ManipalCigna
Health Insurance

EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS

ManipalCigna Super Top Up Customer Information Sheet

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Cover under existing policy, ManipalCigna Super Top Up, will continue to be available for the Insured person, subject to Renewal and policy terms and conditions.
#Waiting Periods here will mean initial waiting period, specific illness waiting period and pre-existing disease waiting period of base policy.
* ManipalCigna ProHealth Insurance – Protect Plan(CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us.
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- Cosmetic or plastic Surgery: Code- Excl 08
- Hazardous or Adventure sports: Code- Excl 09
- Breach of law: Code- Excl 10
- Excluded Providers: Code- Excl 11
- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof: Code- Excl 12
- Treatments received in heath hydros, nature cure clinics, spas or similar establishments
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	- Refractive Error: Code- Excl 15 - Unproven Treatments: Code- Excl 16 - Sterility and Infertility: Code- Excl 17 - Maternity: Code Excl 18 - Dental treatment, dentures or surgery of any kind unless necessitated due to an accident, Circumcision, Prostheses, corrective devices and medical appliances - Costs of donor screening - Any form of Non-Allopathic treatment - All expenses caused by ionizing radiation or contamination by radioactivity, directly or indirectly, caused by or arising from warlike operations - External Congenital Anomaly or defects	
Waiting Period This sections lists the applicable period (days/months) before you can make a claim for the listed diseases/treatments	a. First 30 days from the Policy start date, for all illnesses except Accidents. In case of hospitalisation due to Covid-19, this waiting period will be reduced to 15 days. The applicability of this feature is as specified in the endorsement, attached with the Policy. b. First 24 months from the Policy start date for Specific illnesses. c. A 48 months waiting period will be applicable for any Pre-existing disease.	IV
Payout Basis This section lists the manner in which the proceeds of the Policy will be paid to you	For all covers, pay-out will be on indemnity basis either by way of Cashless to the Hospital/ Network provider when a cashless facility is availed or directly to you as a reimbursement against the bills when you have paid for the expenses.	VI.4. & VI.5.
Cancellation The section explains the Policy cancellation process in brief	Cancellations may be intimated to Us by giving 15 days' notice wherein We shall refund the premium for the unexpired term on the short period scale as mentioned in the Policy wordings enclosed in the kit. The Premium shall only be refunded only if no claim has been made under the Policy. This Policy can be cancelled on grounds of misrepresentation, fraud, non-disclosure of material fact, upon giving 15 days' notice without refund of premium.	VII.11.
Legal disclaimer: The information mentioned above is illustrative and not exhaustive. Information must be read in conjunction with the product brochures/prospectus and Policy document. In case of any conflict between the Prospectus and the Policy document the terms and conditions mentioned in the Policy document shall prevail.		

ManipalCigna Super Top Up Policy Terms and Conditions

I PREAMBLE & OPERATING CLAUSE

This is a legal contract between You and Us subject to the receipt of full premium, Disclosure to Information Norm including the information provided by You in the Proposal Form and the terms, conditions and exclusions of this Policy.

If any Claim arising as a result of a Disease/Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any). All limits mentioned in the Policy Schedule are applicable for each Policy Year of coverage.

Any claim under this policy shall be payable by the Company only if the aggregate of covered Medical Expenses in respect to Hospitalisation (s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Deductible applicable on per Policy Year basis.

BENEFITS UNDER THE POLICY

II BASIC COVERS

II.1. Inpatient Hospitalisation:

We will cover Medical Expenses of an Insured Person in case of Medically Necessary Hospitalisation arising from a Disease/ Illness or Injury provided such Medically Necessary Hospitalisation is for more than 24 consecutive hours provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year. We will pay Medical Expenses as shown in the Schedule for:

a. Reasonable and Customary charges for Room Rent for accommodation in Hospital room,
b. Intensive Care Unit charges,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon,
e. Anaesthetist,
f. Qualified Nurses,
g. Specialists,
h. Cost of diagnostic tests,
i. Medicines,
j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

Medical Expenses related to any admission (under In-patient Hospitalisation or Day Care Treatment) primarily for enteral feedings will be covered maximum up to 7 days in a Policy Year, provided it is Medically Necessary and is prescribed by a Medical Practitioner.

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

Medical expenses related to HIV/AIDS will be covered up to the Sum Insured with a maximum limit of Rs. 2 lacs per Policy year, after a waiting period of 2 years.

Under Hospitalisation expenses, we will cover the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Hospitalisation Expenses and the necessity being certified by an authorised Medical Practitioner. Benefit under this cover is payable, maximum up to the Sum Insured.

All Claims under this benefit can be made as per the process defined under Section VI.4 & 5.

II.2. Pre - hospitalisation:

We will cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalisation up to limits specified in the Schedule, provided that a Claim is admissible under In-patient Benefit under Section II.1 and is related to the same Illness/condition.

All Claims under this benefit can be made as per the process defined under Section VI.5.

II.3. Post - hospitalisation:

We will cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital up to limits specified in the Schedule, provided that a Claim is admissible under In-patient Benefit under Section II.1 and is related to the same illness/condition.

All Claims under this benefit can be made as per the process defined under Section VI.5.

II.4. Inpatient hospitalisation for AYUSH Cover:

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

1) The Insured Person has undergone AYUSH Treatment in a AYUSH Hospital; where 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:

i) Central or State Government AYUSH Hospital; or

ii) Teaching hospitals attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/ Central Council of Homeopathy; or

iii) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

a) Having at least 5 in-patient beds;
b) Having qualified AYUSH Medical Practitioner in charge round the clock;
c) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
d) Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

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

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

All claims under this Benefit can be made as per the process defined under Sections VI.4 & 5.

II.5. Day Care Treatment:

We will cover payment of Medical Expenses of an Insured Person in case of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours Hospitalisation due to advancement in technology and which is undertaken in a Hospital / nursing home/Day Care Centre on the recommendation of a Medical Practitioner. Any treatment in an outpatient department(OPD) is not covered.

