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MANIPALCIGNA SARVAH - UTTAM

(PROSPECTUS)

What are the Key Highlights of the Policy?

BASE COVERS

- In-patient Hospitalization
- Day Care Treatment
- Pre-hospitalization Medical Expenses
- Post-hospitalization Medical Expenses

OPTIONAL COVERS

- Personal Accident Cover
  - Accidental Death (AD)
  - Permanent Total Disablement (PTD)
  - Permanent Partial Disablement (PPD)
- Temporary Total Disablement (TTD)
- Health Check Up
- Air Ambulance
- Restoration
- Gullak (Guaranteed Cumulative Bonus)
- Sarathi
- Room Rent Modification
  - Any Room
  - Twin Sharing AC Room
- Maternity & New Born Hospitalization Expenses
  - Maternity Expenses
  - New Born Baby Expenses
  - First Year Vaccinations
- Sarathi 2.0
- Domiciliary Hospitalization
- Road Ambulance
- Donor Expenses
- AYUSH Treatment
- Surplus Benefit
- Shakti
- Anant
- Deductible
  - Aggregate Deductible
  - Daily Deductible
- Voluntary Co-Payment
- Extension of specific Disease Waiting Period
- Coverage for Non-Medical Items and Durable Medical Equipment's
  - Non-Medical Items
  - Durable Medical Equipment
- Personal Accident Plus

VALUE ADDED COVERS

- Tele-Consultation
- Wellness Program
- Discount from Network Providers

ADD-ON/RIDER COVER

- ManipalCigna Health 360-OPD

What are the Basic covers?

1. **In-Patient Hospitalization**

We will indemnify the medical expenses of an Insured Person upto the Sum Insured in the event of medically necessary hospitalization arising from an 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 is within the Policy Year. The coverage will include reasonable and customary charges towards room rent for accommodation in a hospital room up the category specified in Policy Schedule, Intensive Care Unit (ICU) accommodation charges, operation theatre charges, fees of medical practitioner and Surgeon, anaesthetist, qualified nursing charges, 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 this policy is limited up to Single Private AC Room (unless otherwise specified in the Policy Schedule), subject to the maximum Sum Insured. For ICU accommodation, expenses will be covered up to the Sum Insured.

If the Insured Person is admitted to a room category higher than that specified in the Policy Schedule, the Policyholder/Insured Person shall bear a proportionate share of the total Associated Medical Expenses (including surcharge or taxes as applicable). This proportion will be calculated based on the difference between the entitled room rent and the room rent actually incurred.

Under In-patient Hospitalization, when availed as In-patient Care, we will indemnify the expenses for artificial life maintenance, including the use of life support machine, even when such treatment does not result in recovery or restoration of the insured person's previous state of health, unless the insured person is in a vegetative state, as certified by the treating Medical Practitioner.

The following Modern and Advance procedures will be indemnified (wherever medically indicated) either as In-patient or Day Care Treatment in a Hospital, up to the limit specified in the Policy Schedule within 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. 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.

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), AIDS Related Complex (ARC), any mutant derivative or variations thereof, and Sexually

Transmitted Diseases (STD), up to the Sum Insured specified in the Policy Schedule. Such coverage will be 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 such Hospitalization must be certified by an authorized Medical Practitioner.

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 Mental illness or a medical condition impacting mental health, up to the Sum Insured specified in the Policy Schedule, within a Policy Year. Such coverage will be 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 must 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. Day Care Treatment

We will indemnify the medical expenses incurred for an Insured Person in the event of medically necessary day care treatment or surgery that requires less than 24 hours of hospitalization due to advancement in medical technology. Such treatment must be undertaken in a Hospital, Nursing Home or Day Care Centre on the recommendation of a medical practitioner. We will not cover any OPD Treatment and diagnostic service under this benefit. Coverage will also include pre- hospitalization and post hospitalization medical expenses as specified in Policy Schedule.

3. Pre-hospitalization Medical Expenses

We will reimburse, Pre-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 90 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.1. 'In-patient Hospitalization' or 'Day Care Treatment' under section II.2 and is related to the same illness/injury and if the Pre-hospitalization Medical expenses are

incurred during a Policy Year.

4. Post-hospitalization Medical Expenses

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 as 'Day Care Treatment' under section II.2 and expenses are related to the same illness/condition.

5. Domiciliary Hospitalization

We will reimburse medical expenses of an Insured person, up to the Sum Insured, for the treatment of an illness or injury that would normally require hospitalization but is instead treated at home on the advice of the attending Medical Practitioners, where the Insured person's condition did not allow a transfer to hospital or a hospital bed is unavailable, provided that the condition requires continues treatment for at least 3 days. Claims for Pre-hospitalization Medical Expenses if incurred during the Policy Period and Post-hospitalization medical expense are covered up to 30 days each. We shall not be liable under this policy for any claim in connection with or in respect of the following:

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

6. Road Ambulance

We will reimburse the reasonable and customary expenses incurred for road transportation of an Insured person by registered healthcare or ambulance service provider to the nearest hospital for the treatment of an illness or injury covered under the Policy in case of emergency. The coverage will be up to the Sum Insured as specified in Policy Schedule. This benefit will be applicable per hospitalization, and the necessity must be certified by the attending Medical Practitioner.

7. Donor Expenses

Under donor expenses we cover the following

A. Organ Harvesting Expenses

We will indemnify In-patient Hospitalization Medical Expenses incurred during the Policy Period, upto the Sum Insured, in respect of organ harvesting from the donor where an Insured Person shall be the recipient, subject to the following conditions:

i. The organ donor shall be any person permitted in accordance with the provisions of the Transplantation of Human Organs Act, 1994, as amended from time to time, and other applicable laws, rules, and regulations, provided that the organ is donated for the use of the Insured Person who has been medically advised to undergo an organ transplant.
ii. A claim must be admitted as 'In-Patient Hospitalization' under section D.I.1 of this policy in respect of the Insured Person.

B. Organ Donor Medical Expenses

We will also reimburse the below listed Medical Expenses upto the Sum Insured if incurred during the Policy Period in respect of the organ donor due to organ harvesting:

i. Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses incurred, only during the immediate 30 days prior to admission and only during the immediate 30 days post discharge from the hospital.

C. Organ Donor Complication Support

We will reimburse the below listed Medical Expenses incurred during the Policy Period, in respect of the Organ Donor, for complications arising due to organ harvesting occurring during hospitalisation or within 30 days from the date of discharge of the donor. Such expenses shall be covered upto an additional benefit limit amounting to 25% of the Base Sum Insured subject to a maximum of ₹2Lac in a policy year. This shall be an independent limit over and above the Sum Insured. This limit shall replenish post completion of every policy year.

D. Donor Screening Expenses

We will reimburse medical expenses upto the Sum Insured if incurred during the Policy Period on donor screening for the organ transplant surgery wherein an Insured was the recipient. Such expenses shall be paid only for the donor whose organ was harvested. Claim under Donor Screening Expenses shall be paid only if the organ transplant surgery is successful and only for one such incidence in a policy year.

Note:
We shall not cover any expenses towards the cost of acquisition of the organ from the donor.

8. AYUSH Treatment

We will indemnify the Medical Expenses incurred during the Policy Year, up to the Sum Insured as specified in the Policy Schedule, for an Insured Person in the event of Medically Necessary Treatment taken for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided such treatment is undertaken in an AYUSH Hospital.

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

- Expenses incurred on facilities and services availed for purpose of pleasure, rejuvenation or as a preventive aid, including but not limited to beauty treatments, Panchakarma, purification, detoxification and rejuvenation therapies.

III. What are the Value Added Covers?

1. Tele-Consultation

Insured Person may avail unlimited tele-consultations with our network General Physician in India during the policy year.

For the purpose of this benefit, tele-consultation shall mean a consultation provided by a Medical Practitioner through various communication mode, including but not limited to telephone, videocall or online chat.

2. Wellness Program

You can earn reward points by participating in Our Healthy Life Management Program. By completing the required number of steps per day, as specified in the table below that will help you to improve your overall well-being while also earning reward points.

Healthy Life Management Program - Rewards Structure				
	No. of steps			
No. of days	**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 must fall within the first nine (9) months of each Policy Year. Activities undertaken during the last three (3) months of the Policy Year will not be considered for reward calculation.

ii. In an individual policy, this wellness program is available only for the Insured Person(s) aged 18 years or above.

iii. In a floater policy, this wellness program shall be available only to the adult members and not to dependent children.

iv. In an Individual Policy with one or more members, earning of reward points will be at the member level, where each eligible member may earn up to 20% of their respective expiring base premium subject to the applicable terms and conditions. In a floater policy, earning of reward points will be at the policy level, where all eligible members cumulatively may earn a maximum of 20% of the expiring base premium, subject to the applicable terms and conditions.

v. In a floater policy the above reward percentage will apportioned among the eligible Adult Insured members as per the illustration below.

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

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

vii. The 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 other than 'Deductible' under section IV.13, 'Voluntary Co-Payment' under section IV.14 and Twin sharing AC room option of 'Room Rent Modification' under section IV.9, 'Extension of Specific Disease Waiting Period' under Section IV.16 riders and taxes as applicable) in the existing Policy. In the case of 2 or 3 year policies, the maximum reward points that can be earned shall not exceed 20% of the total premium paid (excluding premium for Optional covers other than 'Deductible' under section IV.13, 'Voluntary Co-Payment' under section IV.14 and Twin sharing AC room option of 'Room Rent Modification' under section IV.9, 'Extension of Specific Disease Waiting Period' under Section IV.16 riders and taxes as applicable) for 2 years or 3 years as applicable.

