ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151 **Call** (Toll Free): 1800-102-4462
Visit: www.manipalcigna.com **E-mail:** customercare@manipalcigna.com

MANIPALCIGNA PROHEALTH PRIME

Plans: Protect | Advantage
(PROSPECTUS)

I. What are the Key Highlights of the Policy?

BASIC COVERS
- In-patient Hospitalization
- Pre-hospitalization
- Post-hospitalization
- Day care Treatment
- Domiciliary Hospitalization
- Road Ambulance
- Donor Expenses
- Restoration
- AYUSH Treatment
- Air Ambulance Cover
- Bariatric Surgery Cover
- Outpatient Expenses
- Daily Cash for Shared Accommodation

VALUE ADDED COVERS
- Health Check Up
- Domestic Second opinion
- Tele-Consultation
- Cumulative Bonus
- Switch Off Benefit
- Wellness Program
- Discount from Network Providers
- Premium Waiver Benefit

OPTIONAL PACKAGES
- Enhance Plus
- Assure
- Enhance
- Freedom

OPTIONAL COVERS
- Non-Medical Items
- Deductible
- Infertility Treatment
- Personal Accident Cover
- Cumulative Bonus Booster

ADD ON/RIDER COVER
- ManipalCigna Critical Illness
- ManipalCigna Prime Plus

II. What are the Basic covers?

1. In-patient Hospitalization

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

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

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

Coverage for Advanced/Modern Treatment procedures

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

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchical Thermoplasty
j. Vaporisation of the 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 opted and as specified in the Policy Schedule in a 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 taken 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 sum insured opted and as specified in the Policy Schedule in a 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, upto the Sum Insured, incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital. This benefit is payable only if a claim has been admitted under Section II.4 ‘Day Care Treatment’ or Section II.1 ‘In-patient Hospitalization’ and is related to the same illness/injury and if the Pre-hospitalization Medical expenses are incurred during a Policy Year.

3. Post - hospitalization

We will reimburse Post-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 180 days immediately post the date the Insured was discharged from the Hospital. This benefit is payable only if 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.

4. Day Care Treatment

We will indemnify the Medical Expenses incurred for an Insured Person upto the sum Insured in the event of medically necessary day care treatment or surgery that requires less than 24 hours hospitalization due to advancement in technology and which is undertaken in a Hospital/ Nursing Home/ Day Care Centre on the recommendation of a medical practitioner. 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 Service under this benefit.
d. Coverage will also include pre-post hospitalization expenses as per the limits applicable and specified in Policy Schedule.

5. Domiciliary Treatment

We will reimburse the Medical Expenses of an Insured Person, up to the limits specified in the Policy Schedule, for an Illness or Injury that would normally require Hospitalization, but it is instead treated at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a Hospital transfer; or
ii. A Hospital bed was unavailable;

Provided that, the treatment of the Insured Person continues for at least 3 days, in which case the reasonable cost of any Medically Necessary treatment for the entire period shall be payable.

a) We will pay for Pre-hospitalization, Post-hospitalization Medical Expenses up to 30 days each.
b) Restoration of Sum Insured shall not be available under this benefit.
c) We shall not be liable under this Policy for any Claim in connection with or in respect of the following:
   i. Asthma, COPD, bronchitis, tonsillitis and upper and lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
   ii. Arthritis, gout and rheumatism including the rheumatism of bones, joints and also rheumatic heart disease,
   iii. Chronic nephritis and nephritic syndrome,
   iv. All types of Diarrhea and dysenteries, including gastroenteritis,
   v. Diabetes mellitus and Diabetes Insipidus,
   vi. Epilepsy / Seizure disorder,
   vii. Hypertension,
   viii. Pyrexia of unknown origin.

6. Road Ambulance

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

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 as specified in the Policy Schedule, subject to the below mentioned conditions:

a) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that the organ donated is for the use of the Insured Person who has been medically advised to undergo an organ transplant.

b) We have admitted a claim under In-patient Hospitalization.

c) We will also cover expenses towards the Donor in respect of:

i. Any Pre or Post-hospitalization Medical Expenses, up to 30 days each.

ii. The Cost of donor screening for organ transplant surgery, provided that the organ transplant surgery is successful.

This benefit shall be payable once in the Policy Year.

d) Any complication in respect of the donor, consequent to harvesting, which arise during Hospitalization or up to 30 days from the date of discharge of the donor, up to the limits specified in the Policy Schedule of this Policy. This benefit shall be over and above the Sum Insured.

e) We will not cover expenses for the Donor associated with the acquisition of the organ.

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 available for both related as well as unrelated illnesses and for all Insured members under the policy.

