ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
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ManipalCigna Health Insurance

Arogya Sanjeevani Policy, ManipalCigna

(PROSPECTUS)

I. What are the Key Highlights of the Policy?

Hospitalization	AYUSH Treatment	Cataract Treatment
Pre Hospitalization	Post Hospitalization	Modern and Advanced Procedures
Cummulative Bonus		

II. What are the Basic covers?

1. **Hospitalization:** We shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,
   i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/Nursing Home up to 2% of the sum insured subject to maximum of ₹5000/-, per day.
   ii. Intensive Care Unit (ICU)/Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of ₹10,000/- per day
   iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/surgeon or to the hospital
   iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics,diagnostic imaging modalities and such similar other expenses.

   1.1. Other expenses

   i. Expenses incurred on treatment of cataract subject to the sub limits.
   ii. Dental treatment necessitated due to disease or injury.
   iii. Plastic surgery necessitated due to disease or injury.
   iv. All day care treatments.
   v. Expenses incurred on road ambulance subject to a maximum of ₹2000/- per Hospitalization

   Note:

   1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
   2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2. **AYUSH Treatment:** We shall indemnify medical expenses incurred for inpatient care/day care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital/ AYUSH Day Care Centre

3. **Cataract Treatment:** We shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or ₹40,000/-, whichever is lower, per each eye in one policy year.

4. **Pre Hospitalization:** We shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring in patient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. **Post Hospitalization:** We shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. The following procedures will be covered (wherever medically indicated) either as inpatient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:
   a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
   b. Balloon Sinuplasty
   c. Deep Brain stimulation
   d. Oral chemotherapy
   e. Immunotherapy - Monoclonal Antibody to be given as injection
   f. Intra vitreal injections
   g. Robotic surgeries
   h. Stereotactic radio surgeries
   i. Bronchical Thermoplasty
   j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   k. IONM - (Intra Operative Neuro Monitoring)
   l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

III. CUMULATIVE BONUS

Cumulative Bonus (CB) will be increased by 5% in respect of each policy year, provided the policy is renewed with us without a break subject to maximum of 50% of the sum insured under the current policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis.
iii. CB shall be available only if the Policy is renewed/premium paid within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year

IV. What are the features of the product?

i. **Eligibility:** The minimum entry age under this policy is 3 months (91 days) for children and 18 years for adults. The maximum age of entry under this policy is 25 years for children and 65 years for adults.

Coverage for children:

a. Children from 91 days to 18 years will only be covered if one of the parents is the proposer.
b. Children up to 25 years can be covered under the floater.
c. Children beyond 25 years can be covered under an individual policy.

ii. Individual/Family Floater: The policy can be purchased on an Individual basis or a Family floater basis.

a. In case of an Individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, lawfully wedded spouse, dependent children (i.e. natural or legally adopted), parents and parents-in law.

b. In case of a floater cover, one family will share a single sum insured as opted. A floater plan can cover self, lawfully wedded spouse, dependent children (i.e. natural or legally adopted), parents or parents-in-law. A floater cover can cover a maximum of 2 adults and 3 dependent children under a single policy. Only one set of parents (parents or parents-in-law) can be covered under one policy.

iii. Policy Period: You can buy the policy for one year. 'One Policy Year' shall mean a period of one year from the inception date of the policy.

iv. Sum Insured Options: You have the option to choose from the below range of Sum Insured's available: ₹50,000, ₹1 Lac, ₹1.5 Lacs, ₹2 Lacs, ₹2.5 Lacs, ₹3 Lacs, ₹3.5 Lacs, ₹4 Lacs, ₹4.5 Lacs, ₹5 Lacs, ₹5.5 Lacs, ₹6 Lacs, ₹6.5 Lacs, ₹7 Lacs, ₹7.5 Lacs, ₹8 Lacs, ₹8.5 Lacs, ₹9 Lacs, ₹9.5 Lacs, and ₹10 Lacs.

v. Discounts under the Policy

- Family discount - of 15% for covering 2 and more family members under the same policy under the individual policy option.
- Online Renewal 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).
- Worksite marketing discount - of 10% will be available on polices which are sourced through worksite marketing

vi. Underwriting Loading and Special Conditions: Underwriting Loadings will be applicable at the time of acceptance of fresh business on a case to case basis depending on the relevance of each of the below mentioned criteria.