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

ix. Earned reward points may be utilized only as a discount against the renewal premium due immediately after accrual. Carry forward of unused reward points shall not be allowed.

x. Redemption of reward points against renewal premium shall be available only at the time such

renewal is due. Any earned reward points not utilized 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

<table>
<tr><td rowspan="11">Reduction of Renewal Policy Year</td><td colspan="6">Policy Term - 3 years
(Premium indicated here is just for illustration purposes in case of 1 Adult policy and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee</td></tr>
<tr><td>Year</td><td>Premium (Excluding optional covers/ Rider and taxes as applicable)</td><td>Activity</td><td>No. of Days</td><td>Reward %</td><td>Reward Points Earned</td></tr>
<tr><td>Year 1</td><td>10000</td><td>10,000 and above steps/day</td><td>240 days and above</td><td>20%</td><td>2000</td></tr>
<tr><td>Year 2</td><td>11000</td><td>8,000 - 9,999 steps/ day</td><td>240 days and above</td><td>15%</td><td>1650</td></tr>
<tr><td>Year 3</td><td>12000</td><td>6,000 - 7,999 steps/ day</td><td>240 days and above</td><td>10%</td><td>1200</td></tr>
<tr><td>Total</td><td colspan="4">33000</td><td>4850</td></tr>
<tr><td colspan="6">The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium
Renewal of Policy as per below table</td></tr>
<tr><td>If Renewed Policy Term is</td><td>Renewal Premium (Excluding optional covers, Rider and taxes as applicable)</td><td colspan="2">Reward discount utilized</td><td colspan="2">Renewal Premium Payable after adjusting Reward discount</td></tr>
<tr><td>1 Year Policy</td><td>13000</td><td colspan="2">1617 (4850*1/3 as Insured is renewing 3 Year policy to 1 Year Policy)</td><td colspan="2">11383</td></tr>
<tr><td>2 Years Policy</td><td>27000</td><td colspan="2">3233 (4850*2/3 as Insured renewing 3 Year policy to 2 Year Policy)</td><td colspan="2">23767</td></tr>
<tr><td>3 Years Policy</td><td>42000</td><td colspan="2">4850 (Insured renewing to the same policy tenure of 3 years)</td><td colspan="2">37150</td></tr>
<tr><td rowspan="4">Increase of Renewal Policy</td><td colspan="6">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</td></tr>
<tr><td>Year</td><td>Premium paid (Excluding optional cover, Rider and taxes as applicable)</td><td>Activity</td><td>No. of Days</td><td>Rewards %</td><td>Points Earned</td></tr>
<tr><td>Year 1</td><td>10000</td><td>6,000 - 7,999 steps/ day</td><td>180 - 239 days</td><td>5%</td><td>500</td></tr>
<tr><td>Total</td><td>10000</td><td></td><td></td><td></td><td>500</td></tr>
</table>

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium **Renewal of Policy as per below table**			
If Renewed Policy Term is	Renewal Premium (Excluding optional cover, Rider and taxes as applicable)	Rewards discount utilized	Renewal Premium Payable after adjusting Rewards Discount
1 Year Policy	11000	500 (as Insured is renewing 1 Year policy to 1 Year Policy)	10500
2 Year Policy	21000	500 (as Insured is renewing 1 Year policy to 2 Year Policy)	20500
3 Year Policy	33000	500 (as Insured is renewing 1 Year policy to 3 Year Policy)	32500

Notifications related to the wellness program shall be communicated to the Policyholder via SMS, email and the program- specific mobile phone/ web application. Details of accrued reward points will be made available through the Mobile app (if any) or shall be communicated through SMS and/or reflected in the Renewal Notice issued to the customers.

3. Discount from Network Providers

The Insured Person shall be entitled to avail discounts on diagnostics, pharmacy and health supplements when availed through our Network Providers.

IV. What are the Optional Covers?

1. Personal Accident Cover

If an Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in death or disablement of the insured person within 365 days from the date of Accident then we shall pay for

i. Accidental Death
ii. Permanent Total disablement
iii. Permanent Partial disablement

Specific conditions applicable to Personal Accident Cover

i. In the lifetime of this policy, our maximum liability in respect of an Insured Person under Personal Accident Cover (which includes AD, PTD and PPD) shall never exceed
   a. 200% of the Benefit Amount applicable to the Insured Person in case even a single claim is related to an injury in a common carrier OR
   b. 100% of the Benefit Amount applicable to the Insured Person if not a single claim is related to an injury in a common carrier
ii. Selection of this cover will be available at member level on individual basis.
iii. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial Disablement shall be payable only in respect of accident occurring within India
iv. If the Policy Schedule states that non-earning spouse and/or dependent children or dependent parents or dependent parent-in-law of the Proposer are covered under this Optional Cover, then their coverage amount may be restricted to:
   a. For non-earning spouse/live-in partner: 60% of the coverage amount chosen for the

Proposer/earning Insured.

b. For per dependent child/dependent parents/dependent parent-in-law: 30% of the coverage amount chosen for the Proposer/earning Insured, subject to maximum of ₹30 Lacs.

v. All claims under this benefit can be made as per the process defined under section G.I.5.

1.1. Accidental Death

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in the death of the Insured Person within 365 days from the date of the Accident, We will pay:

- 100% of the opted benefit amount as specified in the Policy Schedule. OR
- 200% of the opted benefit amount if occurs while the Insured Person was a fare-paying passenger on a common carrier.

Upon payment of a claim under Accidental Death benefit, the entire Personal Accident cover shall automatically terminate for that Insured Person.

1.2. Permanent Total Disablement (PTD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Total Disablement as defined in the table below within 365 days from the date of the Accident, We will pay:

- 100% of the opted benefit amount as specified in the Policy Schedule, Or
- 200% of the opted benefit amount if the injury occurs while the Insured Person was a fare-paying passenger on a common carrier.

Type of Permanent Total Disablement
i. Total and irrecoverable loss of sight of both eyes
ii. Loss by physical separation or total and permanent loss of use of both hands or both feet
iii. Loss by physical separation or total and permanent loss of use of one hand and one foot
iv. Total and irrecoverable loss of sight of one eye and loss of a Limb
v. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
vi. Total and irrecoverable loss of hearing of both ears and loss of speech
vii. Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
viii. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment, occupation, or business for remuneration or profit, resulting in "Loss of Independent Living" (Refer section C.II.15 of Policy Wording)

For the purpose of this benefit:

- **"Limb"** means a hand at or above the wrist(towards the arm) or a foot above the ankle.
- **"Physical separation of one hand or foot"** means separation at or above wrist (towards the arm) and/or at or above ankle, respectively.

The benefits specified above will be payable provided that:

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

b. The Permanent Total Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.

c. If the Insured Person dies before a claim has been admitted under this benefit, no amount will be payable under this benefit. However, a claim may be payable under 'Accidental Death' (Section

IV.1.1), provided coverage under that section applies and intimation of death has been given to Us.

d. Once a claim has been accepted and paid under this benefit, the entire Personal Accident cover shall immediately and automatically terminate for that Insured Person.

1.3. Permanent Partial Disablement (PPD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Partial Disablement as defined in the table below within 365 days from the date of the Accident, We will pay the corresponding percentage of the benefit amount as specified in the table below:

Table of Benefits	Percentage of Benefit amount payable
i. Total and irrecoverable loss of sight of one eye	50%
ii. Loss of one hand or one foot	50%
iii. Loss of all toes - any one foot	10%
iv. Loss of toe great - any one foot	5%
v. Loss of toes other than great, if more than one toe lost, each	2%
vi. Total and irrecoverable loss of hearing in both ears	50%
vii. Total and irrecoverable loss of hearing in one ear	15%
viii. Total and irrecoverable loss of speech	50%
ix. Loss of four fingers and thumb of one hand	40%
x. Loss of four fingers	35%
xi. Loss of thumb-both phalanges	25%
xii. Loss of thumb - one phalanx	10%
xiii. Loss of index finger - three phalanges - two phalanges - one phalanx	10%, 8%, 4%
xiv. Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	6%, 4%, 2%
In case of PPD, the percentage payout shall remain same (no 2x payout) irrespective of whether the Injury was sustained in a common carrier or not.	

The benefits specified above will be payable provided that:

a. The Permanent Partial Disablement is proven; and is supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by the District/State or Government Board; and

b. The Permanent Partial Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement

c. If the Insured Person dies before a claim has been admitted under this benefit, no amount will be payable under this benefit; however, a claim may be payable under 'Accidental Death' under section IV.1.1, provided coverage under that section applies and intimation of death has been given to Us.

d. In case the Insured Person suffers a loss not specifically mentioned in the Permanent Partial Disablement Table, Our medical advisors will determine the degree of disablement and the payable amount, if any.

e. The total amount payable in respect of more than one disablement due to the same Injury is arrived at

by adding together the various percentages of Benefit Amount shown in the Permanent Disablement Table. The cumulative sum in such cases shall be capped at 100%.

f. If in a policy year we pay a claim equal to 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, the entire Personal Accident cover shall automatically terminate for the respective Insured Persons.

g. If in a policy year we pay a claim of less than 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for a particular Insured Person, then at the end of such Policy Year only the remaining Benefit Amount shall replenish from the next policy year onwards under Personal Accident cover. In such an event the eligible premium of Personal Accident cover shall be paid in full. For any claims that arise in the subsequent policy years under Personal Accident cover, the benefit percentage amount shall be applied on the original benefit amount and shall be deducted from the Benefit amount that was remaining.

Specific Exclusions applicable to Personal Accident Cover (includes AD, PTD and PPD)

a. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including 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, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority

b. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof

c. Involvement of Insured person in any unlawful/Criminal activity.

d. Intentional self-injury or attempted suicide.

e. Any Injury sustained while working, storing or transporting explosives.

f. Injury caused due to
   i. Insect bites or
   ii. Animal bites or
   iii. Animal attacks or
   iv. Serpant (snake) bites or attacks

g. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.

h. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand

i. Claims arising out of Non-accidental Injuries

j. Injuries emanating from participation in Adventure Sports (Hazardous Sports, action sports, aggro sports, extreme sports or any such name) irrespective whether the Insured Person is trained or not and also irrespective whether the Insured is a professional or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighing / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving,

gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, luging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkeling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weightlifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

2. Temporary Total Disablement (TTD)

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and such injury results in the Temporary Total Disablement of the Insured Person within 7 days immediately after the Accident, We will pay a fixed benefit amount as specified in the Policy Schedule on a per week basis until the Temporary Total Disablement persists..