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 (In-patient Hospitalization)'
- V.1 'Non-Medical Items'

e. The Restored amount will not be considered while calculating the Cumulative Bonus/ Cumulative Bonus Booster.

f. Such restoration amount will be available any number of times in a Policy Year for each Insured Person under an Individual Policy and may be utilized by Insured Persons covered before the exhaustion of the Base Sum Insured.
g. Under a Floater Policy, the Restored amount shall also apply on a floater basis.
h. Any unutilized Restored amount will not be carried forward to subsequent Policy Years.
i. For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:
   i. Base Sum Insured
   ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
   iii. Restored amount

9. AYUSH Treatment

We will indemnify the Medical Expenses incurred during the Policy Year, up to the Sum Insured as specified in the Policy Schedule, of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalization for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

The Insured Person has undergone treatment in an AYUSH Hospital.

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

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

10. Air Ambulance Cover

We will reimburse the Reasonable and Customary expenses incurred for transporting an Insured Person to the nearest Hospital or for transfer between healthcare facilities within India by an Air Ambulance,during the Policy Year subject to the below conditions:

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

Benefit under this cover is payable Up to the opted Base Sum Insured or ₹10Lacs whichever is lower The benefit is payable over and above the Sum Insured.

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

11. Bariatric Surgery Cover

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

The cover is available subject to below conditions:

i. Surgery is Medically Necessary and is certified by an authorized Medical Practitioner;
ii. Hospitalization is within the Policy Year.
iii. The Insured Person satisfies following criteria as devised by NIH (National Institute of Health):

a. The BMI should be greater than 37.5 without any co-morbidity; or greater than 32 with co-morbidity and
b. Is unable to lose weight through traditional methods like diet and exercise.

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

v. Restoration shall not be available under this benefit

12. Outpatient Expenses

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

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

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

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

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

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

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

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

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

13. Daily Cash for Shared Accommodation

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

a. We have accepted claim under Section II.1 In-patient Hospitalization during the Policy Year
b. The Insured Person has occupied a shared room accommodation during such Hospitalization
c. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

What is not covered:

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

III. What are the Value Added Covers?

1. Health Check-Up

(a) If the Insured Person, covered as adult (excluding dependent children in floater Policy) and is 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.

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

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

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

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

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

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

(h) This benefit will not be available during the free look period of the Policy.

Sr No	*Sum Insured (in ₹ Lacs)*	*Age Group*	*Package Name*	*Tests*
1	**3 \4\5**	**Up to 40**	Cardiac Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, ECG
			Liver Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, SGOT and SGPT
2		**Above 40**	Cardiac Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, ECG
			Liver Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, SGOT and SGPT
			Thyroid Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, Thyroid profile
			Diabetes Screening	CBC-ESR, FBS, Lipid Profile, Sr Creatinine, HbA1c
3	**7.5/10 Lacs**	**Up to 40**	Health Screening Package	CBC-ESR, FBS, BUN, Lipid Profile, TSH, Liver Function Test, Kidney Function Test
4		**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
5	**>10 Lacs**	**Up to 40**	Comprehensive Health Check-up	CBC-ESR, FBS, Lipid Profile, Kidney Profile with Electrolytes, Liver profile, Thyroid Profile, Serum Calcium, Vit D3, Vit B12
6		**Above 40 for males**	Comprehensive Health Check-up - Males	CBC-ESR, FBS, Serum Calcium, HbA1C, Kidney Profile with Electrolytes, Lipid Profile, Liver Profile, Thyroid Profile, Vitamin D3, Vitamin B12, PSA
		Above 40 for females	Comprehensive Health Check-up 1 - Females	CBC-ESR, FBS, Serum Calcium, HbA1C, Kidney Profile with Electrolytes, Lipid Profile, Liver Profile, Thyroid Profile, Vitamin D3, Vitamin B12, CA-125

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

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

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

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

2. Domestic Second Opinion

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

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

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

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

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

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

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

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

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

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

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

3. Tele-Consultation

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

4. 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 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.

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 200% 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

