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ManipalCigna Health Insurance

# MANIPALCIGNA PROHEALTH INSURANCE

# (PROSPECTUS)

## I. What are the Key Highlights of the Policy?

**BASIC COVERS**

- In patient Hospitalisation
- Pre-hospitalisation
- Post-hospitalisation
- Day care Treatment
- Domiciliary Treatment
- Ambulance Cover
- Donor Expenses
- Worldwide Emergency Cover
- Restoration of Sum Insured
- AYUSH Cover
- Health Maintenance Benefit
- Maternity Expenses
- New Born Baby Expenses
- First Year Vaccinations

**VALUE ADDED COVERS**

- Health Check-Up
- Expert opinion on Critical Illness
- Cumulative Bonus
- Healthy Rewards

**OPTIONAL COVERS**

- Hospital Daily Cash Benefit
- Deductible
- Reduction in Maternity Waiting Period
- Voluntary Co-pay
- Waiver of Mandatory Co-pay
- Cumulative Bonus Booster

**ADD ON/RIDER COVER**

- Critical Illness

## II. What are the Basic covers?

**i) In-patient Hospitalisation**

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

Under the Protect and Accumulate Plan coverage is available up to a Single Private Room for Sum Insured Up to ₹5.5 Lacs.
Under the Protect, Accumulate with Sum Insured ₹7.5 Lacs and above, Plus, Preferred and Premier Plan accommodation under any Room Category will be available excluding a suite or higher category.

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

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

The following procedures will be covered (wherever medically indicated) either as inpatient or as part of day care treatment in a hospital up to the Sum Insured, specified in the policy schedule, during the policy period:

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

Medical Expenses related to any admission (under In-patient Hospitalisation, Day Care Treatment or Domiciliary Hospitalisation) primarily for enteral feedings will be covered maximum up to 15 days in a Policy Year, provided it is Medically Necessary and is prescribed by a Medical Practitioner.

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

**ii) Pre - hospitalisation**

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

**iii) Post - hospitalisation**

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

**iv) Day Care Treatment**

We will cover payment of medical expenses of an Insured Person in case of medically necessary day care treatment or surgery that requires less than 24 hours hospitalisation due to advancement in technology and which is undertaken in a hospital / nursing home/day care centre on the recommendation of a medical practitioner. Any treatment in an outpatient department (OPD) is not covered. The list of Day Care Treatments/ Procedures is available as an Annexure to the policy. Coverage will also include pre-post hospitalisation expenses as available under the Plan opted.

**v) Domiciliary Treatment**

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

- Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
- Arthritis, gout and rheumatism,
- Chronic nephritis and nephritic syndrome,
- Diarrhoea and all type of dysenteries, including gastroenteritis,
- Diabetes mellitus and insipidus,
- Epilepsy,
- Hypertension,
- Psychiatric or psychosomatic disorders of all kinds,
- Pyrexia of unknown origin.

**vi) Ambulance Cover**

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

**vii) Donor Expenses**

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

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

**viii) Worldwide Emergency Cover**

We will cover medical expenses incurred during the policy year for emergency treatments for an illness or injury sustained or contracted outside of India which cannot be postponed until the Insured Person has returned to India up to limits specified under the plan opted by the Insured and admissible under In Patient Hospitalisation cover as per the terms of the Policy. Such treatment received outside India should be medically necessary and has been certified as an emergency by a medical practitioner and intimation of such hospitalisation has been made to us within 48 hours of such admission.

The medical expenses payable shall be limited to Inpatient hospitalisation and shall be made in India and in Indian Rupees on reimbursement basis. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance. In case where Cumulative Bonus accumulated is used for payment of claim under this benefit, the maximum liability under a single Policy year shall not exceed the Opted Sum Insured including Cumulative Bonus or Cumulative Bonus Booster as applicable.

**ix) Restoration of Sum Insured**

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

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

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

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

During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:

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

Restoration will not trigger in case of a claim under Maternity, New Born Baby and First Year Vaccinations.

**x) AYUSH Cover**

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

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

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

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

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

**xi) Health Maintenance Benefit (HMB)**

We will cover, only by way of reimbursement costs towards Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred during the Policy Year on:

i. an Out Patient basis for Protect, Plus, Preferred and Premier Plans
ii. an Out Patient and In-patient basis for Accumulate Plan.