Coverage will also include pre-post hospitalisation expenses as available under the opted Plan.

All Claims under this benefit can be made as per the process defined under Section VI.4 & 5.

II.6. Non- medical expenses Cover:

We will cover cost of Non-Medical items, listed under Annexure III of the Policy, incurred towards Medically Necessary Hospitalisation of the insured person, arising out of Disease/ Illness or Injury.

The cover is available subject to the claim being admissible under the Inpatient hospitalisation and/ or Day Care Treatment cover under this policy and the expenses on Non-medical items are related to the same Illness/ Injury.

All Claims under this benefit can be made as per the process defined under Section VI.4. & 5.

II.7. Road Ambulance Cover:

a. We will cover Reasonable and Customary expenses incurred towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury covered under the Policy in case of an Emergency, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.
b. Reasonable and Customary expenses shall include:
   i. Cost towards shifting an Insured person to the nearest hospital or
   ii. Costs towards transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital;

or

iii. When the Insured Person requires to be moved to a better Hospital facility due to lack of super speciality treatment in the existing Hospital.

All Claims under this benefit can be made as per the process defined under Section VI.4 & 5.

II.8. Donor Expenses:

a. We will cover In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -

b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice.

c. A claim is admissible under Section II.1 – towards In-patient Hospitalisation

d. We will not cover expenses towards the Donor in respect of:

i. Any Pre or Post - hospitalisation Medical Expenses,

ii. Cost towards donor screening,

iii. Cost directly or indirectly associated to the acquisition of the organ,

iv. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

All Claims under this benefit can be made as per the process defined under Section VI.4 & 5.

II.9. Guaranteed Cumulative Bonus:

We will increase the Sum Insured by 5% every policy year up to a maximum of 50% of Sum Insured provided that the Policy is renewed with Us without a break.

i. Cumulative bonus will be calculated on sum insured excluding any bonus.

ii. No cumulative bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.

iii. The Cumulative Bonus will not be accumulated in excess of 50% of the Sum Insured under the current Policy with Us under any circumstances.

iv. Wherever the earned cumulative bonus is used for payment of a claim during a particular policy year, any earned Cumulative Bonus will not be reduced for claims made in the future.

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

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

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

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

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

x. This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section VII.11

III. OPTIONAL COVERS

The following optional covers are available under the product.

III.1 Guaranteed Continuity on Deductible

From 5th Policy Year onwards, we will provide an option to the insured persons to opt for a base policy*, with guaranteed continuity on waiting periods# applicable under the base Policy.

No fresh risk assessment shall be done for Sum Insured up to the deductible amount opted under this Policy (ManipalCigna Super Top Up).

Conditions:

1. Selection of the optional cover is available on policy level basis for Individual as well as Floater Policies.
2. If the Insured Person in the Super Top Up Policy is covered on Individual basis, then the guaranteed continuity on deductible, under the base policy shall be provided on Individual basis. Similarly, if an Insured Person in the Super Top Up Policy is covered on Family floater basis, then the guaranteed continuity on deductible, under the base policy shall be provided on floater basis.
3. The optional cover is available only at the inception and cannot be opted after the commencement of this Policy.
4. The option can be exercised only at Renewal.
5. Age of Insured Person/s at inception of this policy should be 54 years or below.
6. Continuity benefit under the base product shall be offered on the Sum Insured up to the Deductible amount opted under this Policy.
7. For the purpose of this optional cover, continuity on waiting period and guarantee of acceptance will be limited to Sum Insured up to the minimum Deductible opted under the ManipalCigna Super Top Up policy for preceding 4 years.
8. If Sum Insured opted under the base policy is higher than the minimum Deductible opted under the ManipalCigna Super Top Up policy for preceding 4 years, the additional Sum Insured will be subject to risk assessment and fresh waiting periods.
9. Cover under existing policy, ManipalCigna Super Top Up, will continue to be available for the Insured person, subject to Renewal and policy terms and conditions.

#Waiting Periods here will mean initial waiting period, specific illness waiting period and pre-existing disease waiting period of base policy.

* ManipalCigna ProHealth Insurance – Protect Plan

(UIN CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us.

III. 2. Reduction in Pre-existing disease waiting period:

We will provide an option to reduce the pre-existing disease waiting period under this Policy to 24 months, on payment of applicable premium for this cover.

This Optional cover is available at the purchase of this Policy and shall apply to all insured persons covered under the policy.

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

UIN: MCIHLIP21128V022021

Deductible opted under 'ManipalCigna Super Top Up' will not be applicable on the ManipalCigna Critical Illness- Add On Cover.

IV. WAITING PERIODS

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

IV.1. Pre-existing Disease Waiting Period Code – Excl-01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months (24 months, if Reduction in Pre-existing disease waiting period, if opted) of continuous coverage after the date of inception of the first policy with us.

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

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

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

IV.2. 30 day Waiting Period Code- Excl03

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

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

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

In case of hospitalisation due to Covid-19, this waiting period will be reduced to 15 days. The applicability of this feature is as specified in the endorsement, attached with the Policy.

IV.3 Two year waiting period (Specified disease/procedure waiting period) Code- Excl 02

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

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

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

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

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

f. List of specific diseases/procedures provided under 'Specified disease/ procedure Waiting period'

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

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

IV.4 Personal Waiting period:

A special Waiting Period not exceeding 48 months, may be applied to individual Insured Persons for the list of acceptable Medical Ailments listed under Policy Clause VII.15.Loadings & Special Conditions, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

V. PERMANENT EXCLUSIONS

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Investigation & Evaluation: Code- Excl 04
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
2. Rest Cure, rehabilitation and respite care: Code- Excl 05
   a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.

