MAGMA HDI
General Insurance Company Ltd.

TRUTH MUST BE TOLD

DOUBLE SURAKSHA PROSPECTUS

www.magmahdi.com

customercare@magma-hdi.co.in

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Eligibility

- This Policy can be offered as an Individual Policy covering one member or as a Family Floater Policy.
- For individual Policies, minimum entry age is 5 years
- For Family Floater Policy dependent child, grandchild can be of age minimum 91 days. An insured Child under a Family Floater policy, on reaching age 26 years will be considered as Adult on renewal. If such Policy was already consisting of 4 Adults, such individual will be moved to a separate individual policy with continuity benefit on waiting periods.
- No cap on maximum entry age.
- Proposer (Policyholder) should be 18 years or above.
- Your employer can also be the Proposer (Policyholder).
- Lifetime renewability.
- Family includes self, spouse, dependent children, dependent parent(s) dependent parents-in-law, son-in-law, daughter-in-law, dependent grandchild(ren), brother and sister. However maximum number of Insured Persons in a Policy can be 4 adults and 3 children.
- The age considered is the completed number of years as on last birthday.
- Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.
- Residents in India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependent pass or work permit and residing in India.

Policy Period

The Policy will be issued for 1 year or 2 years or 3 years period.

Sickness Hospital Cash Sum Insured

Rs. 1,000 / 2,000 / 3,000 / 5,000 / 7,000 / 10,000 Per Day

Number of Hospital Cash Days per Policy Year

30 days/ 60 days / 90 days / 120 days / 180 days

Benefits

The Benefits under this Policy are subject always to the Sum Insured if any, any subsidiary limit specified in the Policy Schedule/Product Benefits Table, the terms, conditions, limitations, deductibles and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for in the Product Benefits Table and as shown in the Policy Schedule

Benefits covered under the policy

Any Claim under the Policy will trigger only after a deductible of one day except for Accident Hospital Cash Benefit (24 continuous hours of Hospitalisation) and will become payable from day two of Hospitalisation unless optional benefit either 'Reduction in Deductible' or 'Increase in Deductible' is selected. In such a case deductible as opted will be applicable. Sum Insured means Sickness Sum Insured opted.

All benefits will be available for a maximum of 30 / 60 / 90 / 120 / 180 days per Policy Year as per the maximum limit opted.

A. Base Covers:

2.A.1 Sickness Hospital Cash

During the period stated in the Schedule, if the insured person shall contract any disease or suffer from any illness and if such disease / illness shall, upon the advice of a duly qualified Medical Practitioner, require admission of the insured Person as an In-patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay to the Insured Person, Hospital Cash Amount mentioned in the schedule for every 24 hours of hospitalization subject to maximum number of days stated in the Schedule.

2.A.2 Accident Hospital Cash Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment due to an Injury that occurred during the Policy Period, we will pay two times the Sickness Daily Cash Benefit amount specified in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalisation.

2.A.3 ICU Cash Benefit

If the Insured Person is Hospitalized in an Intensive Care Unit (ICU) during the Policy Period for Medically Necessary treatment of an Illness or an Injury that occurred during the Policy Period, we will pay two times the Sickness Daily Cash Benefit amount specified in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalisation.

Coverage under this benefit is limited to a maximum of 7 days per Insured Person per Policy Year.

If optional cover 'Increase in Max days for ICU Benefit' is opted the coverage of this benefit will be modified to maximum of 15 days per Insured Person per Policy Year

2.A.4 AYUSH Treatment

We will, cover Your Medical Expenses incurred for Inpatient Care during the Policy Period on treatment taken under AYUSH Treatment in:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. 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:

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;

   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

   iv. Maintaining daily records of the patients and making them accessibl to the insurance company's authorized representative.

Our maximum liability will be limited up to the amount provided in the Policy Schedule/Product Benefits Table under the applicable benefit.

B. Optional Covers:

The following optional Covers shall apply under the Policy for all Insured Persons if specifically opted and thus mentioned in the Policy Schedule without any individual selection. All benefits available under optional covers are in provided in consideration to extra premium as charged.