**Coverage and validity for HMB under Protect, Plus, Preferred, Premier and Accumulate will be as per below table:**

| Plan Name | Coverage | Validity |
|---|---|---|
| Protect, Plus, Preferred & Premier | i. Diagnostic tests, preventive tests, drugs, prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.<br>ii. Towards Dental Treatments and AYUSH Forms of Medicines wherever prescribed by a Medical Practitioner. | i. Fresh limits will be available as per the Plan under the new Policy Year<br>ii. Any unutilised Health Maintenance Benefit limit shall lapse at the end of the Policy Year |
| Accumulate | i. Diagnostic tests, preventive tests, drugs, Non-Medical expenses (as defined under Annexure IV of the policy), prosthetics, medical aids (spectacles and contact lenses, hearing aids, crutches, wheel chair, walker, walking stick, lumbo-sacral belt), crutches and wheel chair prescribed by the specialist Medical Practitioner up to the limits specified in the Schedule.<br>ii. Towards Dental Treatments and AYUSH Forms of Medicines wherever prescribed by a Medical Practitioner as an Out-Patient.<br>iii. Towards payment of the deductible/ co-pay/ Non-Medical expenses (as defined under Annexure IV of the policy) of a claim wherever opted and applicable including any cashless facility in case of a Hospitalisation or Day Care Claim.<br>iv. Towards payment of renewal premium (inclusive of taxes): Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy. Subject to renewal of the policy in Accumulate Plan. | i. Fresh limits will be available as per the Plan under the new Policy Year<br>ii. Any unutilised Health Maintenance Benefit limit shall not lapse at the end of the Policy Year and can continue to be carried forward each year as long as the Policy is renewed with Us in accordance with the Renewal Terms under the Policy.<br>iii. In case of expiry of the policy any unutilized Health Maintenance Benefit limit shall be available for a claim up to a period of 12 months from the date of expiry of the Policy.<br>iv. In case of utilisation of Health Maintenance Benefit post expiry of the policy year, the cumulative bonus shall be suitably adjusted basis revised Health Maintenance Benefit balance for the previous policy year. |

Insured can use Our application or contact Us for scheduling an appointment for availing services covered under this benefit at our Network provider. All Waiting Periods and Permanent Exclusions including Co-pay's applicable on the Policy shall not apply to this section.

**xii) Maternity Expenses**

We cover Maternity Expenses for the delivery of a child and/or maternity expenses incurred during the Policy Year related to medically necessary and lawful termination of pregnancy limited to maximum 2 deliveries during the lifetime of an Insured person between 18 years to 45 years, subject to limits under the plan opted by the Insured.

The Insured person should have been continuously covered under this policy for at least 48 months before availing this benefit, except in case of opting for 'Reduction in maternity waiting period where the limit will be relaxed to 24 months of waiting.

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

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

The following expenses are not covered under maternity benefit:

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

b. Medical expenses for ectopic pregnancy. However, these expenses will be covered under the inpatient hospitalisation.

**xiii) New Born Baby Expenses**

We cover medical expenses towards treatment of the Insured person's new born baby while the Insured Person is hospitalised as an in-patient for delivery, subject to a valid claim being accepted under maternity expenses.
This would include in-patient hospitalisation expenses incurred on the new born baby during and post birth including any complications up to a period of 90 days from the date of birth and within the limits specified under Maternity Expenses cover under the plan opted by You.
We would cover the baby beyond 90 days on payment of requisite premium subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier.
Applicable Deductible or Co-pay under the plan shall also apply to this benefit.

**xiv) First Year Vaccinations**

We will cover vaccination expenses of the new born baby as per National Immunisation Scheme (India), until the new born baby completes one year (i.e.12 months). The coverage will be subject to claims admitted under maternity expenses cover and will be in addition to the Maternity Sum Insured available under the Plan. However maximum liability under the policy shall not exceed the opted Sum Insured. Any restored Sum Insured will not be available for coverage under this section.
If the policy ends before the new born baby has completed one year, then, such vaccinations shall be covered until the baby completes 12 months, subject however to the Policy being renewed in the subsequent year.

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

| 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 |

## III. What are the Value Added Covers?

**i) Health Check Up**

We will provide for a comprehensive Health Check-Up as listed in the eligibility table below, to all Insured Persons who are 18 years of age. Heath Check Ups will be available irrespective of their claim status under the policy and will be arranged by Us at Our network providers. The coverage under this benefit will not be available on reimbursement basis.

For Protect & Accumulate plan –available once every 3rd Policy year.
For Plus, Preferred and Premier Plan –available once each year, excluding the first policy year.