Such disablement must be certified by the treating Medical Practitioner, Civil Surgeon or an equivalent authority appointed by the District/State or Government Board where in the medical practitioner also recommends that the Insured Person must be confined to bed

The commencement date and end date of the Temporary Total Disablement must be as certified in writing by the treating Medical Practitioner

Claim payments under this benefit shall stop at the earliest of the below dates:

A. date the Insured Person returns to work (even modified duties / alternate work / remote work), OR
B. date the Insured Person is certified fit to resume any gainful work by Treating Medical Practitioner OR
C. Expiration of 100 weeks calculated from the date of commencement of the Temporary Total Disablement
D. Death of the Insured Person

Specific Conditions applicable to Temporary Total Disablement

i. The TTD benefit can only be opted if the 'Personal Accident Cover' (Section D.III.1) OR 'Personal Accident Plus' (Section D.III.18) is opted.
ii. The TTD benefit can be opted only by earning members earning members residing in India.
iii. Claims under Total Temporary Disablement shall be payable only in respect of accidents occurring within India.
iv. We shall not be liable to make payments under this benefit for more than a total of 100 weeks in respect.

of any one Injury, calculated from the date of commencement of the Temporary Total Disablement.

v. If the Insured Person is disabled for part of the week, then only a proportionate part of the weekly benefit.
will be payable for such week.Example: If an Insured Person has opted for a Weekly Benefit of ₹70,000 and suffers Temporary Total Disablement (TTD) for a period of 10 days and 23 hours, the benefit shall be payable as follows:

- **First 7 completed days (1 full week):**
  The entire weekly benefit of ₹70,000 shall be payable.
- **Remaining period after the first week:**

After completion of the first 7 days, the TTD continues for 3 additional completed days.
The weekly benefit shall be calculated on a per-day proportionate basis for these days.

- Per-day benefit = ₹70,000 ÷ 7 = ₹10,000 per day
- Benefit for next 3 completed days = 3 × ₹10,000 = ₹30,000
- The remaining 23 hours shall not be considered, as under this benefit payment shall only be made for completed days.

vi. At the time of the Accident, the Insured Person must be an earning member and must provide adequate documentary proof of the same.

vii. TTD must be continuous. Any break, improvement allowing work, or return to work (even partial/alternate) ends the payable period.

viii. In case there is a change in occupation of any Insured Person post inception of this benefit, the same should be communicated to us in writing at the immediate upcoming renewal.

ix. All claims under this benefit must be intimated to Us within the 14 days post the date of Accidental Injury leading to a claim under this benefit

x. All claims under this benefit can be made as per the process defined under section G.I.5.

Specific Exclusions applicable to Temporary Total Disablement

a. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including 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, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority

b. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof

c. Involvement of Insured person in any unlawful/Criminal activity.

d. Intentional self-injury or attempted suicide.

e. Any Injury sustained while working, storing or transporting explosives.

f. Injury caused due to
   i. Insect bites or
   ii. Animal bites or
   iii. Animal attacks or
   iv. Serpant (snake) bites or attacks

g. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.

h. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand.

i. Claims arising out of Non-accidental Injuries.

j. This benefit shall not be payable to any insured person who was not an earning member in India as on the date of the Injury.
k. For salaried Insured Persons, claim shall not be payable if relevant documentary proof substantiating absenteeism / cessation of work is not provided
l. We shall not be liable to pay a claim under this benefit if injury sustained is not detectable by means of clinical examination, radiological scanning and imaging and/or neurological fall out testing.
m. We will not pay for sprains, stress fractures, pain or hairline fractures of any kind.
n. Injuries emanating from participation in Adventure Sports (Hazardous Sports, action sports, aggro sports, extreme sports or any such name) irrespective whether the Insured Person is trained or not and also irrespective whether the Insured is a professional or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighing / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving, gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, luging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkeling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weight lifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

3. Health Check-up

We will provide a Health Check-Up to all Insured Persons covered as adults under this policy (excluding dependent children in floater policy), as per eligibility table specified below. Health Check-Ups will be made available irrespective of claim status under the Policy and shall be arranged by us at our Network Providers.

In the case of an individual policy covering more than one member, upon each member attaining 18 years of age, they become eligible for a health check-up with our Network Provider.

Health Check Up				
			List of tests - Cashless	
Package	**Base Sum Insured**	**Age group**	**Compulsory Tests**	**Optional Tests (Any one)**
1	₹5 Lacs	Upto 40 Years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring – ECG or B2 - Liver screening - SGOT and SGPT
		Above 40 years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring – ECG or B2 - Liver screening - SGOT and SGPT or B3 - Thyroid Screening - Thyroid profile or B4 - Diabetes screening - HbA1c
2	₹7.5 Lacs, ₹10 Lacs,	Upto 40 Years	BUN, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH Liver Function Test, Kidney Function Test, Serum Calcium	
		Above 40 years	ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, HbA1c, Liver Function Test, Kidney Function Test, Serum Calcium, PSA (for Males),), Serum Calcium	
3	> ₹10 Lacs	Upto 40 Years	FBS, Kidney Profile with electrolytes, ECG, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, , Vitamin D3, Vitamin B12, Serum Calcium	
		Above 40 years	FBS, ECG, HbA1C, Kidney Profile with electrolytes, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, PSA, Vitamin D3, Vitamin B12, CA 125	

Full explanation of Tests is provided here:

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

Note:

i. This benefit is available once in every Policy Year, including the first Policy Year.
ii. All tests must be undertaken on the same date.
iii. Copies of all reports will be provided to You.
iv. Health check-up will be covered on a cashless basis only.
v. This benefit will not be available during the free look period of the Policy.

4. Air Ambulance

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. The Air Ambulance is used an Emergency i.e., a life-threatening health condition of the Insured Person requiring immediate and rapid transportation to a Hospital or a medical centre that ground transportation is inadequate,
ii. The Illness/ Injury causing the Emergency is covered under Section II.1 'In-patient Hospitalization',
iii. The transportation is provided by a medically equipped aircraft capable of in-flight medical care including but not limited to ventilators, ECG monitors, CPR equipment, stretchers, and other monitoring/treatment devices;
iv. Restoration shall not apply to this benefit.
v. The Air Ambulance service is provided by a Registered Ambulance service provider,
vi. The treating Medical Practitioner certifies in writing that the Insured Person's Illness/Injury necessitates Air Ambulance,
vii. Payment under this cover is admissible only if a claim is payable under Section II.1 'In-patient Hospitalization' for the same Illness/Injury.

The benefit is payable up to the limits specified in the Policy Schedule, subject to a maximum of ₹10 Lacs in a Policy Year and is payable in addition to the Base Sum insured.

What is not covered: Expenses incurred for return transportation of the Insured Person's to their home by air ambulance are not covered.

5. Restoration

We will provide a 100% restoration of the Base Sum Insured any number of times in a Policy Year, whether unrelated or the same illness/condition and injury, subject to followings:

i. Restoration shall trigger only if the Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak, if opted and earned), is insufficient due to previous claims in the same Policy Year.
ii. The Restored amountwill apply only to future claims payable under Section II and will not apply to the first admissible claim in the Policy Year. Restoration shall be available only for:
    - Section II.1 'In-patient Hospitalization'
    - Section II.2 'Day Care Treatment'
    - Section II.3 'Pre-Hospitalization Medical Expenses'
    - Section II.4 'Post-Hospitalization Medical Expenses'
    - Section II.6 'Road Ambulance'
    - Section II.7 'Donor Expenses'
    - Section II.8 'AYUSH Treatment'
    - Section IV.15 'Coverage for Non-Medical Items and Durable Medical Equipment' (if opted).
iii. The Restored amount will not be considered for calculation of the Guaranteed Cumulative Bonus (Gullak if opted).
iv. Restoration 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.
v. Under a Floater Policy, the Restored amount shall also apply on a floater basis.
vi. Any unutilized Restored amount will not be carried forward to subsequent Policy Years.
vii. For any single claim in a Policy Year, the maximum claim payable shall be the sum of
    a) Base Sum Insured
    b) Guaranteed Cumulative Bonus (Gullak if opted and earned)
    c) Surplus Benefit (Applicable for 1st Claim if opted) / Shakti (if opted)
    d) Restoration (if opted)

6. Gullak (Guaranteed Cumulative Bonus)

On completion of each Policy Year, we shall provide 100% of the Base Sum Insured as Bonus irrespective of claims made during the expiring Policy Year. Such Bonus shall be provided only if the Policy is renewed with Us without any break.

Note:

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

ii. The total accumulated Gullak (Guaranteed Cumulative Bonus) shall not exceed 1500% of the Base Sum Insured under the Current Policy under any circumstances.

iii. Any Gullak (Guaranteed Cumulative Bonus) accrued for a Policy Year will be credited at the end of that Policy Year if the Policy is renewed with Us within the Grace period. It will be available for claims made in the subsequent Policy Year.

iv. Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and are renewed on a Family Floater basis, the Gullak (Guaranteed Cumulative Bonus) carried forward to the renewed policy shall be the lowest percentage applicable to the lowest Base Sum Insured amongst all expiring polices merged.

v. Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and renew by splitting the Base Sum Insured in to two or more Family Floater/Individual policies, the Gullak (Guaranteed Cumulative Bonus) shall be apportioned proportionately to the Base Sum Insured of each Renewed Policy.