   This also includes:

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

   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. Obesity/ Weight Control: Code- Excl 06

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

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

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

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

5. Cosmetic or plastic Surgery: Code- Excl 08

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

6. Hazardous or Adventure sports: Code- Excl 09

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

7. Breach of law: Code- Excl 10

   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. (e.g. Intentional self-Injury, suicide or attempted suicide (whether sane or insane).

8. Excluded Providers: Code- Excl 11

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

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

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

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

12. Refractive Error: Code- Excl 15

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

13. Unproven Treatments: Code- Excl 16 Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility: Code- Excl 17

    Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

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

iii. Gestational Surrogacy
iv. Reversal of sterilization

15. Maternity: Code Excl 18
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii. Expense towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
16. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalisation or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
17. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
18. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
19. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
20. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
21. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
22. Any form of Non-Allopathic treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine except Inpatient hospitalisation under AYUSH covered specifically under Section II.4.
23. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
24. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
25. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.
26. External Congenital Anomaly or defects or any complications or conditions arising therefrom.
27. For complete list of non-medical items, please refer to the Annexure III, list I of "Non Payable Items" and also on Our website.
28. Existing diseases disclosed by the Insured Person (Limited to the extent of the ICD Codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

VI. CLAIM PROCESS & MANAGEMENT

VI.1. Condition Preceding

The fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the claim.

Completed claim forms and processing documents must be furnished to Us within the stipulated timelines for all reimbursement claims. Failure to furnish this documentation 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 submit / give proof within such time.

The due intimation, submission of documents and compliance with requirements as provided under the Claims Process under this Section, by You shall be essential, failing which We shall not be bound to accept a claim.

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on the Health Card issued by Us as well as on our website. For the latest list of network hospitals, you can log on to our website. Wherever a TPA is used, the TPA will only work to facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

VI.2. Policy Holder's / Insured Persons Duty at the time of Claim

You are required to check the applicable list of Network Providers, at Our website or call center before availing the Cashless services.

On occurrence of an event which may lead to a Claim under this Policy, You shall:

(a) Forthwith intimate, file and submit the Claim in accordance to the Claim Procedure defined under Section VI.3, VI.4, and VI. 5 as mentioned below.

(b) If so requested by Us, You or the Insured Person must submit himself/ herself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.

(c) Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalisation records, investigate the facts and examine the Insured Person.

(d) Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

VI.3. Claim Intimation

Upon the discovery or occurrence of any Illness / Injury that may give rise to a Claim under this Policy, You / Insured Person shall undertake the following:

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a claim covered under the Policy, You/the Insured Person, must notify Us either at the call center or in writing, in the event of:

- Planned Hospitalisation, You/the Insured Person will intimate such admission at least 3 days prior to the planned date of admission or in the event when sum insured of the base policy gets exhausted.
- Emergency Hospitalisation, You /the Insured Person will intimate such admission within 48 hours of such admission but not later than discharge from the hospital.

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

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

VI.4. Cashless Facility

Cashless facility is available only at our Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by Us)

(a) For Planned Hospitalisation:

i. The Insured Person should at least 3 days prior to admission to the Hospital approach the Network Provider for Hospitalisation for medical treatment.
ii. The Network Provider will issue the request for authorization letter for Hospitalisation in the pre-authorization form prescribed by the IRDA.
iii. The Network Provider shall electronically send the pre-authorization form along with authorisation letter of the primary Insurer (with whom the insured person has availed cashless) & all the relevant details to the 24 (twenty-four) hour authorization/cashless department along with contact details of the treating Medical Practitioner and the Insured Person. The Network Provider will also send details of the policy by other Insurers.
iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.
v. Wherever the information provided in the request is sufficient to ascertain the authorisation, We shall issue the authorisation Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 4 hours from the receipt of last complete documents.
vi. The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any co-pays or deductibles and non-

medical items if applicable.

vii. The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

In the event that the cost of Hospitalisation exceeds the authorized limit as mentioned in the authorization letter:

i. The Network Provider shall request Us for an enhancement of authorisation limit as described under Section VI.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

ii. We shall accept or decline such additional expenses within 24 (twenty-four) hours of receiving the request for enhancement from You.

In the event of a change in the treatment during Hospitalisation to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under VII.4 (a) above.

At the time of discharge:

i. The Network Provider may forward a final request for authorization for any residual amount to us along with the discharge summary and the billing format in accordance with the process described at VI.4.(a) above.

ii. Upon receipt of the final authorisation letter from us, You may be discharged by the Network Provider.

(b) In case of Emergency Hospitalisation

i. The Insured Person may approach the Network Provider for Hospitalisation for medical treatment.

ii. The Network Provider shall forward the request for authorization within 48 hours of admission to the Hospital as per the process under Section VI.4 (a).

iii. It is agreed and understood that we may continue to discuss the Insured Person's condition with the treating Medical Practitioner till Our recommendations on eligibility of coverage for the Insured Person are finalised.

iv. In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any lifesaving, limb saving, sight saving, Emergency medical attention requiring situation.

v. The Network Provider shall refund the deposit amount to You barring a token amount to take care of non-covered expenses once the pre-authorization is issued.

Note: Cashless facility for Hospitalisation Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy. For all Cashless authorisations, You will, in any event, be required to settle all non-admissible expenses, Co-payment and / or Deductibles (if applicable), directly with the Hospital.

The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us. The following claim documents should be submitted to Us within 30 days from the date of discharge from Hospital –

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

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

Whenever a primary claim is lodged with other insurer and claim above deductible is lodged with Us, a copy of original documents (submitted with the primary insurer) may be submitted to Us.

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

We in our sole discretion, reserve the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable/latest list of Network Hospital on the Company's website or by calling our call centre.