| Sum Insured | Age | List of tests |
|---|---|---|
| Protect, Plus & Accumulate Plan Sum Insured ₹2.5 Lacs, ₹3.5 Lacs, ₹4.5 Lacs, ₹5.5 Lacs, | >18 years | Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT |
| Protect, Plus & Accumulate Plan Sum Insured ₹7.5 Lacs, ₹10 Lacs | 18 to 40 years | Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT |
| | > 40 years (For Females Only) | Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH |
| | > 40 years (For Males Only) | Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT |
| Protect, Plus & Accumulate Plan Sum Insured ₹15 Lacs and Above | 18 to 40 years (For Females Only) | Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH |
| | 18 to 40 years (For Males Only) | Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT |
| | > 40 years (For Females only) | Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT |
| | > 40 years (For Males only) | Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT |
| Preferred & Premier Plan Sum Insured ₹15 Lacs and Above | 18 to 40 years (For Females Only) | Vitals, ECG, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, Pap smear, Mammogram |
| | 18 to 40 years (For Males Only) | Vitals, ECG, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, PSA |
| | > 40 years (For Females only) | Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT, Pap smear, Mammogram, Uric acid, USG Abdomen & Pelvis |
| | > 40 years (For Males only) | Vitals, FBS, Sr. Creatinine, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TMT, PSA, Uric acid, USG Abdomen & Pelvis |

**Full explanation of Tests is provided here:** Vitals - Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth, FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, PSA – Prostate Specific Antigen

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section VII of Policy Terms and Conditions.

**ii) Expert Opinion on Critical Illnesses**

We will provide the Insured person the choice to avail of an expert second opinion from Our network of medical practitioners for an Insured person who is diagnosed with a covered critical illness as listed below, during the policy year.

This benefit can be availed once, by each Insured person during an annual policy period and once during the lifetime for the same Critical Illness.

Covered Critical Illnesses shall include -

- Cancer of specified severity
- Myocardial Infarction (First Heart Attack of specified severity)
- Open Chest CABG
- Open Heart Replacement or Repair of Heart Valves
- Coma of specified severity
- Kidney Failure requiring regular dialysis
- Stroke resulting in permanent symptoms
- Major Organ/Bone Marrow Transplant
- Permanent Paralysis of Limbs

- Motor Neuron Disease with permanent symptoms
- Multiple Sclerosis with persisting symptoms

**iii) Cumulative Bonus**

**a) On Sum Insured**

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

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

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

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

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

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

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

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

h) Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination.

i) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under

**b) On Health Maintenance Benefit for Accumulate Plan**

We will provide a 5% Cumulative Bonus on the unutilised HMB limit available at the end of the Policy Year irrespective of whether a claim is made on the expiring policy. This unutilised HMB limit plus Earned Cumulative Bonus will get carried forward to the next Policy Year.

- Available HMB value in the current Policy will be total of Unutilised HMB limit plus the Earned Cumulative Bonus and the HMB of Current Policy Year.
- Each Year Cumulative Bonus will be calculated on the balance HMB value at the end of the Policy Year, irrespective of any change in Sum Insured or HMB opted on the Plan.
- If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
- If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated HMB limit plus Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the HMB limit plus Cumulative Bonus that will be carried forward for credit in such Renewed Policy shall be the total of all the Insured Persons moving out.
- If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured into two or more Family Floater/individual policies then the Unutilised HMB limit plus Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- Cumulative Bonus on the HMB limit for Accumulate Plan shall not accrue if the Policy is not renewed with us within the Grace Period.

**iv) Healthy Rewards**

You can earn reward points equivalent to 1% of premium paid including taxes & levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being.

In an individual or floater policy: There will be no limitation to the number of programs one can enrol however Rewards can be earned only once for each specific program by a particular Insured Person in a policy year.

Maximum rewards that can be earned in a single policy period will be limited to 20% of premium paid in the Policy.

Details of reward points that can be accrued are listed below.

| Program Type | Points to be earned as a percentage of previous Policy Period Premium |
|---|---|
| Health Risk Assessment (HRA)/ Targeted Risk Assessment (TRA) | 2.5% |
| Lifestyle Management Program (LMP) | 3% |
| Chronic Condition Management Programs | 3% |
| Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives | 2% per program, Maximum 5 programs per policy year |
| Health Check Up | 0.5% |

Reward Points, wherever offered under any specific Sponsored Program will be the same for all customers.

Each earned reward point will be valued at 1 Rupee. Accumulated reward points can be redeemed in the following ways –
- Against payable premium (including Taxes) from 1st Renewal of the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the Policy.
- As equivalent value while availing services through any of Our Network Providers as defined in the Policy.

Refer Annexure for Healthy Reward Process for details of delivery mechanism.

## IV. What are the Optional Covers?

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

**i) Hospital Daily Cash Benefit**

We will pay the Hospital Daily Cash Benefit specified in the Policy for each continuous and completed 24 Hours of Hospitalisation during the Policy

Year, provided that:
a. The hospitalisation claim is admissible under the Base cover.
b. The Benefit will be available up to the maximum 30 days per Policy Year.
c. The Benefit under this cover will be over and above the Sum Insured under Section II.

**ii) Deductible**

We provide an option of selecting a deductible amount as per the Plan opted. Wherever a Deductible option is selected, such deductible amount will be applied on each policy year on the aggregate of all admissible claims in that policy year.