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

vii. Increase in Base Sum Insured: If the Base Sum Insured is increased at Renewal, the Gullak (Guaranteed Cumulative Bonus) will be calculated on the Base Sum Insured of the last completed Policy Year.

viii. If You opt out of this Optional Cover at the time of Policy renewal, the accumulated Gullak (Guaranteed Cumulative Bonus) under the expiring Policy shall be forfeited.

ix. This Gullak (Guaranteed Cumulative Bonus) shall not be available for claims made for Value Added Covers (Section III), for coverage under section IV.1 ‘Personal Accident Cover’ if opted, coverage under section IV.2 Total Temporary Disablement (TTD) if opted, coverage under section IV.4 ‘Air Ambulance Cover’ if opted and coverage under section IV.7 ‘Maternity & New Born Hospitalization Expenses’ if opted, coverage under Section IV.18 ‘Personal Accident Plus’ if opted.

7. Maternity & New Born Hospitalization Expenses

7.1. Maternity Expenses

We will cover Maternity Expenses up to the Maternity Sum Insured as specified in the Policy Schedule for the delivery of a child and/or Maternity Expenses incurred during the Policy Year, related to a Medically Necessary and lawful termination of pregnancy, subject to a maximum of 2 deliveries or terminations during the lifetime of an Insured Person with Us.

You understand and agree that:

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

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

iii. In case the Policy is migrated (i.e. transferred from another health insurance product/plan offered by Us), the Insured Person shall be entitled to continuity of waiting period only up to the Maternity Sum Insured available under the previous policy subject to overall the limit applicable under this benefit.

Any increase in the Maternity Sum Insured under this Policy shall be subject to a fresh waiting period applicable on the enhanced portion.

iv. Payment towards any admissible claim under this benefit for any complication arising out of or as a consequence of maternity or childbirth will be restricted to Maternity Sum Insured specified in the Policy Schedule.

v. The Restoration will not be available for this benefit

vi. Pre or post-natal Maternity Expenses will be covered within the Maternity Sum Insured under this benefit.

vii. The Maternity Sum Insured shall be available in addition to the Base Sum Insured.

viii. Any Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.

ix. The following expenses will not be covered under the Maternity Benefit:

a. Medical Expenses in respect of 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' of base cover under section II.1.

x. Exclusion VII.v.15 (maternity related exclusion) shall not apply to the extent of coverage provided through this cover optional cover, subject to the terms and conditions of this benefit.

xi. For the purpose this benefit, the birth of twin children or more under a single delivery shall be considered as single event.

xii. In Individual/Multi-Individual policies, Maternity Expenses can also be opted by any female who has attained the age of 18 years. Maternity Expenses can also be opted by an Adult Male Insured Person. however, any claim under this benefit shall be payable only to the female spouse of such adult male Insured Person upon adding her as an Insured Person under the Policy. In such cases, the applicable waiting period shall be as per the first inception of this optional cover and its continuity.

xiii. In Floater Policies, the Maternity Expenses optional cover will be available only for female insured (Self, Spouse and Live-In partner).

7.2.New Born Baby Expenses

Subject to a claim being paid under Maternity Cover under Section IV.7.1, We will cover:

i. Medical Expenses for the treatment of the New Born Baby while the Insured Person is hospitalized as an In-patient for delivery.

ii. The Reasonable and Customary Charges incurred on the New Born Baby during and post birth, up to 90 days from the date of delivery, within the limits specified in the Policy Schedule under Maternity Expenses without payment of any additional premium.

iii. Restoration will not be available for coverage under this section.

iv. Subject to the underwriting and the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days upon payment of the requisite premium for adding the New Born Baby into the Policy, either by way of an endorsement or at the next Renewal, whichever is earlier.

v. Any Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.

7.3First Year Vaccinations

We will cover the Reasonable and Customary charges for vaccination expenses for the New-Born Baby as per the National Immunization Scheme (India) listed below, until the child completes 1 year (12 months of age) within the limits specified in the Policy Schedule under Maternity Expenses without payment of any additional premium. If the Policy terminates before the New-Born Baby completes 12 months of age, coverage under this benefit shall continue subject to renewal of the policy in the subsequent Policy Year. Restoration will not be available for coverage under this section.

Time Interval	Vaccinations to be done (Age)	Frequency
0 - 3 months	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 VI.7 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.7.1), New Born Expenses (IV.7.2) and First Year Vaccinations (IV.7.3). Maximum amount of claim payout shall be based on the available Sum Insured of a given Policy Year basis the date of delivery.

8. Sarathi

If the Policyholder has opted for this Optional Cover, any condition, illness, complication or ailment arising out of the below mentioned pre-existing diseases that have been declared by You and accepted by Us, shall not be subject to the standard Pre-Existing Disease waiting period [Exclusion VII.i]. Such conditions will be covered after a 30 days waiting period from the Date of Inception of this Policy with Us.

i. Asthma
ii. Diabetes
iii. Dyslipidemia
iv. Obesity
v. Hypertension

Note - This optional cover can be availed only at the time of purchase of the first Policy Year and shall not be available renewal. Once opted, this cover shall continue Policy inception. It cannot be opted in at the time of renewal. Once opted, this cover cannot be opted out and shall continue for the lifetime of the policy.All other Terms and Conditions applicable to this policy shall remain as it is.

9. Room Rent Modification

We offer the option to modify the eligible room category limit to either "Any Room" or "Twin Sharing AC room" as per the Policyholder's choice. This coverage shall be available up to the Sum Insured specified in the Policy schedule.

For ICU accommodation, coverage by default shall provided at actuals, up to the Sum Insured.

10. Surplus Benefit

We offer an option to avail an additional amount equal to the opted Base Sum Insured as specified in the Policy Schedule for the first claim in every Policy Year, subject to the following:

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted and earned) is insufficient for the first claim in that Policy Year.
ii. The Surplus Benefit will not be considered while calculating Guaranteed Cumulative Bonus (Gullak if

opted and earned).

iii. If the Policy is issued on a floater basis, the Surplus Benefit will also be available on floater basis.

iv. Any unutilized Surplus Benefit after the first claim of a Policy Year shall not be carried forward to subsequent claims in the same Policy Year or to the next Policy Year.

v. The Surplus Benefit and Shakti (Section IV.11) are mutually exclusive, only one may be opted for under the policy.

11. Shakti

We offer an option to avail an additional amount of 100% or 200% of Base Sum Insured, as specified in the Policy Schedule, for all claims in a Policy Year, subject to the following conditions:

i. The Sum Insured, inclusive of the Guaranteed Cumulative Bonus (Gullak, if opted and earned), is insufficient to pay claim.

ii. The benefit amount shall not be considered while calculating the Guaranteed Cumulative Bonus (Gullak if opted and earned).

iii. If the Policy is issued on a floater basis, the benefit amount will also be available on floater basis.

iv. Any unutilized benefit amount of any Policy Year shall not be carried forward to the subsequent Policy Year.

v. The balance benefit amount may be utilized for any number of admissible claims during the Policy Year.

vi. The Surplus Benefit (Section IV.10) and Shakti benefit are mutually exclusive; only one may be opted for under the Policy.

12. Anant

If the Policyholder opts for this Optional Cover, in the event of any Hospitalization related to Cancer, Heart, Stroke, Major Organ / Bone Marrow Transplant or Accident, We will cover all Medical Expenses incurred under:

- Section II.1 “In-patient Hospitalization”,
- Section II.2 “Day Care Treatment”, and
- Section II.8 “AYUSH Treatment”,

without any Sum Insured limit for any number of times in a Policy Year.

Notes:

i. This optional cover can be opted only at the first policy purchase with Us and cannot be opted at subsequent renewal.

ii. Available for Base Sum Insured of ₹10 Lacs and above.

iii. This benefit will apply at the Policy level, irrespective of Policy type.

iv. Voluntary Co-payment and Deductible (if opted) shall also apply to this benefit.

v. Sequence of utilization of benefits will be as follows:

a. Base Sum Insured

b. Gullak (Guaranteed Cumulative Bonus, if opted and earned)

c. Surplus Benefit / Shakti (if opted)

d. Restoration (if opted and applicable)

e. Anant (towards balance claim amount)

vi. This benefit applies only to events diagnosed, or occurrences taking place, and treatment taken in India.

13. Deductible

You can opt for a Deductible and the same shall be specified in the Policy Schedule. There are 2 types

of Deductible options available:

a. **Aggregate Deductible -** The deductible amount will be applied for each Policy Year on the aggregate of all admissible claims in that Policy Year.

b. **Daily Deductible -** The deductible amount will be applied per day of Hospitalization on all admissible claims.

Note:

i. The Deductible can be opted-in or opted out at Inception or at Renewal of the Policy.

ii. Opting out of the Deductible may be subject to underwriting. Once opted-out cannot be opted-in again subsequent renewals.

iii. For Aggregate deductible amount other than ₹10,000 or ₹25,000, if the insured opt out of the Deductible at any renewal, a fresh waiting period shall apply for the initial enhanced limit from the effective date of such enhancement.

iv. Any Voluntary Co-Payment shall not apply to plans with Deductible options.

v. The Deductible opted shall apply on all claims other than those covered under:

- Section IV.1 'Personal Accident Cover'
- Section IV.2 'Temporary Total Disablement'
- Section IV.3 'Health Check-Ups'
- Section IV.4 'Air Ambulance'
- Section III 'Value Added Covers'

14. Voluntary Co-Payment

Irrespective of the Age and number of claims made by the Insured Person and subject to the Co-payment option chosen by You and specified in the policy schedule, . Basis the opted co-pay percentage We will pay 90% or 80% or 70% of any assessed in respect of a claim under the Policy, and the balance will be borne by the Insured Person.