VI.5. Claim Reimbursement Process

(a) Collection of Claim Documents

i. Wherever You have opted for a reimbursement of expenses, You may submit the following documents for reimbursement of the claim to Our branch or head office at your own expense not later than 30 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of our Branch Offices or download a copy from our website: www.manipalcigna.com

ii. List of necessary claim documents to be submitted for reimbursement are as following:

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge/Death summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted
KYC documents (Photo ID proof, address proof, recent passport size photograph)
Cancelled cheque for NEFT payment
Payment receipt.
Original Settlement letter from the primary Insurer

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

Whenever a primary claim is lodged with other insurer and claim above deductible is lodged with Us, a copy of original documents (submitted with the primary insurer) may be submitted to Us.

iii. Insured person shall receive Email and SMS notification as an acknowledgement of the submitted documents once the claim is received at Our branch.

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

VI.6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents. Any deficiency of documents shall be intimated to You and the Network Provider, as the case may be within 5 days of their receipt.

b. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind You of the same and every 10 (ten) days thereafter.

c. We will send a maximum of 3 (three) reminders.

d. We shall settle the claim payable amount arrived post scrutinizing the claim documents excluding the deficiency intimated to You, provided those documents are not mandatory to decide admissibility of the claim.

e. In case a reimbursement claim is received when a Pre-Authorization letter has been issued, before approving such claim a check will be made with the provider whether the Pre-authorization has been utilized as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed.

VI.7. Claim Assessment

We will assess all admissible claims under the Policy in the following progressive order –

a) Arrived payable claim amount will be assessed against the opted deductible.

b) The Claim amount assessed under Section VI.7 a) will be deducted from the following amounts in the following progressive order –

i) Deductible

ii) Sum Insured

iii) Cumulative Bonus

Claim assessment for policies with Monthly, Quarterly and Half-Yearly Premium Payment Mode:

In case of a claim (Cashless/Re-imbursement), an amount equivalent to the balance of the instalment premiums payable, in that policy year, would be recoverable from the admissible claim amount payable in respect of the Insured person.

VI.8. Claims Investigation

We may investigate claims at Our own discretion to determine the validity of claim. Such investigation shall be concluded within 15 days from the date of assigning the claim for investigation and not later than 30 days from the date of receipt of last necessary document. Verification carried out, if any, will be done by individuals or entities authorised by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by Us.

VI.9. Pre and Post-hospitalisation claims

You should submit the Post-hospitalisation claim documents at Your own expense within 15 days of completion of Post-hospitalisation treatment or eligible post hospitalisation period of cover, whichever is earlier.

We shall receive Pre and Post- hospitalisation claim documents either along with the inpatient Hospitalisation papers or separately and process the same based on merit of the claim subject to Policy terms and conditions, derived on the basis of documents received.

VI.10. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject the claim, as the case may be, 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.

VI.11 Representation against Rejection:

Where a rejection is communicated by Us, You may if so desired within 15 days represent to Us for reconsideration of the decision.

VI.12. Payment Terms

The Sum Insured opted under the Plan shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.

If You/ Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for “Any One Illness” under this Policy shall be applied as if they were under a single claim.

For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.

For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will pay the nominee (as named in the Policy Schedule) and in case of no nominee to the Legal Heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of its liability under the Policy.

VI.13. Deductible

a) Any claim towards hospitalisation during the Policy Period must be submitted to Us for assessment in accordance with the claim process laid down under Section VI.4 and Section VI.5 towards cashless or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the deductible, We will assess and pay such claim in accordance with Section VI.6. and VI. 7.b).

b) Wherever such hospitalisation claims as stated under VI.13. a) above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer / TPA as the case may be.

VII. GENERAL TERMS AND CONDITIONS

1. Disclosure of Information

The Policy shall be null and 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. (“ 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)

2. Material Change

Material information to be disclosed includes every matter that You are aware of, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the contract.

3. 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. Alterations in the Policy

This Policy constitutes the complete contract of insurance. 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.

5. 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 Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed upon request in case of his demise, his moving out of India or in case of divorce during the Policy Period.

6. No Constructive Notice

Any knowledge or information of any circumstance 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.

7. Geography

The geographical scope of this policy applies to events within India other than for Worldwide Emergency Cover and which are specifically covered in the Schedule. However, all admitted or payable claims shall be settled in India in Indian rupees.

8. Multiple Policies

i. 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.

ii. 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 of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have right to choose insurer from whom he/she wants to claim the balance amount.

iv. 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.

9. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all medical records pertaining to claim and shall allow Us or our representative(s) to inspect such records. You 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 and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

10. Free Look period

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

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

If the insured has not made any claim during the Free Look Period, the

insured shall be entitled to

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

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

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

11. Cancellation

i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation grid: (Applicable for Single and Yearly premium payment mode)

	Refund Grid as % of Premium		
Policy Cancelation Within	**Policy Year-1**	**Policy Year-2**	**Policy Year-3**
0-30 Days	85.00%	87.50%	89.00%
31-90 Days	75.00%	80.00%	82.50%
91-181 Days	50.00%	70.00%	75.00%
182-272 Days	30.00%	60.00%	70.00%
273-365 Days	0.00%	50.00%	60.00%
366-456 Days	NIL	35.00%	55.00%
457-547 Days	NIL	25.00%	45.00%
548-638 Days	NIL	15.00%	40.00%
639-730 Days	NIL	0.00%	30.00%
731-821 Days	NIL	NIL	25.00%
822-912 Days	NIL	NIL	15.00%
913-1003 Days	NIL	NIL	5.00%
1004 and more Days	NIL	NIL	0.00%

The above grid is applicable to policies issued with Premium Payment mode 'Single' or 'Yearly (with Policy Tenure 1 Year)'. For 'Yearly' premium payment mode with Policy Tenure 2/3 years, premium shall be refunded basis above grid for 'Policy Year- 1'.

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non- disclosure of material facts, fraud by the insured person by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Policy Alignment:

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

All coverage and benefits under the Policy shall automatically lapse upon cancellation of the Policy.

You will have an option to align the date of renewal of Super Top up policy with your existing Indemnity Health Insurance policy with Us or any other insurer in India. The option will be available in the first policy year only.