The deductible options under the various plans are listed below -

Protect & Plus plan: ₹1 Lac, ₹2 Lacs & ₹3 Lacs, ₹ 4 Lacs, ₹ 5 Lacs, ₹7.5 Lacs, ₹10 Lacs.

Accumulate plan: ₹50,000, ₹1Lac, ₹2 Lacs, ₹3 Lacs, ₹4 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs

Note: Voluntary Co-pay will not be available along with the Deductible option on the same policy.

Deductible shall apply to all sections other than Hospital Daily Cash Benefit, Health Maintenance Benefit, Health Check Up benefits and Add On Riders if opted.

**Waiver of Deductible:**

We will offer the Insured Person an option to opt out of the Deductible Option under the product at the time of renewal under below conditions:

**Opt out of deductible Within 48 Months**

- The enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as mentioned under the policy shall apply afresh for this enhanced limit from the effective date of such enhancement.
- Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of the insured member at renewal.

**Opt out of deductible After 48 Months:**

- The enhanced coverage will be available for any illness, disease, injury already contracted under the preceding Policy Periods or earlier with continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy, provided that it has been renewed with Us continuously and without any interruption
- Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of insured member at renewal.

**iii) Reduction in Maternity Waiting Period**

We provide option to the Insured person to reduce the mandatory waiting period on Maternity from 48 months to 24 months from the date of inception of first policy with us, depending upon the plan selected.

In case of opting for this benefit, the new born baby cover and first year vaccinations will also follow reduction in waiting period under maternity cover and coverage under both the features will be capped as per the limits specified under Maternity Sum Insured as opted by the insured. All other terms, conditions and exclusions under Maternity Cover shall apply.

**iv) Voluntary Co-pay**

Irrespective of the age and number of claims made by the Insured person and subject to the co-payment option chosen by you, it is agreed that we will only pay 90% or 80% of any amount that we assess (payable amount) for the payment or reimbursement in respect of any claim under the policy made by that Insured person and the balance will be borne by the Insured person.

Co-pay will be applied on the admissible claim amount. In case You have selected the Voluntary co-pay and/or if You choose to take treatment out of Zone then the co-pay percentages will apply in conjunction with Section V (vii).

Co-pays shall not apply to Hospital Daily Cash Benefit, Critical Illness Add On (if opted), Health Check Up's and Health Maintenance Benefit.

**v) Waiver of Mandatory Co-pay**

We will provide an option to remove Mandatory co-pay under Section V. (viii), which is applicable for persons aged 65 years and above will be available on payment of additional premium.

**vi) Cumulative Bonus Booster**

We will provide an option to increase the Sum Insured by 25% for each policy year up to a maximum of 200% of Sum Insured provided that the policy is renewed with us without a break.

- No cumulative bonus will be added if the policy is not renewed with us by the end of the grace period. The cumulative bonus will not be accumulated in excess of 200% of the sum insured under the current policy with us.
- Any earned Cumulative Bonus will not be reduced for claims made in the future. Wherever

  the earned cumulative bonus is used for payment of a claim during a particular policy year.
- In case of opting for Cumulative Bonus Booster, the Cumulative Bonus under Section III. (iii) shall not be available, however all terms and conditions of the said section shall apply.
- This Cumulative bonus shall not be available for claims made for maternity expenses, new born baby cover, first year vaccination.

**Rider/Add On Benefit:** Along with this Product You can also avail the ManipalCigna Critical Illness- Add On Cover. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All terms and conditions of applicable rider including medical check-up requirement will apply.

## V. What are Features of the Policy?

**i) Eligibility**

The minimum entry age under this policy is 91 days for children and 18 years for adults. There is no limit for entry under this policy.
Coverage for children:
a. Children from 91 days to 18 years will only be covered if one of the parents is the proposer.
b. Children up to 23 years can be covered under the floater
c. Children beyond 23 years can be covered under an individual policy.
Renewals will be available for lifetime.

**ii) Individual and Family Floater**

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

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

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, lawfully wedded spouse, children up to the age of 23 years or parents. A floater cover can cover a maximum of 2 adults and 3 children under a single policy.