Note:

i. The Voluntary Co-payment can be opted-in or opted-out at Inception or at Renewal of the Policy. However, opting out at Renewal will be subject to underwriting evaluation. Once opted-out cannot be opted-in again subsequent renewals

ii. The Voluntary Co-payment shall apply to all Sections other than:

- Section IV.1 'Personal Accident Cover'
- Section IV.2 'Temporary Total Disablement'
- Section IV.3 'Health Check-Ups'
- Section IV.4 'Air Ambulance'
- Section III 'Value Added Covers'

iii. If opted, the Voluntary Co-payment shall apply in addition to any other Co-payment applicable under this Policy

15. Coverage for Non-Medical Items and Durable Medical Equipment

15.1. Non-Medical Items

The cover is available subject to the claim being admissible under

- Section II.1 'In-patient Hospitalization', or
- Section II.2 'Day Care Treatment', or
- Section II.5 'Domiciliary Hospitalization',

and provided that the expenses on Non-Medical Items are related to the same Illness/Injury.

Note:

i. Exclusion with respect to any of the Non-Medical Items listed in Annexure III List-1 shall not apply under this benefit.

ii. Any claim made under this cover will reduce the available Sum Insured of the Policy.

iii. Exclusion under section VII.v.27 shall not apply to this cover subject to terms and conditions under this benefit.

15.2. Durable Medical Equipment

We will cover the Reasonable and Customary expenses towards the cost of purchasing or renting Durable Medical Equipment as listed below, provided the same is prescribed to the Insured Person by the treating Medical Practitioner during or after Hospitalization for medically necessary treatment.

The cover is available subject to below conditions:

i. The Hospitalization claim is admissible under section II.1 'In-patient Hospitalization' or under section II.2 'Day Care Treatment' or under section II.5 'Domiciliary Hospitalization' under the Policy, and the expenses on Durable Medical Equipment must be related to the same Illness/ Injury.

ii. The need for Durable Medical Equipment must be prescribed by an authorized Medical Practitioner during Hospitalization or within 30 days post discharge of the insured from the hospital.

iii. Any purchase/ renting of the Durable Medical Equipment should be done within 30 days of such recommendation. Purchase or rental of the prescribed Durable Medical Equipment must be completed within 30 days of such recommendation

iv. Exclusion VII.v.18 shall not apply to this cover subject to terms and conditions under this benefit.

v. For the purpose of this benefit, Durable Medical Equipment shall mean -

Sr. No	List of Durable Medical Equipment
1	CPAP machine
2	BPAP machine
3	Ventilator
4	Wheelchair
5	Prosthetic device
6	Suction Machine
7	Commode Chairs
8	Infusion pump
9	Continuous Passive motion devices in case of Knee Replacement
10	Oxygen concentrator

Note:

i. For this cover, a Prosthetic device means an externally applied device used to replace wholly or partly an absent or deficient body part (limited to arm or leg or auditory system).

ii. Benefit under this cover is payable up to a maximum of ₹1 Lac in a Policy Year.

iii. Any claim made under this cover will reduce the Sum Insured of the Policy.

16. Extension of Specific Disease Waiting Period

By opting for this optional cover, the Insured Person agrees to extend the waiting period for Specified Diseases or Procedures (as mentioned under Section VII.ii) to 36 months.

Note:

i. This optional cover can be opted at the first policy purchase with Us and cannot be opted at subsequent renewal.

ii. Once this optional cover is opted, it cannot be opted out in subsequent renewal.

iii. This benefit will be applied at the policy level irrespective of policy type.
iv. Selection of this optional cover is not applicable for Portability/Migration cases.

17. Sarathi 2.0

If the Policyholder has opted for this Optional Cover, any condition, illness, complication or ailment arising out of the below mentioned pre-existing diseases that have been declared by You and accepted by Us, shall not be subject to the standard Pre-Existing Disease waiting period [Exclusion E.I.1]. Such conditions will be covered after a 30 day waiting period from the Date of Inception of this Policy with Us.

i. Asthma
ii. Diabetes
iii. Dyslipidemia
iv. Obesity
v. Hypertension

Note:

a) This optional cover can be opted only at the time of Policy inception. It cannot be opted in at the time of renewal. Once opted, this cover cannot be opted out and shall continue for the lifetime of the policy. An applicable premium/loading for this Optional Cover will continue to be charged at each renewal for as long as the policy remains active with us. All other Terms and Conditions applicable to this policy shall remain as it is.

18. Personal Accident Plus

The Policyholder will have the option to choose from any one of the following options below either at policy inception or any renewal. The details pertaining to the selected option will be specified on the Policy Schedule:

- Option 1: Accidental Death Cover (AD) only [IV.18.A.]
- Option 2: Permanent Disablement Cover (includes Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD)) only [IV.18.B.i and IV.18.B.ii]. Herein Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD) will be covered upto a common sum insured
- Option 3: Accidental Death Cover [IV.18.A.] AND Permanent Disablement Cover (includes Permanent Total Disablement & Permanent Partial Disablement) [IV.18.B.i and IV.18.B.ii] covered upto a common sum insured

Specific Conditions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. In the lifetime of this policy, our maximum liability in respect of an Insured Person under Personal Accident Plus (which includes AD, PTD and PPD) shall never exceed 100% of the Benefit Amount applicable to the Insured Person
b. In the lifetime of this policy, if we pay a claim equal to our maximum liability then the entire Personal Accident Plus shall terminate for that Insured Person in respect of whom such claim has been paid.
c. Choice to opt out from this cover or change the coverage option is available only at renewals. The choice of opting in again after opted out shall be subject to underwriting.
d. The geographic scope of Personal Accident Plus (which includes AD, PTD and PPD) cover is restricted to India
e. In case there is a change in occupation of any Insured Person post inception of this benefit, the same should be communicated to us in writing at the immediate upcoming renewal.
f. The Minimum entry age of any Individual at the time of opting for this cover cannot be less than 18 years
g. The Maximum entry age of any Individual at the time of opting for this cover cannot be greater than 65 years
h. All eligible insured persons opting for the Personal Accident Plus cover shall have the same Sum

Insured and cover option.

i. If any insured person is above 75 years of age at the time of renewal, then for all future policy years maximum payout under Personal Accident Plus for that insured person will be limited to ₹10 lakh or the applicable Benefit Amount, whichever is lower. Premium shall be charged according to such applicable Benefit Amount.
j. All claims under this benefit shall be made in accordance with the process specified under Sections G.I.5 of this Policy.

IV.18.A Accidental Death Cover (AD)

If an Insured Person sustains an injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in the Death or Disappearance of the Insured Person within 365 days from the date of the Accident, we will pay the Nominee in Lumpsum 100% of the Benefit Amount stipulated against Accidental Death cover in the Policy schedule

Disappearance Clause

If the Insured Person's body cannot be located within 365 days post happening of the below event it shall be deemed as disappearance

a. Forced landing, stranding, sinking or wrecking of a common carrier in which the insured person were travelling as a fare paying passenger OR
b. Catastrophic event in which the insured person was a victim

To process a claim pertaining to disappearance we will require a missing-person police report and/or any other documents we reasonably request to support the claim. If it was later established that the Insured Person is alive, the settled amount must be repaid to us in full.

IV.18.B. Permanent Disablement Cover

IV.18.B.i Permanent Total Disablement (PTD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a Permanent Total Disablement, as listed in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum 100% of the Benefit Amount stipulated against Permanent Total Disablement benefit in the Policy schedule

	Listed Permanent Total Disablement (PTD) covered
i.	Total and irrecoverable loss of sight of both eyes
ii.	Loss by physical separation or total and permanent loss of use of both hands or both feet
iii.	Loss by physical separation or total and permanent loss of use of one hand and one foot
iv.	Total and irrecoverable loss of sight of one eye and loss of a Limb
v.	Total and irrecoverable loss of hearing of both ears and loss of onGe Limb/loss of sight of one eye
vi.	Total and irrecoverable loss of hearing of both ears and loss of speech
vii.	Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye

Specific Conditions applicable to Permanent Total Disablement (PTD)

i. Claim pertaining to Permanent Total Disablement is admissible only with confirmatory diagnosis of Permanent Total Disablement while the Insured Person is alive.
ii. The Permanent Total Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.

iii. The Permanent Total Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.

IV.18.B.ii Permanent Partial Disablement (PPD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a listed Permanent Partial Disablement, as specified in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum the Benefit Amount stipulated against Permanent Partial Disablement benefit in the Policy schedule in accordance with details specified in the table given below

	Listed Permanent Partial Disablement (PPD) covered	% of Benefit Amount payable
i.	Total and irrecoverable loss of sight of one eye	50%
ii.	Loss of one hand or one foot	50%
iii.	Loss of all toes - any one foot	10%
iv.	Loss of great toe - any one foot	5%
v.	Loss of toes other than great, if more than one toe lost, each	2%
vi.	Total and irrecoverable loss of hearing in both ears	50%
vii.	Total and irrecoverable loss of hearing in one ear	15%
viii.	Total and irrecoverable loss of speech	50%
ix.	Loss of four fingers and thumb of one hand	40%
x.	Loss of four fingers	35%
xi.	Loss of thumb-both phalanges	25%
xii.	Loss of thumb - one phalanx	10%
xiii.	Loss of index finger - three phalanges - two phalanges - one phalanx	 10%, 8%, 4%
xiv.	Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	 6%, 4%, 2%

Specific Conditions applicable to Permanent Partial Disablement (PPD)

i. Claim pertaining to Permanent Partial Disablement is admissible only with confirmatory diagnosis of a Permanent Partial Disablement while the Insured Person is alive.
ii. The Permanent Partial Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
iii. The Permanent Partial Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.
iv. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Benefit Amount shown in the Permanent Disablement Table. The cumulative sum in such cases shall be capped at 100%.
v. If in a policy year we pay a claim equal to 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, the entire Personal Accident Plus section shall automatically terminate for the respective Insured Persons.
vi. If in a policy year we pay a claim of less than 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, then at the end of such Policy Year only the remaining Benefit Amount shall replenish for the next policy year or the renewed policy if the cover is opted. In such an event the eligible premium shall be paid in full. For any claims that arise in the subsequent policy years, percentage shall be applied on the original benefit amount and the resultant amount shall be deducted from the Benefit amount that was remaining.