Cancellation of the Super Top Up policy in order to align it with the base policy will be processed on request from the Policyholder and irrespective of claim. Premium shall be refunded on pro-rata basis for the balance Policy Period. The policy, with aligned date, will be issued subject to payment of premium applicable for Age of Insured Person as on alignment effective date. Continuity with respect to Cumulative bonus and Waiting periods shall be passed on to the policy issued, post alignment.

12.

1. Grace Period

The Policy may be renewed by mutual consent and in such an event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy for Single and Yearly mode of payment. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

2. 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. Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.

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 benefit 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.

13.

1. Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

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

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30/15 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

2. Renewal Terms

- The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.
- We shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.
- Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.
- Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.
- We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.
- Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition deletion of Medical

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

- Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
- Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48/24 consecutive months as applicable to the relevant waiting periods of the Plan opted.
- Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section IV.1 to IV.4 will be applicable considering such Policy Year as the first year of Policy with the Company.
- Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.
- In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits in the policy will remain intact. Guaranteed Cumulative Bonus earned on the Policy will stay with the Insured under the original policy.

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

i. NACH/Standing Instruction Mandate form is completely filled & signed by You.

ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

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

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

4. Following discounts are available under the Policy:

a. Family Discount - Discount of 10% on the premium for covering 2 or more members under the same Policy under the individual policy option.

b. Long Term policy discount - Long term discount, on the premium, of 7.5% for selecting a 2 year policy term and 10% for selecting 3 year policy term. The discount is available only with 'Single' premium payment mode.

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

d. Online Renewal discount: Discount of 3% on the premium from next renewal, if the premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card).

Discount under (a) above, is applicable only to individual policies. All other discounts under (b), (c) and (d) above are available to both individual as well as floater policies. Maximum discount and rebate applicable on a single policy shall not exceed 30%.

Family Discount, Long Term Discount, Worksite Marketing Discount and Online Renewal discount is applied on the total Policy premium excluding statutory levis and taxes which is the sum total of individual premium for Family policies.

14. Premium calculation

Premium will be calculated based on the Plan, Deductible, Sum Insured opted, Policy Tenure, Age, Gender, Optional Cover, Premium Payment mode and Add on Benefits. All Premiums are age based and will vary each year as per the change in age.

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

Premium can be paid on Single, Yearly, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy.

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

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

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

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

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

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

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

15. Loadings & Special Conditions

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

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

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

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

16. Communications & Notices

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

a. The policyholder's, at the address as specified in Schedule.

b. To Us, at the address specified in the Schedule.

c. No insurance agents, brokers, other person or entity is authorised to receive any notice on the 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.

17. Electronic Transactions

You agree to comply with all the terms, conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to You. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by You.

All terms and conditions in respect of Electronic Transactions shall be within the approved Terms and Conditions of the Policy.

18. 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

19. 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.

20. 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 IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule I of IRDAI (health insurance) Regulations 2016 for the Portability norms.

21. Complete Discharge

Any payment to the policyholder, 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.

22. Dispute Resolution

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

23. Redressal of Grievance

In case of any grievance the Insured Person may contact the Company through:

Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com

Toll Free : 1800-102-4462

Contact No.: + 91 22 61703600

Courier: Any of Our Branch office or corporate office during business hours.

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

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at The Grievance Cell, ManipalCigna Health Insurance Company Limited, (formerly known as CignaTTK Health Insurance Company Limited), 401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai-400063, India or email headcustomercare@manipalcigna.com.

For updated details of grievance officer,

kindly refer link https://www.manipalcigna.com/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

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

You may also approach the Insurance Ombudsman if your complaint is open for more than 30 days from the date of filing the complaint.

24. Migration

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

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

25. Moratorium Period

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

26. Withdrawal of Policy

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

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

27. Nomination

The policyholder is required at the inception of the policy 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 the 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.

28. 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.

VIII Definitions

1. **Accident** or Accidental means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** or Aged is the age last birthday, and which means completed years as at the Inception Date.
3. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Any one Illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment may have been taken.
6. **Associated Medical Expenses** shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/ surgeon/ anesthetist/ Specialist excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalisation in ICU.

   Associated Medical Expenses shall be applicable for covered expenses,

incurred in Hospitals which follow differential billing based on the room category.

7. **AYUSH** treatment refers to the medical and /or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.
8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
9. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.
10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. **Internal Congenital Anomaly -** which is not in the visible and accessible parts of the body.

b. **External Congenital Anomaly -** which is in the visible and accessible parts of the body.

11. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
12. **Covered Relationships shall include** spouse, children, brother and sister of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and Nephew.
13. **Cumulative Bonus** Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.
14. **Day Care Treatment** refers to medical treatment, and/or surgical procedure which is:

i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

ii) Which would have otherwise required a hospitalisation of more than 24 hours.

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

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

a. has qualified nursing staff under its employment

b. has qualified medical practitioner (s) in charge

c. has a fully equipped operation theatre of its own where surgical procedures are carried out

d. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

16. **Deductible** is 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.
17. **Dental Treatment** is a treatment carried out by a dental practitioner including examinations, fillings, (where appropriate), crowns, extractions and surgery.
18. **Disclosure to Information Norm** means 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.
19. **Emergency** shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a medical practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the insured person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
20. **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.
21. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Inception Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period.
22. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
23. **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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:

i. 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;

ii. has qualified nursing staff under its employment round the clock;

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.

24. **Hospitalisation or Hospitalised** means admission in a hospital for a minimum period of 24 consecutive 'In-patient' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
25. **Illness** means sickness or 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,
2. and/or tests
3. it needs on-going or long term control or relief of symptoms
4. it requires your rehabilitation or for you to be specially trained to cope with it
5. it continues indefinitely
6. it comes back or is likely to come back.