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

5. Switch Off Benefit

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

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

I. Section V.4. Personal Accident Cover and

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

III. Section V.6.A - ManipalCigna Critical Illness Add On Cover

a. Premium discount shall be calculated on a pro-rata basis the number of days the policy has been switched off on a per day basis and this discount shall be adjusted in the renewal premium falling due immediately after the expiring Policy Period.
b. In a Floater Policy, Switch Off Benefit can be availed only if all the Insured Persons travel outside India. However, in case of an Multi-Individual Policy if any one or more Insured Person (s) travel outside India, You can avail this benefit and the premium discount shall be calculated based on the applicable premium for that/those particular individual (s).
c. This benefit shall not be available in the first Policy Year.
d. This benefit cannot be availed in the last 90 days of the Policy Year.
e. During the Switch-off period, Your cover will be limited only to Section V.4 Personal Accident Cover, Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover and Section V.6.A ManipalCigna Critical Illness Add-on Cover, if opted. Any claim under the floater policy, arising during the switch off period other than claim under Section V.4 Personal Accident Cover, Section IV.D.2 Worldwide Emergency Hospitalization with Outpatient Cover and Section V.6.A ManipalCigna Critical Illness Add-on Cover, shall not be payable. In case of Multi-Individual policies where members are covered on individual basis, the switch off period shall apply only to the respective member for which the request to switch off the coverage is placed with the Insurer. The coverage shall start once the cover is switched on either upon the expiry of the Switch Off period or 30 days from the Switch Off date, whichever is earlier.
f. The date of travel to abroad for all the Insured Members should be same in case of a floater policy in order to be eligible to utilize this cover.
g. In a Floater Policy, Switch Off Benefit can be availed only if all the Insured Persons travel outside India at the same time. The date of travel to abroad and return to India for all the Insured Members should be same to be eligible to utilize this cover.
h. In case of a Multi-Individual Policy, You can Switch Off the Policy for one or more members provided that the date of travel to abroad and return to India for those Insured Members is same to be eligible to utilize this cover.
i. This benefit can be utilized only once in a Policy Year irrespective of Policy type (Floater or Individual/ Multi-Individual).
j. You need to intimate Us at least 72 hours prior to the date of travel to switch off the policy. We would require the following details:
    a. Date and time of leaving India
    b. Date and time of your return to India
k. In case You arrive back to India earlier than the date informed to Us, then You need to intimate us at least 24 hours prior to the return travel to India in order to Switch On the Policy. If out of all members who travelled, only one or few members return to India earlier than the date informed to Us, then the Policy shall be switched on from the earliest date of return to India for all the members.
l. Your coverage shall be switched off and reactivated as per the details provided in clause (j) above subject to a maximum switch off period of 30 days. If the return to India is later than 30 days from the date of Switch off, the coverage shall be reactivated immediately after 30 days irrespective of your return.
m. We may require the following documents to record the date of your travel in order to Switch-Off and Switch-on the policy for You
    a. Flight tickets of the Insured members travelling to abroad
    b. Flight tickets of the Insured members travelling back to India
n. Your Policy coverage will be automatically activated based on the information pertaining to date of return provided to us or 30 days from the Switch Off date, whichever is earlier.

For the purpose of this benefit,

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

6. Wellness Program

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

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

Conditions under this benefit:

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

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

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

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

In a floater policy, the reward percentage would be divided as per the number of eligible Adults covered.

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

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

vi. Maximum reward points that can be earned in a single Policy Year will be limited to 20% of the premium paid (excluding premium for Optional covers, Riders and Taxes as applicable) in the existing Policy.

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

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

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

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

Annexure – A – Illustration of Healthy Life Management Program Rewards

Increase of Renewal Policy Year	**Policy Term - 1 year** (Premium indicated here is just for illustration purposes and may not be the actual premium.) Each earned reward point will be valued at 1 Rupee					
	Year	**Premium paid (Excluding optional cover, Rider and taxes as applicable)**	**Activity**	**No. of Days**	**Rewards %**	**Points Earned**
	Year 1	10000	6,000 - 7,999 steps / day	180 - 239 days	5%	500
	Total	10000				500

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

7. Discount from Network Providers

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

8. Premium Waiver Benefit

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

a) Cancer of Specified Severity
b) Myocardial Infarction (First Heart Attack of Specific Severity)
c) Open Chest CABG
d) Open Heart Replacement or Repair of Heart Valves
e) Coma of Specified Severity
f) Kidney Failure Requiring Regular Dialysis

g) Stroke Resulting in Permanent Symptoms
h) Major Organ/Bone Marrow Transplant

i) Permanent Paralysis of Limbs
j) Motor Neuron Disease with Permanent Symptoms
k) Multiple Sclerosis with Persisting Symptoms

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

IV. What are the Optional Packages?

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

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

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

A. Enhance Plus (Applicable for Protect Plan)

1. Maternity and New Born Hospitalization Expenses

a. Maternity Expenses

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

You understand and agree that:

(a) Our maximum liability per delivery or termination shall be restricted to the Maternity Sum Insured specified in the Policy Schedule.

(b) The female adult Insured Person should have been continuously covered under this Policy for at least 36 months before availing this benefit.

(c) The payment towards any admitted claim under this benefit for any complication arising out of or as a consequence of maternity or child birth will be restricted to Maternity Sum Insured specified in the Policy Schedule however any restored amount will not be available for coverage under this section.