2.B.1 Convalescence Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Illness or an Injury that occurred during the Policy Period and the continuation of such Hospitalisation is Medically Necessary for at least 5 consecutive days, then We will pay a lump sum amount of 7,000 rupees in addition to claim payable under 2.A.1, 2.A.2 and 2.A.3.

2.B.2 Day Care Treatment Cash

If the Insured Person requires and avails a Medically Necessary listed day care Treatment as defined below during the Policy Period, we will pay a lump sum benefit amount which is 2 times the Sickness Daily Cash Benefit for such Day Care Treatment only for five times in a policy year provided the Insured Person is admitted in the Hospital for such Day Care Treatment for less than 24 hours.

- Fractures (other than hairline fractures)
- Cataract,
- Dilatation and curettage
- Hemodialysis
- Parenteral Chemotherapy
- Radio Therapy
- Coronary Angiography
- Lithotripsy
- Manipulation for Dislocation under General Anesthesia
- Cystoscopy under General Anesthesia

2.B.3 Childbirth Hospital Cash

During the period stated in the Schedule the insured person shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person as an In-patient in any Hospital in India for the purpose of Child Delivery, then the Company will pay one time the Sickness Daily Cash Benefit amount specified in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalisation for 2 deliveries.

Special Condition 1. The coverage under this benefit is subject to a waiting period of 2 years from the first commencement of this Policy

2. Only female insured persons are eligible for this benefit

Exclusion 3.2.17 do not apply to this Benefit.

2.B.4 Worldwide Hospital Cash

If the Insured Person is Hospitalized in a Hospital room Or Intensive Care Unit (ICU) outside India in an emergency during the Policy Period for Medically Necessary treatment of an Illness or an Injury that has occurred during the Policy Period, we will pay 3 times the Sickness Daily Cash Benefit or Lumpsum Rs. 15,000 whichever is lower subject to maximum number of days stated in the Schedule for each continuous and completed period of 24 hours of Hospitalisation.

Exclusion 3.2.22 do not apply to this Benefit.

2.B.5 Companion Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Illness or an Injury that occurred during the Policy Period, we will pay additional lumpsum of Rs.5,000 in respect of an accompanying person to take care of the Insured while he is hospitalised.

2.B.6 Compassionate Benefit

If the Insured Person sustains an Injury resulting solely and directly due to an accident anywhere in the world and causes any of the following events during the policy period, then we shall pay the Insured Person or his/her nominee as the case may be, the amount(s) hereinafter set forth.

Events covered:

a) Accidental Death
If such Injury results in the death of the Insured Person within twelve calendar months from the date of the Accident, then We will pay the Sum Insured stated in the Policy Schedule/Product Benefits Table.

b) Permanent Total Disablement

1. If such Injury, within twelve calendar months from the date of the Accident, results in any of the following, then as per the table below, We shall pay a lump sum amount equal to the percentage of limit as mentioned for Personal Accident Benefit in the Product Benefits Table /Policy Schedule,

Nature of Disablement	Percentage of Limit for Personal Accident Cover payable
Total and irrecoverable loss of sight of both eyes	100%
Actual loss by physical separation of two entire hands	100%
Actual loss by physical separation of two entire feet	100%
Actual loss by physical separation of one entire hand and one entire foot	100%
Total & irrecoverable loss of sight of one eye	50%
Actual loss by physical separation of one entire hand or of one entire foot	50%
Total and irrecoverable loss of use of a hand or a foot without physical separation	50%
If such Injury shall, as a direct consequence thereof, immediately, permanently, totally and absolutely, disable the Insured Person from engaging in any employment or occupation of any description	100%

For the purpose of Clause 1.above, physical separation of a hand means separation at or above the wrist and of the foot means separation at or above the ankle.

If a claim becomes admissible under this Benefit where the claim paid is 100% of the limit under this Optional cover, then this Optional Cover shall not be available for that Insured Person at the time of Renewal.