26. **Inception Date** means the Inception date of this Policy as specified in the Schedule.
27. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
28. **In-patient** means an Insured Person who is admitted to hospital and stays for at least 24 consecutive hours for the sole purpose of receiving treatment.
29. **In-patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.
30. **Insured Person** means the person(s) named in the Schedule to this Policy, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.
31. **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.
32. **Medical Advice** means any written consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.
33. **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.

34. **Medical Practitioner** - A Medical practitioner is 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 set up by Government of India or a State Governement and is and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
35. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. Is required for the medical management of the Illness or injury suffered by the Insured;

b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.

c. Must have been prescribed by a Medical Practitioner.

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

36. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
37. **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.
38. **Non- Network Provider** Any hospital, day care centre or other provider that is not part of the network.
39. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
40. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy Contract and shall be read together.
41. **Policy Anniversary** is the same date each year during the Policy Term as the Date of Commencement of Policy. If the date of Commencement of Policy is on 29th February, the Policy Anniversary will be taken as the last date of February.
42. **Policy Period** means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.
43. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
44. **Policy Year** means a period of 12 consecutive months within the Policy Period commencing from the Policy Anniversary Date.
45. **Portability** means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
46. **Post-hospitalisation Medical Expenses** Post-hospitalisation Medical Expenses means medical expenses incurred during predefined 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 hospitalisation was required, and

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

47. **Pre-existing Disease** Pre-Existing Disease means any condition, ailment or injury or disease:

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

48. **Pre-hospitalisation Medical Expenses** Pre-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

49. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
50. **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.
51. **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.

    Revival Period means the specified period of time immediately following the instalment due date during which a payment can be made to revive or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
52. **Room Rent** - Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
53. **Schedule** means schedule issued by Us, attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, Sum Insured, Policy Period, Premium Paid(including taxes).
54. **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of that Insured Person.

i. In case where the Policy Period for 2/3 years, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted will be available for the second/third year.

ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

55. **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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.
56. **TPA** Third Party Administrator (TPA)", means a company registered with the Authority, and engaged by Us, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under TPA Regulations.
57. **Unproven/Experimental Treatment** - Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.
58. **We/Our/Us/Insurer** means ManipalCigna Health Insurance Company Limited
59. **You/Your/Policy Holder** means the person named in the Schedule as the policyholder and who has concluded this Policy with Us.

Annexure I – 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@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, JJeevan Soudha Building,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@ecoi.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.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:- bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Email:- bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@ecoi.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.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Fax: 0141 -Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim and Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:- 0522-2231310 Email:- bimalokpal.lucknow@ecoi.co.inmailto:ioblko@sancharnet.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.:- 022-26106552/6960 Fax:- 022-26106052 Email:- bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal 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, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure – II:

<table>
<tr><td>Title</td><td colspan="5">Description</td></tr>
<tr><td></td><td colspan="5">Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief</td></tr>
<tr><td>Your Coverage Details:</td><td rowspan="7">Deductible amount and Sum Insured combination</td><td colspan="2">Plus</td><td colspan="2">Select</td></tr>
<tr><td rowspan="8">Basic Cover (This section lists the Basic benefits available on your plan)</td><td>Deductible (INR in Lacs)</td><td>Sum Insured (INR in Lacs)</td><td>Deductible (INR in Lacs)</td><td>Sum Insured (INR in Lacs)</td></tr>
<tr><td>3, 3.5</td><td>3, 6</td><td>1</td><td>1, 2, 4</td></tr>
<tr><td>4, 4.5</td><td>4, 8</td><td>2, 2.5</td><td>2, 4, 5</td></tr>
<tr><td>5, 5.5</td><td>5, 10, 15, 20</td><td>3, 3.5</td><td>3, 6, 10</td></tr>
<tr><td>7.5</td><td>10, 15, 20</td><td>4, 4.5</td><td>4, 8, 15</td></tr>
<tr><td>10</td><td>10, 20, 30</td><td>5, 7.5</td><td>5, 10, 15, 20</td></tr>
<tr><td>-</td><td>-</td><td>10</td><td>10, 20, 30</td></tr>
<tr><td>Inpatient Hospitalisation(When you are hospitalized)</td><td colspan="4">Covers Hospital expenses for admission longer than 24 hours. Covered up to any Room Category.</td></tr>
<tr><td></td><td>Pre - hospitalisation</td><td colspan="4">Medical Expenses Covered up to 60 days before date of hospitalisation.</td></tr>
<tr><td></td><td>Post - hospitalisation</td><td colspan="4">Medical Expenses Covered up to 90 days post discharge from hospital.</td></tr>
<tr><td></td><td>Day Care Treatment</td><td colspan="4">Covered up to the limit of Sum Insured opted.</td></tr>
<tr><td></td><td>Non-medical expenses Cover</td><td colspan="4">Actual expense incurred towards non – medical items listed under policy wordings under Annexure III.</td></tr>
<tr><td></td><td>Road Ambulance Cover</td><td colspan="4">Actual incurred expenses paid per hospitalisation event.</td></tr>
<tr><td></td><td>Donor Expenses (Hospitalisation Expenses of the donor providing the organ)</td><td colspan="4">Covered up to full Sum Insured.</td></tr>
<tr><td></td><td>In-patient hospitalisation of AYUSH Cover</td><td colspan="4">Covered up to full Sum Insured.</td></tr>
<tr><td></td><td>Guaranteed Cumulative Bonus</td><td colspan="4">A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 50% of Sum Insured.</td></tr>
<tr><td>Optional Covers (This section lists the available optional covers under your plan and the limits under each of these options)</td><td>Guaranteed continuity on deductible</td><td colspan="4">From 5th Policy Year onwards, the Insured Person will have an option to opt for a base policy*, with guaranteed continuity on waiting periods# applicable under the base Policy. No fresh risk assessment shall be done for Sum Insured up to the deductible amount opted under this Policy (ManipalCigna Super Top Up).
Cover under existing policy, ManipalCigna Super Top Up, will continue to be available for the Insured person, subject to Renewal and policy terms and conditions.
#Waiting Periods here will mean initial waiting period, specific illness waiting period and pre-existing disease waiting period of base policy.
* ManipalCigna ProHealth Insurance – Protect Plan (UIN CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us.
This optional cover is available at the purchase of this Policy and the same shall apply to Insured person/s for which the cover is opted.</td></tr>
<tr><td></td><td>Reduction in Pre-existing disease waiting period</td><td colspan="4">Option to reduce pre-existing waiting period under this Policy from 48 months to 24 months.</td></tr>
</table>

Add on cover (Rider) This section lists the Add on cover available under your plan	Critical Illness UIN: MCIHLIP21128V022021	Lump sum payment of an additional 100% of Sum Insured Opted.