(d) Pre or post natal Maternity Expenses will be covered within the Maternity Sum Insured under this benefit however; any Pre or Post-hospitalization Expenses under Section II.2 and II.3, above will not be applicable for this benefit.

(e) Maternity Sum Insured is 10% of Base Sum Insured Opted subject to a maximum of Rs 1 Lac in addition to the Sum Insured opted.

(f) Applicable Deductible under the applicable plan shall also apply to this benefit.

(g) We will not cover the following expenses under Maternity Benefit:

i) Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.

ii) Medical Expenses for ectopic pregnancy However, these expenses will be covered under the In-patient Hospitalization under Section II.1.

b. New Born Baby Expenses

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

maternity expenses.

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

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

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

c. First Year Vaccinations

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

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

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

Note: Our maximum cumulative liability under Section IV.A.1.i shall be restricted to the 'Maternity & New Born Hospitalization Expenses' Sum Insured specified in the Policy Schedule for any and all claims incurred under Maternity Expenses (IV.A.1.a), New Born Expenses (IV.A.1.B) and First Year Vaccinations (IV.A.1.C). Maximum amount of claim payout shall be based on the available Sum Insured of a given Policy Year basis the date of delivery.

2. Room Accommodation Upgrade

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

3. Health Maintenance Benefit

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

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

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

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

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

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

B. Assure

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

1. Room Accommodation Limit

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

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

2. Disease Specific Sub-limits

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

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

Wherever the above mentioned sub-limits are applied, co-payment for the treatment taken at higher zone as mentioned under section VI.vii shall also apply.

3. Modern and Advanced Treatments

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

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections

g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchial Thermoplasty
j. Vaporization of the 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 hematological conditions to be covered.

C. Enhance (Applicable for Advantage Plan)

1. Maternity and New Born Hospitalization Expenses

a. Maternity Expenses

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

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

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

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

The following expenses are not covered under maternity benefit:

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

b. New Born Baby Expenses

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

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

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

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

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

c. First Year Vaccinations

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

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

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

2. Room Accommodation Upgrade

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

D. Freedom

(Applicable for Protect and Advantage Plans)

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

1. Room Accommodation Upgrade

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

2. Worldwide Emergency Hospitalization with Outpatient Cover

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

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

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

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

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

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

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

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

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

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

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

2. Deductible

You can opt for a Deductible of ₹10,000 or ₹25,000 in the Policy. Wherever a Deductible is selected such amount will be applied for each Policy Year on the annual aggregate of all Claims in that Policy Year other than for claims under fixed benefit covers and Health Check Ups. Deductible shall apply to all sections other than V.4 Personal Accident Cover, II.13 Daily Cash for Shared Accommodation, II.12 Outpatient Expenses, Section III. Value added covers and Add On Riders if opted.

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

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

If the insured opts out from deductible at any renewal, a fresh waiting period will be applied for this enhanced limit from the effective date of such enhancement.

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

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

3. Infertility Treatment

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

a. IV.A 'Enhance Plus' or IV.C 'Enhance' Optional Package is opted and Sum Insured opted under the Policy is ₹7.5 lacs and above.

b. This cover is limited to IVF and/or IUI treatments.

c. The eligible Insured Person should have been continuously covered under this Policy for at least 36 months before availing this benefit.

d. The benefit shall be restricted to two successful procedures leading to conception during the lifetime of the

eligible Insured Person and the coverage shall terminate thereafter.

e. Sum Insured available under this section will be in addition to Maternity Sum Insured under Section IV.A.1 Maternity & New Born Hospitalization Expenses or IV.C.1 Maternity & New Born Hospitalization Expenses.

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

g. The cover shall automatically cease upon the eligible Insured Person attaining 60 years of age.

4. Personal Accident Cover:

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

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

For the purpose of this benefit,

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

The benefits as specified above will be payable provided that:

a. The Permanent Total Disablement is proved to Our satisfaction; and a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and

b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement of the Permanent Total Disablement; provided that We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

c. If We have admitted a claim for Permanent Total Disablement in accordance with this benefit, then We shall not be liable to make any payment under this benefit on the death of the Insured Person, if the Insured Person subsequently dies.

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

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

5. Cumulative Bonus Booster

We will provide a bonus of 50% of the opted Base Sum Insured post completion of each policy year up to a maximum of 200% of Base Sum Insured provided that the Policy is renewed with Us without a break.

a. No cumulative bonus will be added if the Policy is not renewed with Us by the end of the grace period. The Cumulative Bonus will not be accumulated in excess of 200% of the Sum Insured under the current Policy with Us.
b. Any accumulated Cumulative bonus booster shall be carried forward to subsequent policy years.
c. Claims made during a policy year under Cumulative bonus booster shall reduce the balance bonus amount available for the remainder of such Policy Year.
d. In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under section III.4 shall not be available, however all terms and conditions of the said section shall apply.