2.B.7 Pre and Post-Hospitalisation Expenses

We shall cover your relevant pre and post hospitalization medical expenses incurred in respect of an Injury or Illness that occurs during the policy period, immediately prior to Your date of Hospitalization and immediately after Your discharge from the Hospital, then the Company will pay one time the Sickness Daily Cash Benefit amount specified in the Policy Schedule as lumpsum payment. This is provided if a claim has been admitted by us under2.A.1, 2.A.2 and 2.A.3

2.B.8 Health Maintenance Benefit

This optional cover helps you in getting your bill reimbursed upto the limits specified in the schedule over and above the sum insured opted under base cover. The OPD benefit will cover the following on reimbursement basis.

For Sum Insured less than 5,000 per day of Sickness Hospital Cash

One Vison care OPD for ophthalmologist consultation, diagnostics and treatment for maximum of 1000 Rs. for each instance.

Two Orthopaedic care OPD for orthopaedic consultation, diagnostics, and treatment for maximum of 1500 Rs. for each instance.

For Sum Insured equal to more than 5,000 per day of Sickness Hospital Cash

One Vison care OPD for ophthalmologist consultation, diagnostics and treatment for maximum of 1000 Rs. for each instance.

Two Orthopaedic care OPD for orthopaedic consultation, diagnostics, and treatment for maximum of 1500 Rs. for each instance.

Three Physiotherapy care session for physiotherapy consultation and treatment for maximum of 1000 Rs. for each instance.

Exclusion No 3.2.9, 3.2.17 and 3.2.26 will not be applicable to this section to the extent applicable for this clause.

2.B.9 Reduction of deductible days

This optional benefit allows the Insured / Insured Person to opt for 0 day deductible instead of 1 day deductible.

2.B.10 Increase of deductible days

This optional benefit allows the Insured / Insured Person to

opt for 2 days or 3day or 4 days of deductible instead of 1 day deductible.

Only one optional benefit is to be selected between Reduction of deductible days and increase in deductible days.

2.B.11 Increase in Maximum days for ICU Benefit

This optional benefit allows the Insured / Insured Person to opt for 15 days instead of 7-days as maximum coverage period specifically for **2.A.3 ICU Cash Benefit.**

2.B.12 Reduction of Pre existing disease waiting period

This optional benefit allows the Insured / Insured Person to opt for 24 months of waiting Period instead of 36 months.

2.B.1 Reduction of Named Ailments waiting period

This optional benefit allows the Insured / Insured Person to opt for 12 months of waiting period instead of 24 months. This named ailments are listed in SECTION 3 - EXCLUSIONS: 3.1.2 Exclusion Name: Specified disease/procedure waiting period- Code- Excl02

Section 3. Exclusions

3.1 Standard Exclusions

3.1.1) Pre-Existing Diseases (Code- Excl01):

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. The waiting period would be reduced to 24 months if the same is opted and mentioned in policy schedule; 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 above defined months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

This clause will not apply to coverage under Accidental Death & Permanent Total Disability Cover wherever opted.

3.1.2) Specific Diseases Waiting Period (Code- Excl02):

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. The waiting period would be reduced to 12 months if the same is opted and mentioned in policy schedule; 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.

List of these diseases is:

1. Cataract
2. Stones in biliary and urinary systems
3. Hernia / Hydrocele
4. Hysterectomy for any benign disorder
5. Lumps / cysts / nodules / polyps / internal tumours
6. Gastric and Duodenal Ulcers
7. Surgery on tonsils / adenoids
8. Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
9. Fissure / Fistula / Haemorrhoid
10. Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
11. Benign Prostatic Hypertrophy
12. Knee/Hip Joint replacement and any ligament, tendon, or muscle tear
13. Dilatation and Curettage
14. Varicose veins
15. Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
16. Chronic Renal Failure or end stage Renal Failure
17. Internal congenital anomalies/diseases/defects except for new-borns and infants

3.1.3) First Thirty Days Waiting Period (Code- Excl03)

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

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

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

3.1.4) Investigation & Evaluation (Code Excl04):

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.

3.1.5) Rest Cure, Rehabilitation and respite Care (Code Excl05)

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.