Specific Exclusions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including 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, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority
b. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof
c. Involvement of Insured person in any unlawful/Criminal activity.
d. Intentional self-injury or attempted suicide.
e. Any Injury sustained while working, storing or transporting explosives.
f. Injury caused due to
    1. Insect bites or
    2. Animal bites or
    3. Animal attacks or
    4. Serpant (snake) bites or attacks
g. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.
h. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand
i. Claims arising out of Non-accidental Injuries: Injuries emanating from participation in Adventure Sports (Hazardous Sports, action sports, aggro sports, extreme sports or any such name) irrespective whether the Insured Person is trained or not and also irrespective whether the Insured is a professional or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighing / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee

jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving, gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, luging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkeling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weightlifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

V. Add-on/Rider Cover

ManipalCigna Health 360-OPD

Along with this Policy You can also avail the ManipalCigna Health 360-OPD Add On Cover (UIN: MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All exclusions and terms and conditions of applicable rider will apply.

For the purpose of this Benefit, coverages are listed under the ManipalCigna Health 360 Add-on Cover Policy documents.

VI. What are Features of the Policy?

In the event of any inconsistency in details provided in this document, the terms and conditions stated in the policy wordings shall prevail.

1. Eligibility

The minimum entry age under this policy is 91 days for children and 18 years for adults. There is no maximum 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 30 years can be covered under the floater.
c. Children beyond 30 years can be covered under an individual policy.

2. 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, legally wedded spouse, live-in partner, children, father,

mother, father-in-law, mother-in-law, Son-in-law, Daughter-in-law, Grand-parents, Grandchildren, Uncle, Aunt, Nephew, Niece, Brother, Sister, Sister in-law, Brother in-law.

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, legally married spouse or live-in-partner, dependent children (naturally/legally adopted) up to the age of 30 years, parents or parents-in-law. A floater cover can cover a maximum of 2 adults and 3 children's under a single policy.

3. Policy Period option

You can buy the policy for 1, 2 or 3 continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the inception date of the policy.

4. Plan & Sum Insured Options

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

Plan Name	Sum Insured
UTTAM	₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs, ₹100 Lacs, ₹200 Lacs, ₹300 Lacs

5. Discounts under the Policy

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

<table>
<tr><td colspan="3">Lifetime Discounts</td></tr>
<tr><td>a.</td><td>Early Renewal Discount
OR
Standing Instruction Discount</td><td>Early Renewal Discount - You are eligible for a 2.5% discount on the Renewal premium, if the Policy is renewed on or before 15 days of the Policy expiry date.
OR
Standing Instruction Discount - 2.5% discount on the renewal premium, if the payment is received through a standing instruction.
Note - The Early Renewal Discount and Standing Instruction Discount are mutually exclusive, only one discount can be applied at given point in time.</td></tr>
<tr><td>b.</td><td>Long Term Policy Discount</td><td>Discount of 7.5% is applicable for selecting a 2-year Policy and 10% for a 3-year Policy. This discount is available only under the Single Premium payment mode.</td></tr>
<tr><td>c.</td><td>Family Discount</td><td>10% discount on the premium is applicable when covering 2 or more members under the same Individual Policy on a Multi-Individual basis.</td></tr>
<tr><td>d.</td><td>Direct Discount</td><td>5% discount will be offered if the policy is purchased directly from the insurer without any intermediary.</td></tr>
<tr><td>e.</td><td>Employee Discount</td><td>10% discount on the premium is applicable</td></tr>
<tr><td>f.</td><td>No Claim Discount</td><td>The Policy will be eligible for a discount on the Renewal Premium based on the number of previous consecutive claim-free years as per the table below:
<table>
<tr><th>Claim free Years</th><th>Discount</th></tr>
<tr><td>1 year</td><td>2.5%</td></tr>
<tr><td>2 years</td><td>5%</td></tr>
<tr><td>3 years</td><td>7.5%</td></tr>
</table>
Note:
i. In case of any claim, the claim-free count will reset and will start afresh from</td></tr>
</table>

		the subsequent Policy Year. ii. The Calculation of the claim-free discount will not be affected by any utilization of the following benefit: • Section III Value Added Covers, including: - Tele-consultation (Section III.1) - Wellness (Section III.2) - Discount from Network Provider (Section III.3) - Health Check-up (Section IV.3) • Add-ons/Riders iii. Progression to higher discount levels (1 Year, 2 Years, 3 Years) will stop once the eldest member covered under the policy attains the age of 56 years. iv. The attained discount level at the age of 56 will continue until a claim is made under the Policy. After a claim, the discount level will reset to 0 and shall not be accrued in subsequent policy year irrespective of claim history. Note: No Claim Discount and 1st Renewal Discount are mutually exclusive. Insurer to receive maximum discount applied out of the 2.
Short Term Discounts		
a.	1st Policy Renewal Discount	5% discount on your first policy renewal premium.
a.	Worksite Marketing Discount	Discount of 10% will be applicable for policies sourced through the Worksite Marketing channel. This discount is applicable only once, at the inception of the Policy.
b.	Discount in lieu of Commission	Maximum discount up to 15% will be provided on premium once only at inception of the Policy, in case the intermediary forgoes their commission.
Note – i. Direct Discount, Employee Discount, Worksite Marketing Discount and Discount in lieu of commission are mutually exclusive. ii. Maximum cumulative discount on a single policy for the above mentioned parameters shall not exceed 40%		

6. Underwriting Loading & Special Conditions

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

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

We shall inform You about the applicable risk loading or special condition through a counter offer letter or through an electronic mode, as the case may be and You would need to revert with consent and additional premium (if any), within the duration specified in the counter offer letter.

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

7. Premium Calculation and Premium Payment Mode

Premium will be calculated based on the Sum Insured opted, Age, risk classification, optional cover selected, family combination and zone classification. Zone classification will be based on Proposer's city-location pin code as mentioned in KYC document.

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

Premium can be paid on Single, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy by sending a request at least one month in advance.

Change in premium payment mode is subject to:

i. Payment of premium and loading, if any.
ii. Minimum premium requirement for the requested premium payment mode, if any.
iii. Availability of the requested premium payment mode on the day of implementation of request.
iv. 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.

Note - Instalment facility shall not be available for the policy tenure more than 1 year.

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

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 1	**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 **Others:** Rewari, Jind, Jhunjhunu, Patna
Zone 2	**Rest of the Bihar State** **Districts in Andhra Pradesh/Telangana:** Ananthapur, Bapatla, Gadwal, Guntur, Kamareddy, Kurnool, Mahabubnagar, Medak, Nalgonda, Nellore, Nizamabad, Rangareddy, Suryapet, Wanaparthy **Districts in Punjab:** Amritsar, Gurdaspur **Districts in Maharashtra:** Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad **Others:** Chennai, Bangalore, Kolkata, Dhanbad, Bokaro

Zone 3	**Daman & Diu UT, Dadara & Nagar Haveli UT, Rest of Andhra Pradesh State, Rest of Telangana State, Rest of Gujarat State, Rest of Haryana State** **Districts in Karnataka:** Chikkaballapur, Chikkamagaluru, Kolar, Tumakuru, Udupi **Districts in Punjab: R**upnagar (Ropar), Ludhiana, Fatehgarh Sahib, S.A.S. Nagar (Mohali), Patiala **Districts in Rajasthan:** Dausa, Dholpur, Jaipur, Karauli, Sawai Madhopur, Tonk, **Districts in Tamilnadu:** Coimbatore, Erode, Kanchipuram, Karur, Krishnagiri, Tiruppur, Tiruvallur **Districts in Uttar Pradesh:** Kanpur, Banda, Fatehpur **Others:** Chandigarh, Raipur, wayanad
Zone 4	**Rest of India**

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.

8. Renewal of Policy

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

i. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iii. 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.

iv. No loading shall apply on renewals based on individual claims experience.

A. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.

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 before the changes are effected.

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 consecutive months as applicable to the relevant waiting periods of this Policy.

   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 (iv) will be applicable considering such Policy Year as the first year of Policy with the Company.

j. Applicable Guaranteed Cumulative Bonus (Gullak If opted and earned) shall be accrued at the end Policy year as per eligibility under the Policy.

k. In case of floater policies, children attaining 31 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. Guaranteed Cumulative Bonus (Gullak if opted and earned) on the Policy will stay with the floater cover

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

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

- Grace Period of 15 days for Monthly mode and 30 days for Half-Yearly & Quarterly mode would be given to pay the instalment premium due for the Policy.
- If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.
- The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged if the instalment premium is not paid on due date.
- Wherever premium is not received within the grace period of the policy, the policy will be terminated from the date on which such grace period is over to pay the premium and all claims that fall beyond such grace period shall not be covered as part of the policy. However, we will be liable to pay in respect of all claims where the treatment / admission/ accident has commenced/occurred before the expiry of such grace period for the payment of instalment premium.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

C. 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.

9. 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).

10. 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 Policyholder shall be notified at least 45 days before the changes are effected.

11. Free-look Period

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

The insured person shall be allowed a free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

Free look cancellation & refund will be made within 7 days from the date of receipt of request.

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

12. 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 at any time during the term. We shall refund the premium for the unexpired term as mentioned below.

A. Policy Tenure of 1 Year:

- **No claim made:** 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 the expiry date of coverage.
- **Claim made:** No refund will be given if a claim has been made or any benefit has been availed during the Policy period.

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.