**iii) Policy Period option**

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

**iv) Plan & Sum Insured Options**

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

| Plan Name | Sum Insured (Lacs) |
|---|---|
| Protect Plan | ₹2.5L, ₹3.5L, ₹4.5L, ₹5.5L, ₹7.5L, ₹10 L, ₹15L, ₹20L, ₹25L, ₹30L, ₹50L |
| Plus Plan | ₹4.5L , ₹5.5L , ₹7.5L, ₹10L, ₹15L, ₹20L, ₹25L, ₹30L, ₹50L |
| Preferred Plan | ₹15L, ₹30L, ₹50L |
| Premier Plan | ₹100 L |
| Accumulate | ₹5.5L, ₹7.5L, ₹10 L, ₹15L, ₹20L, ₹25L, ₹30L, ₹ 50L |

**v) Discounts under the Policy**

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

a. Family Discount - A discount of 25% % for Protect and Plus Plan and 10% for Preferred, Premier and Accumulate Plans covering 2 and more family members under the same policy under the individual policy option.

b. Long Term policy discount -Long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy.

c. Worksite Marketing Discount – A discount of 10% will be available on polices which are sourced through worksite marketing channel.

d. Voluntary Co-pay Discount – A discount of 7.5% for opting 10% Co-pay and a discount of 15% for opting a 20% Co-pay on the Policy in case of Protect & Plus Plan.

A discount of 5% for opting 10% Co-pay and 10% for opting 20% Co-pay on the Policy in case of Accumulate Plan.

Discount under v (a) is applicable only to individual policies. All discounts under v (b) to (d) are available to both individual as well as floater policies. Maximum discount applicable on a single policy shall not exceed 40%, excluding discount for Voluntary Co-pay which is a cost sharing mechanism.

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

**vi) Underwriting Loading & Special Conditions**

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

We may apply a specific sub-limit on a medical condition/ailment depending on Your medical history and declarations or additional waiting periods (a maximum of 48 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.

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

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

**vii) Premiums**

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

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

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

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

Zone Classification

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

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

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

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

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

(b) Persons paying Zone II premium

i) Can avail treatment in Zone II and Zone III without any co-pay.

ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

(c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any co-pay

ii) Availing treatment in Zone II will have to bear 10% of each and every claim.

iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

1. ***Option to select a Zone higher or lower than that of the actual Zone is available on payment of relevant premium at the time of buying the policy or at the time of renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident. Premium towards Maternity Expenses, Newborn baby expenses and First Year Vaccinations shall be applied to female Insured Members between age group of 18 to 45 years only (both age inclusive).

**viii) Premium payment mode**

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

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

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

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

If we receive any amount in excess of the required premium, we will refund the excess without paying any interest on the excess amount.

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

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

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

**ix) Mandatory Co-pay**

A compulsory co-payment of 20% is applicable on all claims for Insured Persons aged 65 years and above irrespective of the age of entry in to the Policy. Co-pay will be applied on the admissible claim amount. For persons who have opted for a Waiver of Mandatory Co-pay the same will not apply. In case the Insured has selected the Voluntary co-pay under Optional Cover and/or chooses to avail treatment outside his Zone of Cover, then the co-pay percentages will apply in conjunction.

**x) Renewal Terms**

a. The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realisation of Renewal premium.

b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30/15 days (as applicable) between the previous policy expiry date and current Policy start date. We, however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy. In case of Accumulate Plan only the unutilised Health Maintenance Benefit limit (excluding any Cumulative Bonus) will be available for a claim during the grace period.

**Premium Payment in Instalments Revival Period: 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, as mentioned in Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

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

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

i. NACH/Standing Instruction Mandate form is completely filled & signed by You.
ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.
iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

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

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

c. Where the Policy is not renewed before the end of the Grace Period and the Policy is terminated, any unutilised Health Maintenance Benefit limit in respect of the Accumulate Plan shall be available for a claim as defined under II. (xi) above for up to a period of 12 months from the date of expiry of the Policy.

d. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.

e. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.

f. 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.

g. We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

h. Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes of Sum Insured or addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception, on renewal. The terms and conditions of the existing policy will not be altered.

i. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

j. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48/ 36/ 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.

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

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

m. Once an Insured Person attains the age of 65 years on renewal a Mandatory co-payment of 20% will be applicable on all claims irrespective of the age of entry in to the Policy. This clause does not apply to persons who have opted for a Waiver of Mandatory Co-pay.

n. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured under the original Policy.

**xi) Portability**

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section V of the policy terms and conditions shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule 1 of IRDAI(Health Insurance) Regulations 2016 for the Portability norms.

All benefits under the Policy will terminate on successful porting of the Policy other than any Health Maintenance Benefit under Accumulate Plan which will be available for a claim up to a period of 12 months from the date of expiry of such policy.

In case You have opted to switch to any other insurer under portability provisions and the outcome of acceptance of the portability request is awaited from the new insurer on the date of renewal,

a. We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis.

b. If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately, We may deduct the premium for the balance period and pay the balance claim amount if any and issue the Policy for the remaining period.

