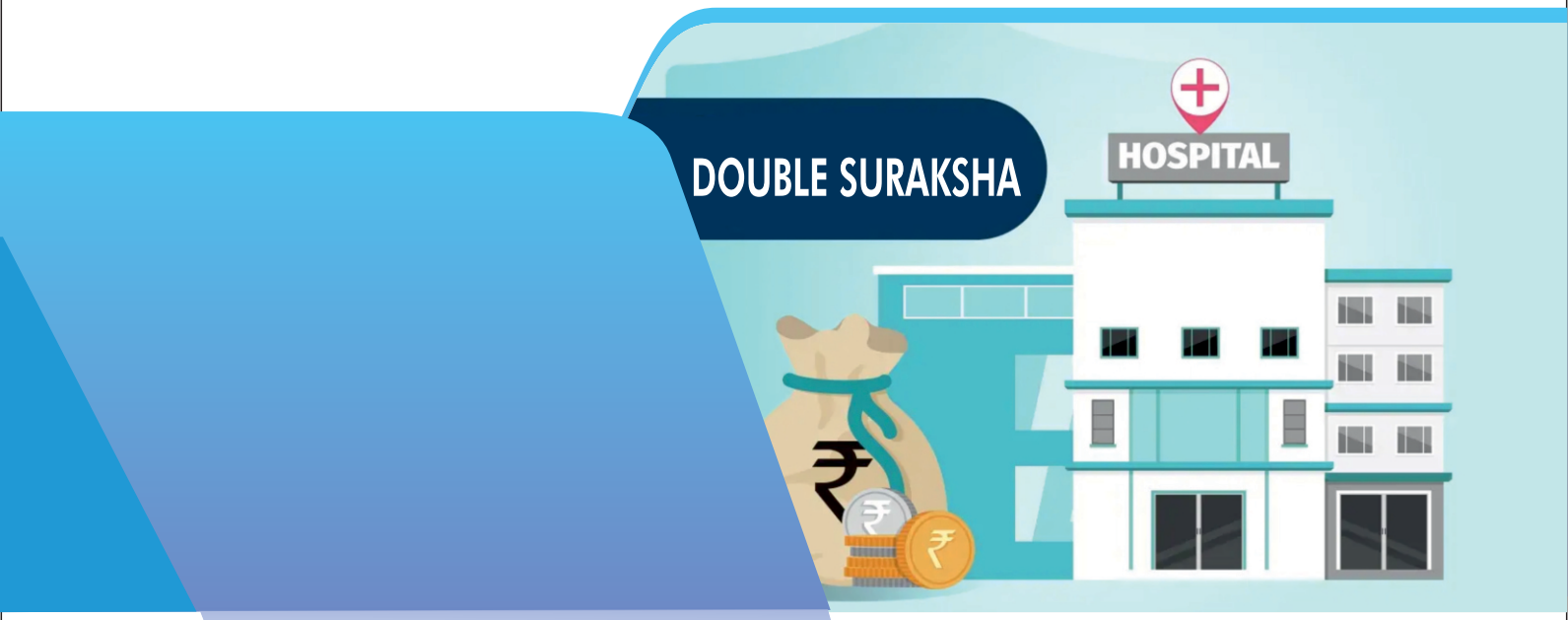
MAGMA
General Insurance Limited

TRUTH MUST BE TOLD

DOUBLE SURAKSHA POLICY WORDINGS



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MAGMA General Insurance Limited

Double Suraksha

Preamble

The insurance cover provided under this Policy up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy, (b) the receipt of premium, and (c) Disclosure to information norm (including information and statements which the Policyholder has provided in the proposal form or Information Summary Sheet as applicable) for all persons to be insured. Please inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting any Insured Person.

If any claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable if the covered Medical Expenses in respect to Hospitalisation (s), then We shall pay the Benefits in accordance with the terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Deductible (if any).

Section 1. Definitions

The terms defined below have the meaning ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural, references to male include female and references to any statutory enactment include subsequent changes, replacements or amendments to the same:

1.1 Standard Definitions:

Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

AYUSH treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

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 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 accessible to the insurance company's authorized representative.

AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Poliyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/ para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

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

iii. Mainitaining daily records of patient and making them accessible to the insurance company's authorized representative.

Any One Illness: Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

Condition Precedent: Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Congenital Anomaly: Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) **Internal Congenital Anomaly**

Congenital anomaly which is not in the visible and accessible parts of the body.

b) **External Congenital Anomaly**

Congenital anomaly which is in the visible and accessible parts of the body.