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

6. Add on -

A. ManipalCigna Critical Illness Add-on Cover

Along with this Product You can also avail the ManipalCigna Critical Illness Add On Cover. Please ask for the Terms & Conditions and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider including medical check-up requirement will apply.

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

B. ManipalCigna Prime Plus

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.

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

2 **Surplus Benefit:** Additional 100% of Base Sum Insured, available from day 1 for 1st claim only, in each policy year.

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

4 **Premium Management Cover:** Once opted below benefits shall not be available in Base product

a. Air Ambulance Cover
b. Bariatric Surgery Cover
c. Daily Cash for Shared Accommodation
d. Health Check Up
e. Domestic Second Opinion
f. Tele Consultation
g. Premium Waiver Benefit

5 **Women Care:** Coverage for Mammography, Cervical Cancer screening and PCOS/PCOD diagnostic tests

on cashless basis from MCHI network for women aged 18 years and above. The limit for the same is ₹10,000 per female insured.

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

Vi. What are Features of the Policy?

i). Eligibility

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

Coverage for children:

a. Children from 91 days to 17 years will only be covered if one of the parents is the proposer.
b. Children up to 25 years can be covered under the floater
c. Children beyond 25 years can be covered under an individual policy.

Renewals will be available for lifetime.

ii). Individual and Family Floater

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

a. In case of an Individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, lawfully wedded spouse, children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, uncle, aunty, nephew & niece.
b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, lawfully wedded spouse, children up to the age of 25 years or parents or parents-in-laws. A floater cover can cover a maximum of 2 adults and 3 children under a single policy.

iii). Policy Period option

You can buy the policy 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 different plans.

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

v). Discounts under the Policy

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

i. **Lifetime Discounts**

a. **Employee Discount**: 10% discount on the premium
b. **Standing Instruction Discount:** 3% discount on the renewal premium, if the renewal premium is received through standing instruction.

c. **Family discount:** A discount of 10% shall be applicable when the eldest insured member is below 60 years of age, and 20% when the eldest insured member is 60 years or above. This discount shall be applied at the policy level, irrespective of the policy type.

d. **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 - Health Check
b. III.2 - Domestic Second Opinion,
c. III.3 – Tele Consultation,
d. III.5 – Switch-off Benefit
e. III.6 - Wellness Program, and
f. III.7 - Discount from Network Providers

(ii) The No Claim Discount shall be applicable on the renewal premium, including premium of all optional covers/riders and any applicable loading, except for the ManipalCigna Critical Illness Add-on.

(iii) For floater policy, the discount shall be applied at the policy level and for individual/multi-individual policies, the No Claim Discount shall be applied individually at the insured person level.

ii. Short Term Discounts

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

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

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

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

vi). Underwriting Loading & Special Conditions

We may apply a risk loading on the premium payable (excluding statutory levis & taxes as applicable) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

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

We will inform You about the applicable risk loading or special condition through a counter-offer letter or through an electronic mode, as the case may be and We will only issue the Policy once We receive your consent and applicable 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, Optional Covers, Add-on Covers and Zone of Cover opted. Additionally the health status of the individual will also be considered.

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

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

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

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.

viii). Premium payment mode

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

In case of premium payment modes other than Single, 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). 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 Freedom optional package shall be renewed subject to the Insured Person being an Indian resident at the time of renewal.

b. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.

c. Renewals will not be denied except on grounds of misrepresentation, 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 as mentioned below shall be waived only up to the lowest Base Sum Insured of the last 36/24 consecutive months as applicable to the relevant waiting periods of the Plan opted.

j. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section VII (i) to VII (ix) will be applicable considering such Policy Year as the first year of Policy with the Company.

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

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

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

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

Grace Period of 15 days for Monthly mode and 30 days for Half-Yearly & Quarterly mode would be given to pay the instalment premium due for the Policy.

- 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 case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

i. NACH/Standing Instruction Mandate form is completely filled & signed by You.
ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.
iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.
iv. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/ Standing Instruction facility.
v. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy.

x). Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 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 diseases, Moratorium period etc. as per IRDAI guidelines on portability.

xi). 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).

xii).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.

xiii).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.

xiv).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 detailed 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 subject to moratorium clause, by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

xv). Endorsements

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

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

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

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

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

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

xvi).Redressal of Grievance

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

xvii). 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.

xviii).Migration

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

xix).Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

xx).Moratorium Period:

After completion of 60 continuous months of coverage (including Portability and Migration) in health insurance policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of 60 continuous months is called as moratorium period. The moratorium would be applicable for the Sums 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. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

xxi) 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.