**xii) Income Tax benefit**

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

**xiii) Fre-look Period**

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

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

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

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

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

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

**xiv) Cancellations**

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

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

| | Refund Grid as % of Premium | | |
|---|---|---|---|
| In force Period-Up to | 1 Year | 2 Year | 3 Year |
| 0 - 30 Days | 75.00% | 85.00% | 90.00% |
| 31 - 90 Days | 50.00% | 75.00% | 85.00% |
| 91 - 180 Days | 25.00% | 60.00% | 75.00% |
| 181 - 365 Days | NIL | 50.00% | 60.00% |
| 366 - 455 Days | | 30.00% | 50.00% |
| 456 - 545 Days | | 20.00% | 35.00% |
| 546 - 730 Days | | NIL | 30.00% |
| 731 - 910 Days | | | 15.00% |
| More than 910 Days | | | NIL |

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

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, moral hazard, fraud or non-disclosure of material fact without any refund of premium.

Cover may end immediately for all Insured Persons, if there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

An individual policy with a single insured shall automatically terminate in case of Your death or if You are no longer a resident of India. In case of an Individual Policy with multiple Insured Persons and in case of a floater, the Policy shall continue to be in force for the remaining members of the family up to the expiry of current Policy Period. The Policy may be Renewed on an application by another adult Insured Person under the Policy whenever such is due. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with You) must be given to Us along with the Application.
All coverages and benefits including any earned Healthy Reward Points under the Policy shall automatically lapse upon cancellation of the Policy.

Wherever a Policy under the Accumulate Plan is cancelled, any unclaimed Health Maintenance Benefit will be active on the Policy and available for a claim over the next 12 month period. You may convert any available Healthy Reward Points in to Health Maintenance Benefit before initiating the cancellation of the Policy.

**xv) Endorsements**

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

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

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

**b) Financial Endorsements – which result in alteration in premium**

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

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

**xvi) Redressal of Grievance**

In case of a grievance, You can contact Us with the details through:
Our website: www.manipalcigna.com
Email: customercare@manipalcigna.com

Toll Free: 1800-102-4462

Contact number: + 91 22 61703600

Post/Courier: Any of Our Branch office or Corporate office at the addresses available on Our website.

You can also walk-in and approach the grievance cell at any of Our branches. If in case You are not satisfied with the response then You can contact Our Head of Customer Service at the following email headcustomercare@manipalcigna.com

If You are still not satisfied with Our redressal, You may approach the nearest Insurance Ombudsman. The Contact details of the Ombudsman offices are provided on Our Website.

Grievance may also be lodged at IRDAI Integrated Grievance Management System – https://igms.irda.gov.in/

**xvii) Pre-Policy Medical Check-up**

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

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

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

| Plan Name | Sum Insured (Lacs) | Age Group (years) | Medical Tests |
|---|---|---|---|
| Protect, Plus Preferred & Accumulate Plan | 2.5L, 3.5L, 4.5 L, 5.5L,7.5 L, 10 L, 15L, 20L, 25L, 30L, 50L | Up to 45 | NO TEST |
| | | 46-55 | Tests shall be based on Medical declarations by the Insured and underwriting evaluation. |
| | | >55 | SET 14- MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG |
| Premier & Preferred Plan | >50L | Up to 18 | SET 1 – MER |
| | | >18 | SET 14- MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG |

The above list of Medical Tests and age criteria may be modified after due approval from the Head of Underwriting.

**Full explanation of Tests is provided here:** MER – Medical Examination Report, FBS – Fasting Blood Sugar, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate.

**xviii) Migration:**

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

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

**xix) Moratorium Period:**

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

## VI. What are the Waiting Period and Exclusions?

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

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

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of applicable months (24 months for Preferred, Premier plan /36 months for Plus, Accumulate plan/48 months for Protect plan) of continuous coverage after the date of inception of the first policy with us.

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

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

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

**ii. 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 sum insured in the event of granting higher sum insured subsequently.

**iii. Specified disease/procedure Waiting Period - Code- Excl. 02**

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

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

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

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

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then

waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures:

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing then they will have to be covered after the pre-exiting disease waiting period of (24 months for Preferred, Premier Plan/ 36 months for Plus, Accumulate Plan/ 48 months for Protect Plans).

**iv. Maternity Waiting Period:**

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed for that particular Insured Person since the inception of the first policy with us. However, this exclusion / waiting period will not apply to ectopic pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.

Wherever Optional Cover for 'Reduction in Maternity Waiting Period' has been opted this limit will be reduced to 24 months of continuous cover.

**v. Personal Waiting Period:**

A special waiting period not exceeding 48 months, may be applied to individual Insured persons for the list of acceptable Medical Ailments listed under Section V (vi). Underwriting Loading & Special Conditions , depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

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

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

**vii. Permanent Exclusions**

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

**1. Investigation & Evaluation- Code- Excl 04**

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

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

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

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

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

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

**3. Obesity/ Weight Control: Code- Excl 06**

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

1. Surgery to be conducted is upon the advice of the Doctor

2. The surgery/Procedure conducted should be supported by clinical protocols

3. The member has to be 18 years of age or older and

4. Body Mass Index (BMI);

a. greater than or equal to 40 or

b. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

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

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

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

**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. (e.g. Intentional self-Injury, suicide or attempted suicide (whether sane or insane).