Annexure III

SNO	Item
LIST I - ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY	
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/ BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL / INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLTNDER (FOR USAGE OUTSTDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG/ SHORT/ HTNGED)
46.	KNEE IMMOBILIZER/ SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53.	SUGAR FREE TABLETS
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES	
1.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU.DE-COLOGNE / ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP

19.	DISINFECTANT LOTIONS	13.	SURGICAL DRILL
20.	LUXURY TAX	14.	EYE KIT
21.	HVAC	15.	EYE DRAPE
22.	HOUSE KEEPING CHARGES	16.	X-RAY FILM
23.	AIR CONDITIONER CHARGES	17.	BOYLES APPARATUS CHARGES
24.	IM IV INJECTION CHARGES	18.	COTTON
25.	CLEAN SHEET	19.	COTTON BANDAGE
26.	BLANKETA/VARMER BLANKET	20.	SURGICAL TAPE
27.	ADMISSION KIT	21.	APRON
28.	DIABETIC CHART CHARGES	22.	TORNIQUET
29.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	23.	ORTHOBUNDLE, GYNAEC BUNDLE
30.	DISCHARGE PROCEDURE CHARGES	**LIST IV - ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT**	
31.	DAILY CHART CHARGES		
32.	ENTRANCE PASS / VISITORS PASS CHARGES	1.	ADMISSION/REGISTRATION CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	2.	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
34.	FILE OPENING CHARGES	3.	URINE CONTAINER
35.	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)	4.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
36.	PATIENT IDENTIFICATION BAND / NAME TAG		
37.	PULSEOXYMETER CHARGES	5.	BIPAP MACHINE
LIST III- ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES		6.	CPAP/ CAPD EOUIPMENTS
		7.	INFUSION PUMP_ COST
1.	HAIR REMOVAL CREAM	8.	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
2.	DISPOSABLES RAZORS CHARGES (for site preparations)	9.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
3.	EYE PAD		
4.	EYE SHEILD	10.	HIV KIT
5.	CAMERA COVER	11.	ANTISEPTIC MOUTHWASH
6.	DVD, CD CHARGES	12.	LOZENGES
7.	GAUSE SOFT	13.	MOUTH PAINT
8.	GAUZE	14.	VACCINATION CHARGES
9.	WARD AND THEATRE BOOKING CHARGES	15.	ALCOHOL SWABES
10.	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	16.	SCRUB SOLUTION/STERILLIUM
11.	MICROSCOPE COVER	17.	GLUCOMETER & STRIPS
12.	SURGICAL BLADES, HARMONICSCALPEL, SHAVER	18.	URINE BAG

ManipalCigna Critical Illness Add On Cover

Terms and Conditions

I. General Provisions

1. It is agreed and understood that the Add On Cover can only be bought along with the Underlying Plan and cannot be bought in isolation or as a separate product.
2. The Add On Cover is subject to the terms and conditions stated below and the Policy terms, conditions and applicable endorsements of the Underlying Plan.
3. The Add On Cover shall be available under your policy only if the same is specifically opted and specified in the Policy Schedule.
4. All applicable Terms and Conditions of the Underlying Policy shall apply to the Add On Cover.

II. Definitions

1. **Add On Cover** means ManipalCigna Critical Illness Add On Cover
2. **Critical Illness** means the following:

a) Cancer of Specified Severity

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded -

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
9. All tumors in the presence of HIV infection.

b) Myocardial Infarction (First Heart Attack of Specific Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (for e.g. typical chest pain)
2. New characteristic electrocardiogram changes
3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris.
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

c) Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s) by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures.The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

1. Angioplasty and/or any other intra-arterial procedures.

d) Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

e) Coma of Specified Severity

1. A state of unconsciousness with no reaction or response to external stimuli or internal needs.

   This diagnosis must be supported by evidence of all of the following:

   i. no response to external stimuli continuously for at least 96 hours;

   ii. life support measures are necessary to sustain life; and

   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

2. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

f) Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

g) Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
2. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

i) Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

j) Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

k) Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

   1. investigations including typical MRI findings which unequivocally

confirm the diagnosis to be multiple sclerosis and;

2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

3. Underlying Policy - means the Insurance Policy or any other insurance plan issued by ManipalCignaHealth Insurance including its terms and conditions, any annexure thereto and the Schedule (as amended from time to time), the statements in the proposal form or the Customer Information Sheet and the Policy wording (including endorsements, if any) and to which this Add On Cover is attached.

III. Coverage

a) We will pay a fixed lump sum amount, to the Insured Person suffering from a disease/ Illness/ Injury or medical condition which shall lead to the diagnosis of the named Critical Illnesses or the performance of any of the named Surgical Procedures listed and defined under this Add on.

i. Cancer of Specified Severity

ii. Myocardial Infarction (First Heart Attack of Specific Severity)

iii. Open Chest CABG

iv. Open Heart Replacement or Repair of Heart Valves

v. Coma of Specified Severity

vi. Kidney Failure Requiring Regular Dialysis

vii. Stroke Resulting in Permanent Symptoms

viii. Major Organ/Bone Marrow Transplant

ix. Permanent Paralysis of Limbs

x. Motor Neuron Disease with Permanent Symptoms

xi. Multiple Sclerosis with Persisting Symptoms

b) The Sum Insured will be payable once in a lifetime of an Insured subject to the following conditions:

i. The Critical Illness is specifically listed and defined in this Cover;

ii. The Critical Illness experienced by the Insured person is the first incidence of that Critical Illness;

iii. The Insured Person survives for at least 30 days following the diagnosis of Critical Illness;

iv. The Insured Person is at least 18 years of age at the time of taking the Cover.

v. Coverage will not apply to persons between the age group of 18 to 23 years who are covered as “Child”.

vi. Once a claim has been accepted and paid for a particular Critical Illness for that particular Insured, the cover shall cease in respect of that Insured Person.