- Medical History & Declarations on the Proposal Form/medical documents
- Subsequent Diagnosis from the Pre - Policy Medical Tests and/or Tele/Video underwriting
- Overall Health Risk Scoring Generated in the UW Tool

Objective criteria for the same will be as per Our Underwriting policy.

We may also apply a permanent exclusion for a specific condition as defined in the underwriting criteria.

vii. remiums: The Premium charged on the policy will depend on Sum Insured, Age, Policy Type, Number of members covered and Gender. Additionally, the health status of the individual will also be considered.

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

For detailed premium chart please refer Annexure "Rate Chart".

viii.Premium payment mode: The premium should always be paid in advance for a full Policy Year However, for your convenience, we may allow you other modes of payment of premium. Premium can be paid on Yearly, Half yearly, Quarterly or 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 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

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

Change in premium payment mode is subject to:

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

ix. Grace Period and Premium Payment in Installments

For half yearly and quarterly payment of mode, a fixed period of 30 days will be allowed as Grace Period and for monthly mode of

payment a fixed period of 15 days will be allowed as Grace Period.

If the insured person opts for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly the following Conditions shall apply

i. Grace Period of 15/30 days would be given to pay the installment premium due for the Policy.
ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
iii. The Benefits provided under - “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated Grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received with in the Grace Period, the Policy will get cancelled.
vi. Wherever premium is not received within the grace period of the policy, the policy will be terminated from the date on which such grace period is over to pay the premium and all claims that fall beyond such grace period shall not be covered as part of the policy. However, we will be liable to pay in respect of all claims where the treatment / admission/ accident has commenced/occurred before the expiry of such grace period for the payment of instalment premium

x. Renewal Terms

The policy shall ordinarily be renewable except on grounds of established fraud, non-disclosure of material facts and misrepresentation by the insured person. The Company shall give notice for renewal at least 30 days in advance from the Policy due date.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by us before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

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

i. The waiting periods specified in Section V shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

xii. Migration: The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

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

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

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

xiv. Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of 30 days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

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

xv. Cancellations:

i. The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

1. If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of the cancellation request will be considered as the expiry date of coverage.
2. If a claim has been made during the Policy period, no refund will be given to the Policyholder.

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure	1
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	285
Premium Refund	77.87 (100*285/365)

2. Where the Policyholder has made a claim during the Policy Year

Policy Start Date	01-07-2023
Policy End Date	30-06-2024
Tenure	1
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2024
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	-

No refund would be given to Policyholder as he had made a claim during the Policy Period.

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.

xvi.Automatic change in Coverage under the policy: The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/her (Insured Person) demise.

   However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other 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 the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

xvii.Endorsements:

1. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
2. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

xviii.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. For Claim settlement under reimbursement, the Company will pay the policyholder. 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.

xix.Grievance Redressal

If you have a grievance that you wish us to redress, you may contact us with the details of the grievance through Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at - seniorcitizensupport@manipalcigna.com

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact

the grievance officer at,

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India

or

Email - headcustomercare@manipalcigna.com.

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

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

Grievance may also be lodged at IRDAI complaints management system - https://bimabharosa.irdai.gov.in/

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

The office Name and address details applicable for your state can be obtained from - https://www.cioins.co.in/Ombudsman.

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

Full cost of all such tests / tele underwriting will be borne by us for all proposals.