3.1.6) Change of Gender treatment (Code Excl07)

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

3.1.7) Cosmetic or Plastic Surgery (Code Excl08)

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.

3.1.8) Hazardous or Adventure sports: (Code- Excl09)

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.

3.1.9) Breach of law (Code Excl10)

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

3.1.10) Excluded Providers (Code Excl11)

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.

List of these have been provided on Our website.

3.1.11) Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

3.1.12) Treatment 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**

3.1.13) 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- Excl14**

3.1.14) Refractive Error (Code Excl15)

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

3.1.15) Unproven treatments (Code Excl16)

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

3.1.16) Sterility and Infertility (Code Excl17)

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

3.1.17) Maternity expenses (Code Excl18)

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

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

3.1.18) Obesity/Weight Control (Code Excl06)

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 co-morbidities 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

3.2) Specific Exclusions:

3.2.1) Any Alternative Treatment

3.2.2) Charges related to a Hospital stay not expressly mentioned as being covered. Service charges levied by the Hospital under whatever head. Complete list of these excluded expenses are mentioned in Annexure II of this Policy. The list is available on our website www.magma hdi.com.

3.2.3) Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Illness or Injury.

3.2.4) Circumcision unless necessary for the treatment of an Illness or disease or necessitated by an Accident.

3.2.5) Treatment for any Illness or Injury resulting from nuclear or chemical contamination, war, riot, revolution or acts of terrorism (other than natural disaster or calamity).

3.2.6) Treatment for any External Congenital Anomaly.

3.2.7) Dental Treatment including Surgical Procedures for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the temporomandibular joint.

EXCEPTION: We will pay for a Surgical Procedure wherein the Insured Person Hospitalized as a result of an Accident and which is undertaken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

3.2.8) Any drugs or Surgical dressings that are provided or prescribed in the case of OPD treatment, or for the Insured Person to take home on leaving the Hospital, for any condition, except as included in post-hospitalization.

3.2.9) We will not pay for routine eye examinations, contact lenses spectacles.

3.2.10) We will not pay for hearing aids, dentures and artificial teeth.

3.2.11) Private nursing/attendant's charges incurred during pre-hospitalization or post-hospitalization.

3.2.12) Drugs or treatment not supported by prescription.

3.2.13) Issue of fitness certificate and fitness examinations.

3.2.14) Any charges incurred to procure any treatment/ Illness related documents pertaining to any period of Hospitalization/Illness.

3.2.15) External and/ or durable medical/non-medical equipment used for diagnosis and/ or treatment

3.2.16) Ambulatory devices, walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and also any medical equipment which is subsequently used at home.

3.2.17) OPD treatment is not covered.

3.2.18) All preventive care, vaccination including inoculation and immunisations.

3.2.19) Treatment for, or arising from, an Injury that is intentionally self-inflicted, including attempted suicide.

3.2.20) Treatment of any sexual problem including impotence (irrespective of the cause) or erectile dysfunction.

3.2.21) Treatment for any sexually transmitted disease except HIV / AIDS, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

3.2.22) Treatment for sleep apnea, snoring, or any other sleep-related breathing problem.

3.2.23) Any treatment received outside India.

3.2.24) Treatment provided by a Medical Practitioner who is not recognized by the Medical Council of India.

3.2.25) Treatment provided by anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family.

3.2.26) X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization.

3.2.27) Any treatment arising out of engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.

3.2.28) Any treatment arising out of engaging in flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air charter company.

The following exclusions shall be applicable in respect of the Benefit specified under **Compassionate Benefit** section.