B. If Policy Tenure is more than 1 year:

- **No claim in the current policy year:**
  i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
  ii. The date of cancellation will be considered as the expiry date of coverage.
- **Claim made in the current policy year:**
  i. Premium for the remaining complete policy year(s) will be refunded on cancellation.
- **Claim made in a previous policy year:**
  i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
  ii. The date of cancellation will be considered as the expiry date of coverage.

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure (In Years)	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure (In Years)	2
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2025
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	2.60 (100*19/731)

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, established fraud by the Policyholder/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.

13. 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
- Change in caregiver details
- Change in Claim Status (for cases where claims are reported post issuance of renewal notice and renewal policy issued before expiry date).

b) Financial Endorsements - which result in alteration in premium

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

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

14. 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.: + 91 22 71781300

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.

15. 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.

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16. 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 Base Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period as per IRDAI guidelines on migration.

17. 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 Base Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, moratorium period as per IRDAI guidelines on portability.

18. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholder 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 Gullak (Guaranteed Cumulative Bonus), waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

19. 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 Base Sum Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Base Sum 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.

20. Revival of Policy

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

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

a. The policy could be revived maximum within 180 days from lapse of the first payment due date

b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):

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

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

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

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

21. Coverage Standards and 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.

22. Utilization of Sum Insured

Sequence of utilization of Sum Insured will be as follows:

a. Base Sum Insured (if remaining for that claim)
b. Gullak (Guaranteed Cumulative Bonus if opted, earned and remaining for that claim)
c. Surplus Benefit / Shakti (if opted and remaining for that claim)
d. Restoration (if opted and applicable for that claim)
e. Anant (if opted, towards balance admissible claim amount)

23. 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).

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 to 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 36 months of continuous coverage after the date of inception of the first Policy with Insurer.

b. In case of enhancement of Base Sum Insured, the exclusion shall apply afresh to the extent of Base 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 (36 months in case 'Extension of Specific Disease Waiting Period' is opted) 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 Base sum insured the exclusion shall apply afresh to the extent of Base 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:

a) Cataract,

b) Endometriosis, Dilatation and curettage, Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus or myomectomy for fibroids unless necessitated by malignancy,

c) 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, Removal of Implants and all diseases of Ligament, tendon, meniscal tear (other than caused by accident or malignancy).

d) Varicose Veins and Varicose Ulcers,

e) Stones in the urinary genito-urinary and biliary systems including calculus diseases and complications thereof,

f) Benign Prostate Hypertrophy, all types of Hydrocele,

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

h) 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.

i) 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,

j) Any surgery of the genito-urinary & biliary system unless necessitated by malignancy.

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

a. 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.

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

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

iv. Personal Waiting period:

A special waiting period not exceeding 36 months, may be applied to individual Insured persons for specific Medical Ailments listed under the Underwriting Manual of this Product. The applicability of such a waiting period will depend upon the health declarations made in the Proposal Form and the Insured Person's existing medical condition. Such waiting periods shall:

- Be specifically stated in the Schedule and,

-Be applied only after receiving the **explicit consent** of the Insured Person/Proposer.

v. 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

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:

a) Surgery to be conducted is upon the advice of the Doctor

b) The surgery/Procedure conducted should be supported by clinical protocols

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI);

a. greater than or equal to 40 or
b. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

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

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded, except for sex reassignment surgery for transgender persons.

5. **Cosmetic or Plastic Surgery: Code - Excl 08**

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

6. **Hazardous or Adventure sports: Code - Excl 09**

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

7. **Breach of law: Code - Excl 10**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers: Code - Excl 11**

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

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

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code - Excl13**

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

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

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

13. Unproven Treatments: Code - Excl 16

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

14. Sterility and Infertility: Code - Excl 17

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

15. Maternity: Code - Excl 18

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

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

17. Circumcision unless necessary for treatment of an 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.

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

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

25. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, 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 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 Policy Wordings subject to conditions mentioned in section IV.15 'Coverage for Non-Medical Items and Durable Medical Equipment's'.

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

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

30. Expenses incurred towards all types of multi-focal lenses, multi-focal toric lenses and Femto Laser-assisted surgeries for the treatment of cataract subject to Policy terms and conditions.

Note:

a. Femto laser surgeries refer to advanced medical procedures utilizing femtosecond laser technology for precision-based treatment, commonly used in ophthalmic surgeries such as Lasik or cataract removal.

b. Multi-focal lenses include intraocular lenses designed to provide vision correction at multiple distances, such as bifocal, trifocal, or any other premium intraocular lenses.

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

32. Out patient treatment expenses.

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

34. Preventive care, vaccination, inoculation, or immunization, except when administered as part of hospitalization required for post-animal bite treatment.

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

36. 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.

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

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

39. 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.

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

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

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.
- Policyholders / Insured Person(s) / any person behalf of You are strictly advised not to share or post any claim-related information, personal details, or medical records on any medium or platform other than those officially specified by the Company in this Policy, as doing so may compromise the confidentiality and security of your personal information and personal health details.

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

The Claim documents specified above may be securely uploaded on either our official mobile application – 'myManipalCigna' or on our website https://claim.manipalcigna.com/claims/. It can also be submitted in physical form at our designated Claims Office-

Address- Techweb center 2nd Floor New Link Rd,

Anand Nagar, Jogeshwari West,

Mumbai, Maharashtra 400102, India'

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
- Hospital Discharge summary
- Operation Theatre notes
- Hospital Main Bill
- Hospital Break up bill
- Investigation reports
- Original investigation reports, X Ray, MRI, CT films, HPE, ECG
- Doctors reference slip for investigation
- Pharmacy Bills
- MLC/ FIR report, Post Mortem Report if applicable and conducted

- KYC documents of Policyholder (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment of Policyholder
- Payment receipt.

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

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

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

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on our website as also provided to you along with the Policy documents. The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on Our's website: https://www.manipalcigna.com/our-tpas . 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 Benefit covered under this Policy?

The benefit details are as mentioned below:

Title	**Description** Please refer to the Plan and Base Sum Insured you have opted to understand the available benefits under your plan in brief:	
	Relationship Covered	**Individual:** Self, legally married spouse or live-in partner, son, daughter, father/ mother/ father-in-law/ mother-in-law/ son-in-law/ daughter-in-law/ grand-parents/ grandchildren/ uncle/ aunt/ nephew/ niece/ brother/ sister/ sister in-law/ brother in-law. **Floater:** Self, legally married spouse or live-in partner, dependent children (natural / legally adopted), dependent parents/ parents-in-law
Your Coverage Details:	**Identify your Plan**	**ManipalCigna Sarvah - Uttam**
Basic Cover	Identify your Opted Base Sum Insured (in ₹)	₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs, ₹100 Lacs, ₹200 Lacs, ₹300 Lacs

<table>
<tr>
<td>This section lists the Basic benefits available in your plan</td>
<td>In-patient Hospitalization (When you are hospitalized)</td>
<td>Covered up to Sum Insured
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. Modern and Advanced Treatments: Covered up to Sum Insured
b. HIV/AIDS & STD: Covered up to Sum Insured
c. Mental Illness: Covered up to Sum Insured
For ICD Codes mentioned below: Waiting Period of 24 months shall apply
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F10</td><td>Alcohol related disorders</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table>
</td>
</tr>
<tr>
<td></td>
<td>Day Care Treatment</td>
<td>All Day Care Procedure covered up to Sum Insured.</td>
</tr>
<tr>
<td></td>
<td>Pre-hospitalization Medical Expenses</td>
<td>Medical Expenses incurred during policy period covered up to 90 days before the date of hospitalization; covered up to the Sum Insured</td>
</tr>
<tr>
<td></td>
<td>Post-hospitalization Medical Expenses</td>
<td>Medical Expenses covered up to 180 days post discharge from the hospital; covered up to the Sum Insured</td>
</tr>
<tr>
<td></td>
<td>Domiciliary Hospitalization (Treatment at Home)</td>
<td>Covered up to the Sum Insured
Pre and Post Hospitalization Expenses: 30 days each</td>
</tr>
</table>

	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 Base Sum Insured subject to maximum of ₹2 Lacs, Over and above Base Sum Insured We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.
	AYUSH Treatment	Covered up to the Sum Insured
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Tele-Consultation	Unlimited Tele-consultation with General Physician during the Policy Year
	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 other than Deductible, Voluntary Co-Payment, Twin Sharing AC Room, Extension of Specific Waiting Period, Rider and taxes as applicable). These earned Reward Points can be used as premium 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

<table>
<tr>
<td>Optional Covers

This section lists the available optional covers under your plan and the limits under each of these options</td>
<td>Personal Accident Cover</td>
<td>
Coverage under this option is available on Individual and Family Basis.
Min Age at Entry – 5 Years, Max Age at Entry 65 Years. Relationships Covered - Self, Lawfully Wedded Spouse/Live-in Partner, Dependent Children, Dependent Parents/Parent in laws Individual Benefit Amount ₹10L, ₹15L, ₹20L, ₹25L, ₹30L, ₹40L, ₹50L, ₹1Cr, ₹2Cr, ₹3Cr
<table>
<tr><td>Scope of Cover</td><td>% of PA Cover</td></tr>
<tr><td>Accidental Death (AD)</td><td rowspan="2">100% of the Personal Accident Cover Benefit Amount.
200% of Benefit amount (if Death/PTD) occurs due to an Accident while travelling as a fare paying passenger on a common carrier.</td></tr>
<tr><td>Permanent Total Disablement (PTD)</td></tr>
<tr><td>Permanent Partial Disablement (PTD)</td><td>% of Personal Accident Benefit Amount (a defined in the Grid)</td></tr>
</table>
Family Cover Sum Insured Eligibility
<table>
<tr><td>Earning Member</td><td>As per the Benefit Amount Opted</td></tr>
<tr><td>Non- earning Spouse/Live-in Partner</td><td>60% of the Benefit Amount of Earning member</td></tr>
<tr><td>Dependent Children /Parents/ Parents-in-Laws</td><td>30% of the Benefit Amount, max up to ₹30Lacs</td></tr>
</table>
<table>
<tr><td>Age wise</td><td>Eligibility of Benefit Amount will be up to a maximum times of Annual Income of the Proposer or Earning member to be Insured. (as detailed below)</td></tr>
<tr><td>18-45</td><td rowspan="2">Max 20 times of the Gainful Annual Income</td></tr>
<tr><td>46- 60</td></tr>
<tr><td>>60 above</td><td>Max 10 times of the Gainful Annual Income</td></tr>
</table>
Note:
i. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial Disablement shall be payable only in respect of accident occurring within India.
</td>
</tr>
</table>