Specific conditions applicable to revival of policy

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.

xxii) 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.

xxiii) 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)

xxiv) 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).

xxv) 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.

xxvi) 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.

VII. What are the Waiting Period and Exclusions?

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

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the applicable waiting period

   a. 24 months of continuous coverage from the date of commencement of coverage for Sum Insured ₹7.5 Lacs and above.

   b. 36 months of continuous coverage from the date of commencement of coverage for Sum Insured up to ₹5 Lacs.

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

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

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

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

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

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

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

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

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

f. List of specific diseases/procedures:

i. Cataract,

ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus or myomectomy for fibroids unless necessitated by malignancy,

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,

iv. Varicose Veins and Varicose Ulcers,

v. Stones in the urinary uro-genital and biliary systems including calculus diseases and complications thereof,

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region.

viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.

ix. gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,

x. Any surgery of the genito-urinary system unless necessitated by malignancy.

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

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

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

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

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

iv) Maternity Waiting Period

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

v) Personal Waiting Period

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

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

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

vii) Mental Illness Cover Waiting Period

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

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

viii) Bariatric Surgery Waiting Period

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

ix) Infertility Treatment Waiting Period

Any treatment taken for Infertility Treatment until 36 months of continuous coverage has elapsed for the particular Insured Person since selection of the Optional Cover V.3 Infertility Treatment.

x) Permanent Exclusions

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

1. Investigation & Evaluation- Code- Excl 04

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

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

2. Rest Cure, rehabilitation and respite care- Code- Excl 05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control: Code - Excl 06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe comorbidities

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

4. Change-of-Gender treatments: Code - Excl 07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex 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 - Excl 13**

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

12. **Refractive Error: Code - Excl 15**

    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13. **Unproven Treatments: Code - Excl 16**

    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. **Sterility and Infertility: Code - Excl 17**

    Expenses related to sterility and infertility. This includes:

    (i) Any type of contraception, sterilization

    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

    (iii) Gestational Surrogacy

    (iv) Reversal of sterilization

15. **Maternity: Code - Excl 18**

    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

    ii. Expense towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

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

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

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

20. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the 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 Emergency Hospitalization with Outpatient Cover under Freedom optional package if opted.

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

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

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

26. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

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

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

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

29. 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

VIII. How can I buy the Policy?

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

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

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

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.

IX. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy

b) Claim Process

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

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

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

For a Cashless Claim -

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

For a Reimbursement Claim -

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

- Claim Form Duly Signed
- Copy of Photo ID of Patient
- KYC documents (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment
- 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.
2	Day Care Treatment	
3	Donor Expenses	
	AYUSH Treatment	
5	Bariatric Surgery cover	

6	Worldwide Emergency Hospitalization with Outpatient Cover	• 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.
7	Pre – hospitalization	• Pharmacy Bills • Diagnostic tests reports in relation to admitted hospitalization expenses • Prescription in support of Pharmacy, Investigations
8	Post – hospitalization	
9	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
10	Road Ambulance	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance
11	Air Ambulance cover	• Original Bill as provided by Registered Ambulance Service Provider • Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/ Injury warrants the Insured Person's requirement for Air Ambulance
12	Maternity & New Born Hospitalization Expenses	• We may call for any additional documents/information as required based on the circumstances of the claim.
13	Health Maintenance Benefit	• Invoice/Hospital Bill • Investigation reports • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices
14	Infertility Treatment	Same as in-patient hospitalization
15	Personal Accident Cover	• In case of Accidental Death (AD) • Original treating Medical Practitioner's certificate describing • the disablement; • MLC/ FIR report, Post Mortem Report if applicable and conducted • Original Death certificate issued by the office Registrar of • Birth & Deaths • Occupation Certificate • Death summary issued by a Hospital along with the Injury event • Occupation Certificate • Last 3 months Salary Slips as at the time of the accident • Form 16 / ITR / P&L Statement • Identity proof of Nominee or Original Succession Certificate/ Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased

		• In case of Permanent Total Disablement (PTD) • MLC/FIR if applicable • Original treating Medical Practitioner's certificate describing the disablement along with the injury event; Occupation Certificate • Original Discharge summary from the Hospital; • Photograph of the Insured Person reflecting the disablement; • Prescriptions and consultation papers of the treatment; • Disability certificate issued by civil surgeon or equivalent • appointed by the District/State or Government Board. • Medical Practitioner's certificate confirming the injury, commencement date of the Injury, total duration of the disablement and an advisory for rest or unfit to work for specified number of days. • Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.

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 from the stipulated time for such submission. We will condone delay on merit for delayed Claims where the delay has been proved to be for reasons beyond Your/Insured Persons control.