Day Care Centre: A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:-

i) has qualified nursing staff under its employment;

ii) has qualified medical practitioner/s in charge;

iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Day Care Treatment: Day care treatment means medical treatment, and/or *surgical procedure* which is:

i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and

ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Deductible: Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Dental Treatment: Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Disclosure to information norm: The policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health.

Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. 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.

Provided the insurers shall offer coverage during the grace period, if the premium is paid ininstalments during the policy period.

Hospital: A hospital means any institution established for *in-patient care* and *day care treatment* of illness and / or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;

ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii) has qualified medical practitioner(s) in charge round the clock;

iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with relevant section (Treatment outside India), Hospital (outside India) means an institution (including nursing homes) established outside India for indoor medical care and treatment of Illness and/or Injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a medical practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, and old age home.

Hospitalization : Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Illness: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

(b) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Injury: Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Inpatient Care: Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

Intensive Care Unit: Intensive care unit means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

ICU Charges: ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Maternity expenses: Maternity expenses means:

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) expenses towards lawful medical termination of pregnancy during the policy period.

Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Medical Expenses: Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy setup by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of licence.

Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in hospital which:

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a *medical practitioner*;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Network Provider: Network Provider means hospitals enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

New Born Baby: New born baby means baby born during the Policy Period and is aged up to 90 days.

Non-Network Provider: Non-Network means any hospital, day care centre or other provider that is not part of the network.

Notification of Claim: Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

OPD treatment: OPD treatment means the one in which the Insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Pre-Existing Disease: Pre-Existing Disease means any condition, ailment , injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Pre-hospitalization Medical Expenses: Pre- hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post-hospitalization Medical Expenses: Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Reasonable and Customary Charges: Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Surgery or Surgical Procedure: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *medical practitioner*.

Unproven/Experimental treatment: Unproven/ Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Break in policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

Complaint or Grievance means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

Explanation: An inquiry or service request would not fall within the definition of the "complaint" or "grievance".

Complainant means a policyholder or prospect or nominee or assignee or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer and / or distribution channel.

Mis-selling includes sale or solicitation of policies by the insurer or through distribution channels, directly or indirectly by

a. exercising undue influence, use of dominant position or otherwise, or

b. making a false or misleading statement or misrepresenting the facts or benefits, or

c. concealing or omitting facts, features, benefits, exclusions with respect to products, or

d. not taking reasonable care to ensure suitability of the policy to the prospects/policyholders.

Proposal form means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages terms and conditions of the cover to be granted.

Prospectus means a document either in physical or electronic format issued by the insurer to sell or promote the insurance product.

1.2 Specific Definitions

Age or Aged means age as on last birthday.

Cosmetic Surgery means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.

Daily Cash Benefit means the per day Sum Insured Unit opted under the Plan and specified in the Schedule to this Policy.

Day means a continuous period of 24 hours.

Diagnosis means Diagnosis by a registered medical practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to the Company.

Emergency means a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Family Floater Policy means a policy named as a Family Floater Policy in the Policy Schedule in terms of which, two or more persons of a family are named in the Policy Schedule as Insured Persons. In a Family Floater Policy, family means a unit comprising of up to seven members who are related to the Policyholder in the following manner:

1) Self (ie, the Policyholder); and/or
2) Legally married spouse as long as they continue to be married; and/or
3) Up-to three children (children who are up to 25 years of Age on the Policy Start Date shall be considered as dependent children, if Aged 26 and above, they shall be considered as adults in this Policy); and/or
4) Natural parents or parents that have legally adopted the Policyholder; or
5) Parents-in-law as long as the Policyholder continues to be legally married to the spouse referred above.
6) Grand children
7) Daughter-in-law and Son-in-law
8) Brother(s) and Sister(s)

All parents and parents- in- law referred above must be financially dependent on the Policyholder.

Hazardous Activities means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt / obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/pot holing, cave tubing, rock limbing / trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quadbiking,

river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type.

Individual Policy means a policy named as an Individual Policy in the Policy Schedule in terms of which only one person is named in the Policy Schedule as the Insured Person.

IRDAI means the Insurance Regulatory and Development Authority of India.

Insured Person/You/Your/Yours means the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.

Policy means this Policy document, any annexures thereto and the Policy Schedule including endorsements, if any, and Your statements in the proposal form.