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

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

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

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of hospitalisation 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** (applicable to Protect and Accumulate plan)
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) 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 Hospitalisation. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the Policy.
17. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
18. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
19. External Congenital Anomaly or defects or any complications or conditions arising therefrom.
20. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
21. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
22. Treatment received outside India other than for coverage under World Wide Emergency Cover, Expert Opinion on Critical Illnesses.
23. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
24. Any form of Non-Allopathic treatment (except AYUSH In-patient Treatment), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.
25. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack or in any other sequence to the loss..
26. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.
27. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment.
For complete list of Non-medical expenses, Please refer to the Annexure IV List – I "Items for which Coverage is not available in the Policy"
28. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.
29. Existing diseases disclosed by the Insured Person ((limited to the extent of the ICD codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

## VII. How can I buy the Policy?

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

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

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

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

**Step 5:** Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and

associated documents will be sent to you.

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

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

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

## VIII. What is the Claim Process?

**a) Duties of the claimant**

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

**b) Claim Process**

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

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

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

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

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

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

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

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

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

- o Claim Form Duly Signed
- o Original pre-authorisation request
- o Copy of pre-authorisation approval letter (s)
- o Copy of Photo ID of Patient Verified by the Hospital
- o Original Discharge/Death Summary
- o Operation Theatre Notes(if any)
- o Original Hospital Main Bill and break up Bill
- o Original Investigation Reports, X Ray, MRI, CT Films, HPE
- o Doctors Reference Slips for Investigaions/Pharmacy
- o Original Pharmacy Bills
- o MLC/FIR Report/Post Mortem Report (if any)

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 Hospitalisation 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. Wherever a TPA is used, the TPA will only work to facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

## IX. What are the Plans Benefit Details?

The policy is available under 5 Plans as detailed below: ManipalCigna ProHealth Insurance (Plan Benefit Structure)