In case of a floater policy, We will provide for a 100% reinstatement of Sum Insured once during the lifetime of the Policy for the other adult Insured Person in the Policy.

“Reinstatement of Sum Insured” for the purpose of this Policy means the amount reinstated in accordance with the terms and conditions as stated above under this Policy.

Discounts

1. Family Discount: Discount of 10% on the premium for covering 3 or more individuals with individual sum insured.
2. Long Term Discount: Long term discount, on the premium, of 7.5% for selecting a 2 year policy term and 10% for selecting 3 year policy term. The discount is available only with 'Single' premium payment mode.
3. Direct Policy Discount: Discount of 10% on the premium for policies issued directly without the involvement of any intermediary.
4. Worksite Marketing Discount: Discount of up to 10%, on the premium, will be available on polices sourced through worksite marketing channel.
5. Social Media Discount: Discount of 2.5%, on the premium will be available on policies sourced through online channel and policyholder opts to post the pre-defined marketing message to all contacts in his social media account.

IV. Waiting Periods

We shall not be liable to make any payment under this Add On Cover directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

a) **First 90 days Waiting Period:** Any Critical Illness or Injury which was diagnosed or existed within the first ninety (90) days of the Add On Cover start date will not be covered.

b) **Pre-existing disease Waiting period:** Any Pre-existing Critical Illness as defined in the Policy until the specified months of continuous covers have elapsed since inception of the first Policy with Us. Waiting period for the specified months as mentioned in the Schedule against this Benefit shall apply.

Pre-existing disease for the purpose of this waiting period is defined as below:

Pre-existing Disease means any condition, ailment or injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

or

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

c) Personal Waiting Period: A special Waiting Period not exceeding 48 months, may be applied to Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving the Insured Person's specific consent.

V. Survival Period

The benefit payment shall be subject to survival of the Insured Person for more than 30 days post the first diagnosis of the Critical Illness/ undergoing for the first time of the Surgical Procedures/ for the first time of occurrence of medical events.

VI. Cancellations

Request for Cancellation shall be intimated to Us from Your side by giving 15 days' notice in which case We shall refund the premium for the unexpired term as per the short period scale mentioned below.

Premium shall be refunded only if no claim has been made under the Policy.

1 Year		2 years		3 years	
Policy in force upto	**Premium Refund %**	**Policy in force upto**	**Premium Refund %**	**Policy in force upto**	**Premium Refund %**
1 month	75%	1 month	87.5%	1 month	90%
3 months	50%	3 months	75%	3 months	85%
6 months	25%	6 months	62.5%	6 months	75%
More than 6 months	NIL	12 months	50%	12 months	60%
		15 months	37.50%	15 months	50%
		18 months	25%	18 months	35%
		Above 18 months	NIL	24 months	30%

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

Where the Policy has been issued for two years and a claim for Critical Illness becomes payable in the first year the cover shall cease and any premium collected for the second year in respect of a particular Insured Person will be refunded after deduction of applicable discounts and commissions (if any).

VII. Permanent Exclusions

We shall not be liable to make any payment under this Add On Cover, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Any Illness, sickness or disease, other than specified as Critical Illness, as mentioned in the Schedule;
2. Any Critical Illness directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV;
3. Any Critical Illness arising out of use, abuse or consequence or influence

of any substance, intoxicant, drug, alcohol or hallucinogen;

4. Any Critical Illness directly or indirectly caused due to Intentional self-injury, suicide or attempted suicide.
5. Any treatment/surgery for change of sex or any cosmetic surgery or treatment/surgery /complications/illness arising as a consequence thereof;
6. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power;
7. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
8. Congenital anomalies or any complications or conditions arising therefrom;
9. Insured Persons whilst 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;
10. Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy;
11. Any Critical Illness based on Certification / Diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven or any kind of self-medication and its complications;
12. Cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs, or treatment of an optional nature;
13. Any critical illness arising or resulting from the Proposer or any of his family members committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion;

In the event of death of the Insured within the stipulated survival period applicable under each category.

Applicable exclusions of the Underlying Policy will apply in addition to the Add On exclusions.

VIII Claim Process:

In the event of a claim arising out of any of the listed Critical Illnesses covered under this Add on, the Insured Person shall submit the claim documents to Us within ninety (90) days of date of first diagnosis of the Illness/ date of surgical procedure or date of occurrence of the medical event, as the case may be.

Insured Person shall submit the following documents in original for assessment and upon request we will return the Original documents.

1. Claim Form Duly Filled and Signed- Part A and B
2. Original Discharge Certificate/ Card from the hospital/ Doctor
3. Original investigation test reports confirming the diagnosis, Indoor case papers if applicable
4. Any other documents as may be required by Us
5. In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will be required.

In the unfortunate event of the death of the Insured Person post the survival period, someone claiming on his behalf must inform Us in writing immediately.

Claim payment for policies with Monthly, Quarterly and Half-Yearly Premium Payment Mode:

In case of a claim, an amount equivalent to the balance of the instalment premiums payable, in that policy year would be recoverable from the claim amount payable in respect of the Insured person.

Manipal Cigna
Health Insurance

For any assistance contact: 1800-102-4462 customercare@manipalcigna.com www.manipalcigna.com

Corporate Office: ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited)
401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai - 400063. IRDAI Registration No. 151