted) duly attested by the concerned Police Station in case of Accident.
2	Day Care Treatment	
3	Donor Expenses	
4	AYUSH Treatment	
5	Worldwide Accidental Emergency Hospitalization Cover	
6	Pre – hospitalization	• Pharmacy Bills • Diagnostic tests reports in relation to admitted hospitalization expenses • Prescription in support of Pharmacy, Investigations
7	Post – hospitalization	
8	Domiciliary Hospitalization	• Certificate from treating Medical Practitioner that condition of the Insured Person does not allow a Hospital transfer; or • Evidence that hospital bed was unavailable in nearest hospitals. • Final Bill and invoice • Nursing chart/TPR chart • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation Pharmacy bills, prescription and invoices
9	Road Ambulance	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance

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 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 Policyholder / 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.

IX. What are the Plan wise Benefit Details?

The Plan wise benefit details are as mentioned below:

<table>
<tr><th colspan="2">Title</th><th colspan="5">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><td>Your Coverage Details:</td><td>Identify your Plan</td><td colspan="5">Active</td></tr>
<tr><td rowspan="10">Basic Cover
This section lists the Basic benefits available on your plan
Basic Cover</td><td>Identify your Opted Base Sum Insured (in ₹)</td><td colspan="5">₹3 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹12.5 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹30 Lacs, ₹40 Lacs, ₹50 Lacs & ₹1 Cr</td></tr>
<tr><td rowspan="9">In-patient Hospitalization (When you are hospitalized)</td><td colspan="5">Room Rent :
For Base Sum Insured ₹3 lacs: 1% of Sum Insured
For Base Sum Insured ₹5 lacs and above: Single Private A/C Room For ICU - Up to Sum Insured</td></tr>
<tr><td>Base Sum Insured (in ₹)</td><td>₹3 Lacs</td><td>₹5 Lacs</td><td>₹7.5 and ₹10 Lacs</td><td>>₹10 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 Hypertrophy
4. Surgical treatment of stones of renal system</td><td>₹50,000</td><td>₹65,000</td><td>₹80,000</td><td>NA</td></tr>
<tr><td>Treatment of Cataract (Per Eye)</td><td>₹20,000</td><td>₹30,000</td><td>₹30,000</td><td>NA</td></tr>
<tr><td>Treatment of Total Knee replacement (Per knee)</td><td>₹80,000</td><td>₹1,00,000</td><td>₹1,20,000</td><td>NA</td></tr>
<tr><td>Treatment for breakage of bones</td><td>₹2,00,000</td><td>₹2,50,000</td><td>₹3,00,000</td><td>NA</td></tr>
<tr><td colspan="5">Wherever the above mentioned Sub-limits are applied, the Mandatory Co-payment shall not be applicable however co-payment for the treatment taken at higher zone as mentioned under section V.vii will continue to apply.</td></tr>
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<table>
<tr><td></td><td></td><td>This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments: up to 50% of Sum Insured
b. HIV/AIDS & STD: up to Sum Insured
c. Mental Illness: up to 50% of 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></td><td>Pre – hospitalization</td><td>Medical Expenses Covered up to 30 days before the date of hospitalization; Covered upto the Sum Insured</td></tr>
<tr><td></td><td>Post – hospitalization</td><td>Medical Expenses Covered up to 60 days post discharge from the hospital; Covered upto the Sum Insured</td></tr>
<tr><td></td><td>Day Care Treatment</td><td>Covered up to the Sum Insured</td></tr>
<tr><td></td><td>Domiciliary Hospitalization (Treatment at Home)</td><td>Covered up to 10% of the Sum Insured.
Pre and Post Hospitalization Expenses: 30 days each</td></tr>
<tr><td></td><td>Road Ambulance (Reimbursement of Ambulance Expenses)</td><td>Covered up to the Sum Insured</td></tr>
<tr><td></td><td>Donor Expenses (Hospitalization Expenses of the donor providing the organ)</td><td>Covered up to the Sum Insured</td></tr>
</table>

	Restoration (When opted Base Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses, in addition to the Sum Insured
	AYUSH Treatment	Covered up to the Sum Insured
	Convalescence Benefit (For Hospitalization >=10 days)	Applicable for Base Sum Insured of ₹5 lacs and above: Lump sum benefit amounting to ₹30,000 per hospitalization upon completion of at least 10 consecutive days of hospitalization.
	Daily Cash for Shared Accommodation	Daily Cash benefit for occupying shared accommodation while hospitalized shall be covered as below:- a. For Base Sum Insured from ₹5 lacs up to ₹10Lacs: ₹800 per day up to maximum of ₹5600 b. For Base Sum Insured above ₹10Lacs: ₹1,000 per day up to maximum of ₹7000 Payable 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	Domestic Second Opinion	Available for 36 listed Critical Illness/es
	Tele consultation	Unlimited Tele-consultation in a Policy Year
	Cumulative Bonus	Bonus of 10% per year, subject to a maximum: upto 100% of Base sum insured.
	Wellness Program (For Lives suffering from one or more of the following conditions: Asthma, Diabetes, Hypertension, Dyslipidaemia, Obesity)	Rewards can be earned by adhering to Condition Management Program and improving the Health Parameters. These earned Reward Points can be used against payable Renewal premium (excluding premium for optional covers, Rider and taxes as applicable) as discount from 1st Renewal of the Policy. Reward Accrual - Max upto 15% of the expiring base Premium (excluding premium for optional covers, Rider and taxes as applicable), applicable for the respective insured. Reward Redemption: The earned reward points could be redeemed as discount to pay a portion of the renewal premium (excluding premium for optional covers, Rider and taxes as applicable). The earned rewards shall lapse, in case the same is not used at the time of subsequent renewal (renewal falling due immediately after the accrual).
	Discount from Network Provider	Discount on Pharmacy, Diagnostics and Health Supplement 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 as applicable) 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.

Optional Covers	Non-Medical Items	Non-Medical items covered up to Sum Insured opted in case of In-patient Hospitalization and/or Day Care Treatment.
	Waiver of Mandatory Co-payment	Waiver of Mandatory Co-payment of 10% per claim subject to underwriting.
	Worldwide Accidental Emergency Hospitalization Cover (Applicable to Indian Residents only)	Covered up to Sum Insured opted for Emergency In-patient Hospitalization outside India. This benefit is available once in a Policy Year for each Insured Person.
	Health Check Up	Available once every third policy year, to all Adult insured persons who have completed 18 years of Age in lieu of 'Wellness Program'. This benefit shall be offered on cashless basis only.
	Waiver of Disease Specific Sublimit	Disease Specific Sublimit which is applicable for listed ailments / procedures as specified under In-patient hospitalization shall be waived subject to underwriting
	Cumulative Bonus	Option to choose any one of the following: Option a): 10% of Base Sum Insured, Max upto 200% of Base Sum Insured. OR Option b): 25% of Base Sum Insured, Max upto 200% of Base Sum Insured. OR Option c): 50% of Base Sum Insured, Max upto 200% of Base Sum Insured.
	Modification of Pre & Post Hospitalization Days	Option to Modify Pre-Hospitalization & Post-Hospitalization days: Option A) 60/90 days respectively Option B) 60/180 days respectively
Add-on Cover	**ManipalCigna Prime Plus**	
	Room rent Medication (Available for Base Sum Insured of ₹ 5 Lacs and above)	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
	Deductible	Option to opt from ₹ 10,000, ₹ 25,000, ₹ 50,000, ₹ 1,00,000, ₹ 2,00,000, ₹ 3,00,000, ₹ 4,00,000 and ₹ 5,00,000 on aggregate basis.

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