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

X. What are the Plan wise Benefit Details?

The Plan wise benefit details are as mentioned below:

<table>
<tr><th>Title</th><th colspan="3">Description
Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief</th></tr>
<tr><th>Your Coverage Details:</th><th>Identify your Plan</th><th>Protect</th><th>Advantage</th></tr>
<tr><td rowspan="2">Basic Cover

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

	Pre - hospitalization	Medical Expenses Covered up to 60 days before date of hospitalization; Covered upto the Sum Insured	
	Post - hospitalization	Medical Expenses Covered up to 180 days before date of hospitalization; Covered upto the Sum Insured	
	Day Care Treatment	Covered up to the Sum Insured	
	Domiciliary Hospitalization (Treatment at Home)	Covered up to 10% of the Sum Insured Pre and Post Hospitalization Expenses: 30 days each	
	Road Ambulance (Reimbursement of Ambulance Expenses)	Covered up to the Sum Insured	
	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to the Sum Insured • Pre & Post Hospitalization expenses (Up to 30 days each) of the donor • Cost towards donor screening once in a Policy year for successful transplant • Complications arising during hospitalization or up to 30 days from date of discharge - Covered up to 25% of SI subject to maximum of ₹2 Lacs, Over and above Sum Insured. We will not cover expenses towards the Donor in respect of cost associated to the acquisition	
	Restoration (When opted Base Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, in addition to the Base Sum Insured Restoration shall not get triggered for the 1st claim	
	AYUSH Treatment	Benefit under this cover is payable Up to the opted Base Sum Insured or ₹ 10Lacs whichever is lower. The benefit is payable over and above the Sum Insured.	
	Air Ambulance cover	Benefit under this cover is payable Up to the opted Base Sum Insured or ₹ 5Lacs whichever is lower. Waiting Period of 36 months is applicable.	
	Bariatric Surgery cover	Covered up to the Sum Insured opted subject to maximum of ₹5 Lacs Waiting Period of 36 months shall apply for Bariatric Surgery	
	Outpatient Expenses	Not Available	Option to choose from - ₹20,000, ₹30,000, ₹50,000 Per policy Year Can be used to pay for Consultations and Diagnostics including Dental and Vision: Up to 100% of the Sum Insured opted for Outpatient benefit. Up to 20% of the Outpatient Limit can be used for Pharmacy (Drugs and Medicines prescribed by Medical Practitioners). This benefit is available only on cashless basis from the Network providers of ManipalCigna Health Insurance Company Limited. Any unutilized amount under this benefit shall not be carried forward to subsequent Policy Year.

	Daily Cash for Shared Accommodation	Daily Cash benefit for occupying shared accommodation while hospitalized, shall be covered as below:- a. For Base Sum Insured up to ₹10Lacs: ₹800 per day up to maximum of ₹5,600 b. For Base Sum Insured above ₹10Lacs: ₹1,000 per day up to maximum of ₹7,000 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	Health Check-Up	Available each policy year (including the first year), to all Adult insured persons who are 18 years or above of at the start of the policy year. • For Base Sum Insured up to ₹5 lacs: Package 1 subject to a maximum of up to ₹1000 per adult member • For Base Sum Insured above ₹5 lacs and up to ₹10 lacs: Package 2 subject to a maximum of up to ₹2500 per adult member • For Sum Insured above ₹10 lacs: Package 3 subject to maximum of up to ₹5000 per adult member Annually from 1st year onwards Annually from 1st year onwards. This benefit will not be available during the free look period of the Policy. The packages shall be offered on cashless basis only. However, the eligible insured may avail any health check from the MCHI Network of Health Check Up Center upto the limit specified
	Domestic Second Opinion	Available for 36 listed Critical Illnesses
	Tele-Consultation	Unlimited Tele-consultation during the Policy Year
	Cumulative Bonus	A guaranteed bonus of 25% of Base Sum Insured for every completed Policy Year, subject to a maximum accumulation up to 200% of the Base Sum Insured.
	Switch Off Benefit	The Policy can be Switched Off, after one year, any time during the Policy Year except for Personal Accident Cover, Worldwide Emergency Hospitalization with Outpatient Cover under Freedom optional package and ManipalCigna Critical Illness Add-On cover, if opted, in case you/ Insured Person travel out of India, for a period maximum up to 30 days. This benefit shall not be available for the last 90 days of the Policy Year. Premium discount shall be calculated on pro-rated basis if Policy is switched off due to Insured Person (in individual policy) or all Insured Persons (under floater policy) travelling out of India and this discount shall be adjusted in the renewal premium falling due immediately after the expiring Policy Period. The Policy will reactivate the cover Switch-On on the requested date of Switch On as intimated to Us by You/ Insured Person. The option to Switch Off the cover shall be available only once in a policy year and up to a maximum of 30 days at a stretch. This shall not deactivate the following cover, if opted: 1. Worldwide Emergency Hospitalization with Outpatient Cover under Freedom optional package 2. Personal Accident Cover 3. ManipalCigna Critical Illness Add-on Cover
	Wellness Program	Rewards can be earned by completing activities specified under Our Healthy Life Management Program up to maximum of 20% of expiring base Premium (excluding Premium for optional covers, Rider and taxes as applicable). 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. Carry forward of earned Reward Points shall not be allowed.