This Policy does not provide benefits for any death, disablement, expenses, or loss incurred as a result of any Injury attributable to the following:

- Injury or treatment related to addictive conditions and disorders resulting from any kind of substance abuse or misuse including alcohol abuse or misuse.
- Participation in Hazardous Activities.
- Insured person committing any breach of law with criminal intent or participation in any riots, civil commotion, or felony.
- Any intentional self-injury, suicide or attempted suicide, insanity, or stress.
- Condition resulting due to any disease or infection unless arising directly and solely due to accident
- Any change of profession after inception of policy which results in increase in risk, unless declared by insured person and accepted & endorsed by Us.
- Any sexually transmitted disease.
- Related to or traceable to Pregnancy or childbirth.
- Whilst mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airlines in the world or in any aircraft whether privately owned or chartered or operated by scheduled airlines.
- Insured person operating or learning to operate any aircraft or performing duties as member of crew on any aircraft or scheduled airlines or any airline personnel.
- War or war like operations, Civil War, invasion, act of foreign enemies, revolution, insurrection, mutiny, terrorism, military or usurped power, seizure, capture, arrest, restraint, or detainment, confiscation, or nationalisation or requisition by or under the order of any government or public authority.
- Any act of Nuclear, Chemical, Biological Terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss.
- Radioactive, chemical, nuclear contamination, or ionizing radiation.
- Any insured person's participation or involvement in any branch of naval, air force or military operations or any paramilitary forces.
- Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.
- Existing diseases disclosed by the Insured Person (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.

Discount/ Loading Factors:

Maximum up to 20% discount shall be offered based on following parameters. The discount is applicable on insured level in case of Individual policy. In case of Family floater policy, the discount is on policy level and not on insured level. Therefore, even if one of the insured under the floater cover fulfils the criteria, discount would be given on entire policy.

1. Tenure discount

Policy Period	Discount percentage
2 years	10%
3 years	12.5%

2. Employee Discount: A discount of 15% is offered for employees of Magma HDI General Insurance Companies Limited and its parent group and its subsidiaries and other affiliated companies provided the Policy is purchased without any intermediary.
3. Cross sell discount: A discount of 5% will be offered if the proposer is a Policyholder with Magma HDI on or prior to inception of this Policy.
4. Direct Sourcing Discount: A discount of 10% will be offered if the Policy is purchased through direct channel of distribution. This discount will not be offered if Employee discount is availed.

Loading: We shall apply a risk loading on the premium payable as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Policy Schedule. The maximum risk loading applicable shall not exceed 100% per diagnosis / medical condition and an overall risk loading of 150%. These loadings are applied from the Policy Inception Date including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured).

No loading shall be applied at the time of Renewal on the basis of individual claim experience.

Loading for Instalment Option: If You want to opt for premium payment in instalments following loading shall be applicable. Tenure discount shall not be applicable if instalment option is chosen.

Instalment Option	**Factor to be applicable on premium for one year tenure Policy**	**Factor to be applicable on premium for two year tenure Policy**	**Factor to be applicable on premium for three year tenure Policy**
Monthly	1.05/12	1.05/24	1.05/36
Quarterly	1.04/12	1.04/24	1.04/36
Half Yearly	1.03/12	1.03/24	1.03/36

Pre Policy Medical Grid

- The Company will reimburse 50% of the cost of medical examination underwent by the Insured person(s) at the designated Hospital/ Diagnostic centre, if the proposal

is accepted. The medical reports are valid for a period of 30 days from the date of pre-Policy check-up.

- The Company can call for additional medical test(s) based on declaration in proposal form or based on findings of first set of medical reports.

Section 4. General Terms and Clauses

4.1) Standard General Term and Clauses

4.1.1) Disclosure to Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

4.1.2) Condition Precedent to admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

4.1.3) Claim Settlement (Provision for penal interest)

(i) The Company shall settle or reject a claim, as may be the case, within 30 days from the date of receipt of last necessary document.

(ii) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(iii) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

(iv) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank Rate" means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.)

4.1.4) Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4.1.5) Multiple Policies

1. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions this Policy.
3. If the amount to be claimed exceeds the sum insured under a single policy, the Insured Person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
4. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

4.1.6) Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any Benefit under this Policy,all benefits under this Policy and the premium paid shall be forfeited. .

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent, or the hospital/doctor/any other party acting on behalf of the insured person with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and/or forfeit the policy benefits, on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

4.1.7) Cancellation/ Termination (other than Free Look cancellation)

(i) The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall

a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

(ii) The Company may cancel the policy at any time on grounds of established fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation.