| Title | Description<br>Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief | | | | | |
|---|---|---|---|---|---|---|
| **Your Coverage Details:** | *Identify your Plan* | ***Protect*** | ***Plus*** | ***Preferred*** | ***Premier*** | Accumulate |
| **Basic Cover**<br><br>This section lists the Basic benefits available on your plan | *Identify your Opted Sum Insured* | ₹ 2.5 Lacs<br>₹ 3.5 Lacs<br>₹ 4.5 Lacs,<br>₹ 5.5 Lacs,<br>₹ 7.5 Lacs,<br>₹ 10 Lacs,<br>₹ 15 Lacs,<br>₹ 20 Lacs,<br>₹ 25 Lacs,<br>₹ 30 Lacs,<br>₹ 50 Lacs | ₹4.5 Lacs,<br>₹5.5 Lacs,<br>₹7.5 Lacs,<br>₹10 Lacs,<br>₹15 Lacs,<br>₹20 Lacs,<br>₹25 Lacs,<br>₹30 Lacs,<br>₹50 Lacs | ₹15 Lacs,<br>₹30 Lacs,<br>₹50 Lacs | ₹100 Lacs | ₹5.5 Lacs,<br>₹7.5 Lacs,<br>₹10 Lacs,<br>₹15 Lacs,<br>₹20 Lacs,<br>₹25 Lacs,<br>₹30 Lacs,<br>₹50 Lacs |
| | Inpatient Hospitalisation (When you are hospitalised) | For Sum Insured up to ₹5.5 Lacs - Covered up to Single Private Room<br>For Sum Insured ₹7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category | Covered up to any Room Category except Suite or higher category | | | For Sum Insured ₹5.5 Lacs - Covered up to Single Private Room<br>For Sum Insured ₹7.5 Lacs and Above - Covered up to any Room Category except Suite or higher category |
| | Pre - hospitalisation | Medical Expenses Covered up to 60 days before date of hospitalisation. | | | | |
| | Post - hospitalisation | Medical Expenses Covered up to 90 days post discharge from hospital | Medical Expenses Covered up to 180 days post discharge from hospital | | | Covered up to 90 days post discharge from hospital |
| | Day Care Treatment | Covered up to the limit of Sum Insured opted | | | | |
| | Domiciliary Treatment (Treatment at Home) | Covered up to the limit of Sum Insured opted | | | | |
| | Ambulance Cover (Reimbursement of Ambulance Expenses) | Up to ₹2000 paid per hospitalisation event | Up to ₹3000 paid per hospitalisation event | Actual incurred expenses paid per hospitalisation event | | Up to ₹2000 per hospitalisation event |
| | Donor Expenses (Hospitalisation Expenses of the donor providing the organ) | Covered up to full Sum Insured | | | | |
| | Worldwide Emergency Cover (Outside India) | Covered up to full Sum Insured once in a Policy Year | | | | |
| | Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims) | Multiple Restoration is available in a Policy Year for unrelated illnesses in addition to the Sum Insured opted | | | | |
| | AYUSH Cover | Covered up to full Sum Insured | | | | |
| | Health Maintenance Benefit (Treatment that does not require hospitalisation and can be carried out in an Out Patient Department) | Covered up to ₹500 Per Policy Year | Covered up to ₹2000 Per Policy Year | Covered up to ₹15000 per policy year. | | Option to choose from - ₹5000, ₹10000, ₹15000, ₹20000 Per Policy Year Can also be used to pay for Co-pay or Deductible. Up to 50 % of the accumulated Health Maintenance Benefit can be utilised for payment against premium from first renewal of the policy |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Cumulative Bonus on Health Maintenance Benefit | NA | NA | NA | | 5% Cumulative Bonus on the unutilized Health Maintenance Benefit limit (HMB) available at the end of the Policy Year irrespective of whether a claim is made on the expiring policy. |
| | Maternity Expenses | Not Available | Covered upto ₹ 15,000 for normal delivery and ₹ 25,000 for C-Section per event, after a Waiting Period of 48 months | Covered upto ₹50,000 for normal delivery and ₹100,000 for C-Section per event, after a waiting Period of 48 months | Covered upto ₹100,000 for normal delivery and ₹200,000 for C-Section per event, after a waiting Period of 48 months | Not Available |
| | New Born Baby Expenses | | Covered for the inpatient hospitalisation expenses of a new born up to the limit provided under Maternity Expenses | | | |
| | First Year Vaccinations | | Covered as per national immunisation programme over and above Maternity Sum Insured | | | |
| **Value Added Covers**<br><br>This section lists the additional value added benefits that are available along with your plan | Health Check-Up | Available once every 3rd Policy year to all insured persons who have completed 18 years of Age | Available each policy year(excluding the first year) , to all insured persons who have completed 18 years of Age | | | Available once every 3rd Policy year to all insured persons who have completed 18 years of Age |
| | Expert Opinion on Critical illness (By a Specialist) | Available once during the Policy Year | | | | |
| | Cumulative Bonus | A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured. | A guaranteed 10% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured | | | A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 200% of Sum Insured. |
| | Healthy Rewards | Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used against payable premium (including Taxes) from 1st Renewal of the Policy.<br>OR they can be redeemed for equivalent value of Health Maintenance Benefits any time during the policy<br>OR as equivalent value while availing services through our Network Providers as defined in the policy. | | | | |
| **Optional Covers**<br><br>This section lists the available optional covers under your plan and the limits under each of these options | Hospital Daily Cash Benefit | ₹1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year | ₹2000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year | ₹3000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year | | ₹1000 for each continuous and completed 24 Hours of Hospitalisation during the Policy Year up to a maximum of 30 days in a policy year |
| | Deductible#<br>(Please select the Sum Insured and Deductible amount as you have opted on the Policy. Deductible is the amount beyond which a claim will be payable in the Policy) | ₹1/ 2/ 3/ 4/ 5/ 7.5 /10 Lacs | ₹1/ 2/ 3 / 4 / 5 / 7.5 / 10 Lacs | Not Available | | ₹0.5/1/2/3/4/ 5/7.5/10 Lacs |
| | Waiver of Deductible | Available | Available | Not Available | | Available |

| | | | | | |
|---|---|---|---|---|---|
| | Reduction in Maternity Waiting Period | Not Available | Maternity waiting period Reduced from 48 months to 24 months | | Not Available |
| | Voluntary Co-pay# (The cost sharing percentage that you have opted will apply on each claim.) If you have opted for a Deductible, Voluntary Co-payment does not apply | 10% or 20% Voluntary Co-payment for each and every claim as opted | | Not Available | 10% or 20% voluntary co-payment for each and every claim as opted on the Policy |
| | Waiver of Mandatory Co-pay | Waiver of Mandatory co-payment of 20% for Insured Persons aged 65 years and above | | | |
| | Cumulative Bonus Booster | A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured | | Not Available | A guaranteed 25% increase in Sum Insured per policy year, maximum up to 200% of Sum Insured |
| **Add on cover (Rider)** This section lists the Add on cover available under your plan | Critical Illness | Lump sum payment of an additional 100% of Sum Insured Opted | | Not Available | Lump sum payment of an additional 100% of Sum Insured Opted |

#Voluntary Co-pay and Deductible cannot be taken under a single plan

**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:**

**Illustration of Benefits**
**Rate Charts**