	Discount from Network Provider	Discount on Pharmacy, Diagnostics and Health Supplements offered by the Network Providers of ManipalCigna Health Insurance Company Limited	
	Premium Waiver Benefit	Waives off one year Policy Premium (including premium for optional covers, rider and taxes 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 Packages This section lists the available optional packages under your plan and the limits under each of these options. The limits specified under these optional packages shall override the applicable limits mentioned as part of base cover for the respective coverages.	Enhance Plus	1. Maternity & New Born Hospitalization Expenses a. Maternity Cover (up to maximum 2 deliveries or terminations) - Covered up to 10% of Base Sum Insured Opted subject to a maximum of ₹1 Lac in addition to the Sum Insured opted b. New Born Baby - Coverage for the In-patient hospitalization expenses of a new born up to the limit provided under Maternity Expenses c. First Year Vaccination Covered as per national immunization program, up to the limit provided under Maternity Expenses	Not Available
		2. Room Accommodation upgrade The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to "Any Room Category" in a Hospital.	
		3. Health Maintenance Benefit Up to ₹3000 per Policy Year. Reimbursement of the Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on an Out Patient basis for: i. Consultation with Medical Practitioner, Diagnostic tests, preventive tests, drugs, prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), prescribed by the specialist Medical Practitioner. ii. Towards Dental Treatments and AYUSH forms of Medicines wherever prescribed by a Medical Practitioner.	

<table>
<tr>
<td></td>
<td>Assure
(Applicable for Sum Insured ₹3 Lacs, ₹4 Lacs and ₹5 Lacs)</td>
<td>
i. Room Accommodation Limit
Room Rent - Up to 1% of Base Sum Insured per day. ICU - Up to 2% of Base Sum Insured per day.

ii. Disease Specific Sub-limits
<table>
<tr><td>Sum Insured</td><td>₹3 and ₹4 Lacs</td><td>₹5 Lacs</td></tr>
<tr><td>Treatment for each Ailment/ Procedure mentioned below:
1. Surgery for treatment of all types of Hernia
2. Hysterectomy
3. Surgeries for benign Prostate Hyper trophy
4. Surgical treatment of stones of renal system</td><td>₹50,000</td><td>₹65,000</td></tr>
<tr><td>Treatment of Cataract (Per Eye)</td><td>₹20,000</td><td>₹30,000</td></tr>
<tr><td>Treatment of Total Knee replacement (Per knee)</td><td>₹80,000</td><td>₹1,00,000</td></tr>
<tr><td>Treatment for breakage of bones</td><td>₹2,00,000</td><td>₹2,50,000</td></tr>
</table>
Wherever the above mentioned sub-limits are applied, co-payment for the treatment taken at higher zone as mentioned under section VI.vii shall also apply.

iii. Modern and Advanced Treatments Covered Up to 10% of Sum Insured
</td>
<td></td>
</tr>
</table>

<table>
<tr><td></td><td rowspan="2">Enhance</td><td rowspan="2">Not Available</td><td>1. Maternity & New Born Hospitalization Expenses
a. Maternity Cover (up to maximum 2 deliveries or terminations) - Covered up to 10% of Base Sum Insured Opted subject to a maximum of ₹1 Lac in addition to the Sum Insured opted
b. New Born Baby - Coverage for the In-patient hospitalization expenses of a new born up to the limit provided under Maternity Expenses
c. First Year Vaccination Covered as per national immunization program, up to the limit provided under Maternity Expenses</td></tr>
<tr><td></td><td>2. Room Accommodation upgrade The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to “Any Room Category” in a Hospital.</td></tr>
<tr><td></td><td rowspan="2">Freedom (Applicable to Indian Residents only)</td><td colspan="2">1. Room Accommodation upgrade
The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to “Any Room Category” in a Hospital.</td></tr>
<tr><td></td><td colspan="2">2. Worldwide Emergency Hospitalization with Outpatient Cover
Covered up to Sum Insured opted for Emergency In-patient Hospitalization or Emergency Outpatient outside India.
Any claim payable under this benefit is over and above the Sum Insured.</td></tr>
</table>

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

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

** Supreme Bonus can be opted only when Cumulative Bonus Booster optional cover is not opted.

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