Policy Inception Date means the Policy Start Date of the first Policy with Us, as specified in the Policy Schedule, and renewed with Us continuously thereafter.

Policy Start Date means the start date of the Policy as specified in the Policy Schedule.

Policy Expiry Date means the date on which the Policy expires as specified in the Policy Schedule.

Policy Period means the period between the Policy Start Date and the Policy Expiry Date as shown in the Policy Schedule.

Policy Year means a period of twelve consecutive months commencing from the Policy Start Date as specified in the Policy Schedule or any anniversary thereof.

Policyholder means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us. Policyholder may be related to Insured Person as:

a) Self

b) Spouse

c) Son/Daughter

d) Son-in law/ Daughter-in-law

Policy Schedule means the schedule issued by Us along with this Policy mentioning the details of the Policyholder and Insured person, period of Policy and other details. Any changes made to it shall be issued as Endorsement Schedule and shall be considered a part of this Policy.

Product Benefits Table means the Product Benefits Table issued by Us and accompanying the sales literatures, including the prospectus of this product.

Sum Insured means:

i) For an Individual Policy, the sum shown in the Policy Schedule/ Product Benefits Table against an Insured Person which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of that Insured Person.

ii) For a Family Floater Policy, the sum shown in the Policy Schedule/ Product Benefits Table which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of any and all Insured Persons.

TPA or Third Party Administrator means a company registered with the Authority, and engaged by an insurer, for a fee, by whatever name called and as may be mentioned in the agreement, for providing health services.

We/Our/Us means Magma General Insurance Limited.

Section 2. 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 (24 continuous hours of Hospitalisation) except for Accident Hospital Cash Benefit and will become payable from day two of Hospitalisation unless optional benefit either 'Reduction in Deductible' or 'Increase in Deductible'. 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 Rs. 7,000 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 under 2.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 Rs. 5,000/- per day of Sickness Hospital Cash

One Vison care OPD for ophthalmologist consultation, diagnostics and treatment for maximum of Rs. 1,000/- for each instance.

Two Orthopaedic care OPD for orthopaedic consultation, diagnostics, and treatment for maximum of Rs. 1,500/- for each instance.

For Sum Insured equal to or more than Rs. 5,000/- per day of Sickness Hospital Cash

One Vison care OPD for ophthalmologist consultation, diagnostics and treatment for maximum of Rs. 1,000/- for each instance.

Two Orthopaedic care OPD for orthopaedic consultation, diagnostics, and treatment for maximum of Rs. 1,500/- for each instance.

Three Physiotherapy care session for physiotherapy consultation and treatment for maximum of Rs. 1,000/- 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.

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.13 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.magmainsurance.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.

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 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.

a) 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 including senior citizens may contact the Company through
Website: www.magmainsurance.com
Toll free: 1800 266 3202
E –mail: gro@magmainsurance.com
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 General Insurance Limited
Equinox Business Park, Tower 3,
2nd Floor, Unit no. 1A and 1B, LBS Marg,
Kurla West, Mumbai, Maharashtra 400070.
E mail id : gro@magmainsurance.com

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

If Insured Person is not satisfied with the redressal of grievance through above methods, insured person mayalso 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.

MAGMA General Insurance Limited

Double Suraksha

Annexure I

The contact details of the **Insurance Ombudsman** offices are as below:

Office of the Ombudsman	Contact Details	Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan SoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chhattisgarh.
BHABUNESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468. Email: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, UT of Jammu and Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of UT of Puducherry)+C8.
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122. Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of the UT of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338. Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of UT of Puducherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.ernakulam@cioins.co.in	West Bengal, UT of Andaman and Nicobar Islands.

Office of the Ombudsman	Contact Details	Jurisdiction
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038821/23/24/25/26/27/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (Excluding Navi Mumbai & Thane).
NOIDA	Office of the Insurance Ombudsman, BhagwanSahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane (Excluding Mumbai Metropolitan Region).

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 day 1st day of hospitalisation
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 the 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 1000 Rs. Two Orthopaedic care OPD for orthopaedic (consultation / diagnostics or treatment) for maximum of 1500 Rs. for each OPD.
	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 1000 Rs. Two Orthopaedic care OPD for orthopaedic (consultation / diagnostics or treatment) for maximum of 1500 Rs. for each OPD. Three Physiotherapy care session for phsiotherapy (consultation or treatment) for maximum of 500 Rs. for each OPD.
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