4.1.8) 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 the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

4.1.9) Portability

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

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

4.1.10) Renewal of Policy

a) A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured.The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

b) An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.

c) Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

d) At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits with Break in Policy. Coverage is not available during the grace period.

e) An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

4.1.11) Withdrawal of the Policy

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

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

4.1.12) Moratorium Period:

After completion of sixty 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 sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanceed limits.

4.1.13) Premium Payment in Instalments (Wherever applicable)

If the Insured Person has opted for Payment of Premium on

an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefits in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

4.1.14) Possibility of Revision of Terms of the Policy including the Premium Rates

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

4.1.15) Free Look Provision

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 shall be allowed a free look provision of thirty days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

i. 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

ii. 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

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

4.1.16) Redressal of Grievance

In case of any grievance, the insured person may contact the Company through
Website: www.magma-hdi.co.in
Toll free: 1800 266 3202
E –mail: Gro@magma-hdi.co.in
Fax: 91 033 4401 7471

Courier: Any of Our branch offices or corporate office during business hours

Insured person may also approach the grievance cell at any of the company's branches with the details of 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:

Magma HDI General Insurance Co Ltd
Equinox Business Park, Tower 3,
2nd Floor, Unit no. 1A and 1B, LBS Marg,
Kurla West, Mumbai, Maharashtra 400070.
E mail id : gro@magma-hdi.co.in

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

If Insured Person is not satisfied with the redressal of grievance through above methods, insured person may may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules, 2017. Detailed process along with list of Ombudsman offices are available at council of Insurance Ombudsman https://www.cioins.co.in/

The contact details of the Insurance Ombudsman offices have been provided as Annexure-I

Grievance may also be lodged at IRDAI Integrated Grievance management System: https://bimabharosa.irdai.gov.in

4.1.17) Nomination

The Policyholder is required at the Policy Inception Date to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder.

Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in Policy Schedule/Policy certificate/Endorsement, (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

4.2) Specific Terms and Clauses

4.2.1) Alteration to the Policy

This Policy constitutes the complete contract of insurance. Subject to the provisions of applicable law, no change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

4.2.2) Change of Policyholder

The Policyholder may be changed only at the time of Renewal of the Policy. The new Policyholder must be a member of the original Policyholder's immediate family. The Renewed Policy shall be treated as having been Renewed without break.

The Policyholder may be changed upon request in situations like Policyholder's demise, moving out of India or in case of divorce

4.2.3) No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/ Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

4.2.4) Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

4.2.5) Records to be maintained

The Policyholder or the Insured Person, as the case may be shall keep an accurate record containing all relevant and accurate medical records like in-patient records, Discharge summary , medical certificates, medical prescriptions, diagnostic reports and reports confirming the need for treatment (if any) and shall allow Us or our representative(s) to inspect such records. The Policyholder or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all claims under this Policy.

4.2.6) Geographical Scope

The geographical scope of this Policy applies to events within India other than for Worldwide Hospital Cash Cover and for Compassionate Benefit Optional Covers. However, all admitted or payable claims shall be settled in India in Indian rupees other than for Worldwide Hospital Cash Cover.

4.2.7) Policy Disputes

Any and all disputes or differences under or in relation to this Policy herein shall be determined by Indian law and shall be subject to the jurisdiction of the Indian Courts.

4.2.8) Material Change

It is a Condition Precedent to the Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in the nature of occupation or business at his/her own expense. We may, in Our discretion, adjust the scope of cover and/ or the premium payable, accordingly. The Policyholder/You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy. The Policy terms and conditions shall not be altered.

4.2.9) Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

a) To Us, at the address as specified in Policy Schedule

b) The Policyholder's, at the address as specified in Policy Schedule

c) No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us

d) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

Section 5) Other Terms and Conditions:

5.1) Loading

We shall apply a risk loading on the premium payable as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Policy Schedule. The maximum risk loading applicable shall not exceed 100% per diagnosis / medical condition and an overall risk loading of 150%. These loadings are applied from the Policy Inception Date including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured).