	Temporary Total Disablement (TTD)	If the Insured Person suffers an injury due to an accident that occurs during the policy period and such Injury results in the Temporary Total Disablement of the Insured Person immediately after an Accident, We will pay fixed weekly benefit for the duration of the TTD. Coverage Options ₹5K, ₹10K, ₹15K, ₹20K, ₹25K, ₹50K, ₹1L per week **Note:** i. Max No. of Weeks Covered - 100 in respect of any one Injury calculated from the date of commencement of the Temporary Total Disablement. ii. Available only if Personal Accident Cover is opted. iii. TTD Cover is available only for the earning members in India in the Policy. iv. This benefit shall be applicable only for events or occurrences taking place within the geographical boundaries of India.
	Health Check Up	Available each policy year (including the first year), to all Adult insured persons who have completed 18 years of Age. • For Base Sum Insured of ₹5 lacs: Package 1 • For Base Sum Insured o f ₹7.5 lacs and ₹10 lacs: Package 2 • For Base Sum Insured above ₹10 lacs: Package 3 The packages shall be offered on cashless basis only.
	Air Ambulance	Covered up to Sum Insured subject to maximum of ₹10 Lacs in addition to the Base Sum Insured, for expenses incurred on Air Ambulance
	Restoration (When opted Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for all illnesses and injury, in addition to the Base Sum Insured Applicable for below covers only 1. II.1 – In-patient Hospitalization 2. II.2 – Day Care Treatment 3. II.3 – Pre - hospitalization Medical Expenses 4. II.4 – Post – hospitalization Medical Expenses 5. II.6 – Road Ambulance 6. II.7 – Donor Expenses 7. II.8 – AYUSH Treatment Restoration shall not get triggered for the 1st claim.
	Gullak (Guaranteed Cumulative Bonus)	We will provide an option to the policyholder to the get Guaranteed increase 100% of Base Sum Insured for each policy year up to the maximum of 1500% of Base Sum Insured irrespective of any claim made in the previous Policy Year.

	Maternity & New Born Hospitalization Expenses	**Maternity & New Born Hospitalization Expenses** **a. Maternity Cover** (up to maximum 2 deliveries or terminations) - Covered up to 20% of Base Sum Insured opted subject to a maximum of ₹5 Lac in addition to the Base 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. In Individual Policies, Maternity Expenses will be offered to Adult Insured Male members as well. However, claims under this benefit shall be payable to the female spouse upon adding her as an Insured in the Policy. In such cases, the applicable waiting period shall be as per the first inception of the Policy. **Note:** i. The female adult Insured Person should have been covered under the base Policy & Maternity Expenses for at least 36 months before availing this benefit. ii. The payment towards any admitted claim will be restricted to Maternity Sum Insured however any restored amount (if applicable) will not be available for coverage under this section. iii. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit. iv. In case the Policy is migration/Portability, the Insured Person shall be entitled to continuity of waiting period only up to the Maternity Sum Insured available in previous policy subject to overall limit applicable under this benefit.

	Sarathi	If the Policyholder has opted for this optional cover, any condition, illness, complication, or ailment arising out of the below mentioned declared and accepted Pre-existing Diseases shall not be subject to the Pre-existing Disease Waiting Period. Such conditions shall be covered after the first 30 days from the Inception Date of the first Policy with Us: i. Asthma ii. Diabetes iii. Dyslipidemia iv. Obesity v. Hypertension **Note –** This optional cover is available only at inception (First Policy Year) and not at renewal. Once opted, it cannot be withdrawn in subsequent renewals
	Room Rent Modification	The Policyholder shall be eligible to modify the room type category eligibility under the Policy as follows: **Option 1:** Any room; ICU Up to Sum Insured or **Option 2:** Twin Sharing AC room; ICU Up to Sum Insured
	Surplus Benefit	Additional 100% of Base Sum Insured, available from day 1 for 1st claim only, in each policy year. (Surplus Benefit and Shakti are mutually exclusive)
	Shakti	The Insured Person can avail an additional 100% or 200% of the Base Sum Insured, as specified in the Policy Schedule, for all admissible claims in a Policy Year. Conditions: i. Applicable only after exhaustion of the Base Sum Insured. ii. Can be utilized for any number of admissible claims during the Policy Year iii. Any unutilized benefit amount will not be carried forward to the next Policy Year. iv. Shakti and Surplus Benefit are mutually exclusive.
	Anant	If the Insured Person opts for this Optional Cover, in the event of any Hospitalization related to Cancer, Heart, Stroke, Major Organ / Bone Marrow Transplant, or Accident, We will cover all Medical Expenses incurred under: • Section II.1 – In-patient Hospitalization • Section II.2 – Day Care Treatment • Section II.8 – AYUSH Treatment without any Sum Insured limit, for unlimited times during the Policy Year. **Notes:** i. This cover can only be opted at the time of first Policy purchase and cannot be added at subsequent Renewals. ii. Available only with Base Sum Insured of ₹10 Lacs and above.. iii. This benefit applies at the Policy level, irrespective of Policy type (Individual/Family Floater). iv. Voluntary Co-payment, Deductible (if opted), and applicable Sub-limits shall also apply. v. This cover is applicable only for diagnosis, occurrences, and treatments taken within India.

	Deductible Option	Insured has option to choose either **Option 1 -** Aggregate Deductible of ₹10K, ₹25K, ₹50K, ₹1L, ₹2L, ₹3L, ₹4L or ₹10L, or **Option 2 -** Per Day Deductible of ₹1K, ₹2K, ₹3K, ₹4K or ₹5K per day of Hospitalization on all admissible claims.
	Voluntary Co-Payment	Options of 10%, 20% or 30% will be applicable on each and every claim
	Coverage for Non-Medical Items and Durable Medical Equipment	**1. Non-Medical Items** Covered up to the Sum Insured opted under the policy, in case of In-patient Hospitalization or Day Care Treatment or Domiciliary Hospitalization. **2. Durable Medical Equipment** Covered up to ₹1Lac in case, prescribed during hospitalization or within 30 days post-discharge. (CPAP Machine, BPAP Machine, Ventilator, Wheelchair, Prosthetic Device, Suction Machine, Commode Chairs, Infusion Pump, Continuous Passive Motion Devices In case of Knee Replacement, Oxygen Concentrator)
	Extension of Specific Disease Waiting Period	By opting for this optional cover, the Insured Person agrees to extend the waiting period for Specified Diseases or Procedures (as mentioned under Section VII (ii)) to 36 months. Note: i. This optional cover is available only at inception of the Policy (first Policy Year) and cannot be availed at the time of renewal. It is not available for ported or migrated policies. ii. Once this benefit is opted cannot be opted out in subsequent renewals. 3. This benefit will apply at the Policy level, irrespective of Policy type.
	Sarathi 2.0	If the Policyholder has opted for this optional cover, any condition, illness, complication, or ailment arising out of the below mentioned declared and accepted Pre-existing Diseases shall not be subject to the Pre-existing Disease Waiting Period. Such conditions shall be covered after the first 30 days from the Date of Inception of this Policy with Us: i. Asthma ii. Diabetes iii. Dyslipidemia iv. Obesity v. Hyperte nsion Note – This optional cover is available only at inception (First Policy Year) and not at renewal. Once opted, it cannot be withdrawn in subsequent renewals.

<table>
<tr>
<td></td>
<td>Personal Accident Plus</td>
<td>Coverage Basis
Available on Individual and Family Floater basis.
Entry Age

Minimum Entry Age: 18 Years
Maximum Entry Age: 65 Years
Relationships Covered - Self, Lawfully Wedded Spouse/Live-in Partner, Dependent Children, Dependent Parents/Parent in laws
Individual Benefit Amount - ₹5L- ₹10Cr

Coverage Options (Choose any one)
Policyholder may opt for any one option at policy inception or renewal. Selected option will be mentioned in the Policy Schedule.
<table>
<tr><th>Option</th><th>Coverage</th></tr>
<tr><td>Option 1</td><td>Accidental Death (AD) only</td></tr>
<tr><td>Option 2</td><td>Permanent Disablement only (includes PTD & PPD)</td></tr>
<tr><td>Option 3</td><td>Accidental Death (AD) + Permanent Disablement (PTD & PPD)</td></tr>
</table>
Note:
1.Maximum payout under Personal Accident Plus (AD + PTD + PPD) shall not exceed 100% of the Benefit Amount during the policy lifetime.
2.On payment of 100% Benefit Amount, the Personal Accident Plus cover terminates for that Insured Person.
3.Change of option or opting out is allowed only at renewal. Re-entry after opting out is subject to underwriting.
4.All insured members opting for this cover must have same Benefit Amount and same option.
5.If an insured person is above 75 years at renewal, maximum payout shall be limited to ₹10 L or opted Benefit Amount, whichever is lower.</td>
</tr>
<tr>
<td>Add on cover (Rider)
This section lists the Add on cover available under your plan</td>
<td>ManipalCigna Health 360 - OPD</td>
<td>Coverage available for OPD as per package opted.</td>
</tr>
</table>

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.

Annexure:

Benefits Illustration

Rate Charts