We will inform the Policyholder about the applicable risk loading through post/courier/email/phone. The Policyholder shall revert to Us with his/her written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, the Policyholder neither accepts the counter offer nor reverts to Us within 15 days, We shall cancel his/her application and refund the premium paid within the next 15 days.

No loading shall be applied at the time of Renewal on the basis of individual claim experience.

5.2) Endorsements

We may allow the following endorsements. You/the Policyholder should request for any endorsement in writing. Any endorsement that is accepted by Us shall be effective from the date of the request as received from You/the Policyholder, or the date of receipt of premium, whichever is later.

(i) Non-Financial Endorsements – which do not affect the premium.

- (1) Minor rectification/correction in name of the Policyholder/ Insured Person)
- (2) Rectification in gender
- (3) Rectification in relationship of the Insured Person with the Policyholder
- (4) Rectification of date of birth of the Insured Person (if this does not impact the premium)
- (5) Change in the address of the Policyholder
- (6) Change/Updation in the contact details
- (7) Change in Nominee Details

(ii) Financial Endorsements – which result in alteration in premium

- (1) Addition of any Insured Person
- (2) Deletion of Insured Person
- (3) Change in Age/Date of Birth (if this impacts the premium)
- (4) Change in plan and/or Sum Insured
- (5) Addition/removal of Optional Cover(s)

Financial endorsements (1), as mentioned above, can be allowed during the term of Policy, all other financial endorsements are allowed at the time of renewal only.

We reserve the rights to do underwriting in case of any such endorsement requests.

Fresh waiting period shall be applicable with respect to the Insured person added after Policy Inception Date. Where the Policy is Renewed for enhanced Sum Insured, all waiting periods would start and apply afresh for increase in Sum Insured.

5.3) Claim Procedure

This section explains about the procedures involved to file a valid claim by the insured person and processes related in managing the claim by Us. All the procedures and processes such as notification of claim, supporting claim documents are explained in this section.

Notification of Claim Treatment:

We must be informed: 1) If any treatment for which a claim may be made and that treatment requires planned Hospitalisation: At least 48 hours prior to the Insured Person's admission. 2) If any treatment for which a claim may be made and that treatment requires emergency Hospitalization Within 24 hours of the Insured Person's admission to Hospital.

Failure to furnish such intimation within the time required shall not invalidate nor reduce any claim if You can satisfy us that it was not reasonably possible for You to give proof of such delay within such time. The Company may relax these timelines only in special circumstances and for the reasons beyond the control of the Insured.

1. **Submission of claim:** The claim form along with the attending Medical Practitioner's certificate duly filled and signed in all respects with the following claim documents will be submitted to Us not later than 30 days from the date of discharge from the Hospital.

Claim Documents:

1. Duly filled and signed claim form
2. Copy of Discharge Summary
3. Copy of Hospital bill Breakup
4. Cancel cheque copy of Policyholder / Nominee (in case of death) with name printed on it
5. KYC (Govt approved Photo ID proof and Address proof)
6. Any other documents required while processing the claim.

Compassionate Benefit:

Accident Death:

- Claim form
- Death Certificate
- Investigation reports along with original bills
- FIR Copy, Postmortem Copy
- ID proof of Insured and Nominee
- PAN card/ Form 60, CKYC form and Address proof of Nominee
- Cancel Cheque copy with Name printed
- Medical records, information and evidence from a hospital or medical practitioner or otherwise required by us shall be provided by you at your expense. (May be required in some cases)
- Any other documents as requested by our claims team

Permanent Total Disability:

- Claim form duly filled and signed
- Pan Card copy/Aadhar card copy of Injured as well as Insured
- Medical Certificate issued by treating doctor confirming disability

- Photographs of showing injury.
- Original Copy of Discharge Summary with all medical papers with X-rays Film
- NEFT Details (cancel cheque copy)
- All medical bills in original along with payment proofs. If the medical expenses are borne by Insured, please provide necessary proofs such as cash vouchers, ledger sheet, etc.
- FIR COPY if any
- Duly Filled CKYC form
- Any other additional document while processing the claim

Pre Post Hospitalization Expenses: In addition to claim documents mentioned above, Pre and post Hospitalization expenses bills

Health Maintenance Benefit:

Ophthalmologist: Consultation papers, all diagnostic reports and Treatment bills

Orthopedic: Consultation papers, All diagnostic reports and Treatment bills

Physiotherapy: Consultation papers and Treatment bills

For AYUSH Claims:

- AYUSH claims would be payable as per the guidelines determined by Ministry of AYUSH, Government of India or any such committee of experts constituted to determine in-patient admissibility of claims, treatment modalities and corresponding treatment cost for providing AYUSH Coverage as defined from time to time.
- In patient admissibility of AYUSH claims would be determined in line with reasonable admissibility and its reasonable claim cost, as under allopathy or modern medicine for the same ailment or medical condition.

Address for claim documents submission:
Family Health Plan Insurance TPA limited
Srinilaya Cyber Spazio, Ground Floor,
Road No.2, Banjara Hills, Hyderabad,
Telangana – 500034
Toll Free No 1800 266 3202

2. Payment of Claim

a) No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.

b) The Insured Person or any person acting on behalf of the Insured Person, as the case may be, must provide at his/her expense, all the information asked by Us in relation to the claim and he/she must provide all reasonable cooperation and assistance to Us as may be required.

c) If required, the Insured Person or any person acting on behalf of the Insured Person, as the case may be, must give consent to obtain medical reports from the Medical Practitioner at Our expense.

d) If requested by Us, the Insured Person must agree to be examined by a Medical Practitioner of Our choice and at Our expense.

e) All claims under this Policy shall be payable in Indian Currency.

f) Claims under this Policy shall be settled or rejected, as the case may be, within 30 days of the receipt of the last necessary document.

Trade Logo disclaimer:

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Annexure II

Schedule of benefits / product benefit table

Base Cover	
Sickness Hospital Cash	Coverage only for Sickness (Sum Insured Per Day); 1st day of hospitalisation as deductible
Accident Hospital Cash Benefit	Double the Sum Insured per day for Accident Injury; covered from 1st day of hospitalization
ICU Cash Benefit	Double the Sum Insured per day for maximum 7 days for both Sickness and Accident
Optional Benefit	
Convalescence benefit	Lumpsum payment of Rs. 7,000
Day Care Treatment Cash	Double the per day sickness SI
Child Birth Hospital Cash	Coverage only for Childbirth
World Wide Hospital Cash	Three times per day sickness SI or Lumpsum of payment of Rs.15,000 whichever is lower for both Sickness and Accident
Companion Benefit	Lumpsum payment of Rs. 5,000
Compassionate Benefit	Accidental Death & PTD Benefit - Sum Insured Rs. 10L, 20L and 25L
Pre Post Hospitalisation Expenses	Benefit of one per day sickness SI for pre and post hospitalisation. Common limit for both pre and post hospitalisation.
Increase in Deductible	Increase to 2 days,3 days and 4 days
Reduction in Deductible	0 days
Increase in Max days for ICU Benefit	15 days
Health Maintenance Benefit	**For SI less than Rs. 5,000 per day** One Vison care OPD; for opthalmologist (consultation / diagnostics or treatment) for maximum of Rs. 1000 for each instance. Two Orthopaedic care OPD for orthopaedic (consultation / diagnostics or treatment) for maximum of Rs. 1500 for each each instance.
	For SI equal to or more than Rs. 5,000 per day One Vison care OPD for opthalmologist (consultation / diagnostics ore treatment) for maximum of Rs. 1000 for each instance. Two Orthopaedic care OPD for orthopaedic (consultation / diagnostics or treatment) for maximum of Rs. 1500 for each instance. Three Physiotherapy care session for phsiotherapy (consultation or treatment) for maximum of Rs. 500 for each instance.
Policy Period	1year, 2 years or 3 years
Waiting Periods	
Initial Waiting Period	30 days
Specific Waiting Period	24 months / Option to reduce to 12 months
Pre Existing Waiting Period	36 months / Option to reduce to 24 months

Annexure:
Rate charts for Individual and Family Floater Policies are attached.
Annexure Benefit Premium Illustration