<table>
<tr><th>Sum Insured (Lacs)</th><th>Age Band (Years)</th><th>Risk Assessment Tool (Single Individual)</th><th>Risk Assessment Tool (Family Floater and Multi Individual)</th><th>Risk Assessment Tool (Family Floater, Multi-Individual & Individual)</th></tr>
<tr><td rowspan="4">50K to 5L</td><td>Up to 17</td><td>NO TEST</td><td rowspan="3">NO TEST</td><td rowspan="4">Tele-Underwriting</td></tr>
<tr><td>18 - 35</td><td>Tele Underwriting</td></tr>
<tr><td>36 - 45</td><td>NO TEST</td></tr>
<tr><td>46 - 55</td><td>Tele Underwriting</td><td>Tele Underwriting</td></tr>
<tr><td></td><td>>55</td><td>Medical Test (Set 14 -MER, CBC-ESR, FBS,Lipid Profile, Sr.Creatinine, ECG)</td><td>Medical Test (Set 14 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG)</td><td>Medical Test (Set 17 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG, CEA)</td></tr>
<tr><td rowspan="5">>5L to 10L</td><td>Up to 17</td><td>NO TEST</td><td rowspan="3">NO TEST</td><td rowspan="3">Tele-Underwriting</td></tr>
<tr><td>18 - 35</td><td>NO TEST</td></tr>
<tr><td>36 - 45</td><td>NO TEST</td></tr>
<tr><td>46 - 55</td><td>Tele Underwriting</td><td>Tele Underwriting</td><td></td></tr>
<tr><td>>55</td><td>Medical Test (Set 14 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG)</td><td>Medical Test (Set 14 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG)</td><td>Medical Test (Set 17 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG, CEA)</td></tr>
</table>

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

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

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

V. What are the Waiting Periods and Exclusions?

We shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

i. Pre - Existing Diseases (Code - Excl 01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

ii. First Thirty Days Waiting Period (Code - Excl 03)

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

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

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

iii. Specific Waiting Period: (Code - Excl 02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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.

i. 24 Months waiting period

1. Benign ENT disorder
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele

14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period
1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

iv. PERMANENT EXCLUSIONS: We shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

1. Investigation & Evaluation (Code - Excl 04)

i. Expenses related to any admission primarily for diagnostics and evaluation purposes.
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

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:
- Obesity related cardiomyopathy
- Coronary Heart Disease
- Severe sleep apnea
- Uncontrolled Type^2 diabetes

4. Change of Gender treatments: (Code-Excl 07): Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded, except for sex reassignment surgery for transgender persons.

5. Cosmetic or plastic Surgery: (Code-Excl 08): Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. **Hazardous or Adventure sports: (Code-Excl 09):** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. **Breach of law: (Code-Excl 10):** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

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

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

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code - Excl14)**

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 un proven 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 Expenses (Code - Excl 18):**

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

16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of th is exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, in capacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

19. Treatment taken outside the geographical limits of India

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

VI. How can I buy the Policy?

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

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

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

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured and Age, we would arrange the medical check-ups at Our network. Basis health declarations or findings of the pre policy medical tests if the terms and conditions of the policy are altered, same will be intimated to you and issuance will be subject to acceptance of the revised offer and submission of your consent premium for the revised offer.

Step 5: Based on the above information we will process Your proposal for Insurance and a policy kit containing the Customer Information Sheet, Policy Terms and associated documents will be sent to you.

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

VII. What is the claim process?

1. Procedure for Cashless claims:

(i) Treatment may be taken in a network provider or common empanelment of hospital/healthcare providers as specified by Insurance Council and is subject to pre authorization by the Company or its authorized TPA.

(ii) Cashless request form available with the network provider or common empanelment of hospital/healthcare providers as specified by Insurance Council and TPA shall be completed and sent to the Company/TPA for authorization.

(iii) The Company/TPA upon getting cashless request form and related medical information from the insured person/network provider or common empanelment of hospital/healthcare providers, will issue pre-authorization letter to the hospital after verification within 1 hour from the receipt of last completed documents.

(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses. Company We shall accept or decline such additional expenses within 3 (Three) hours of receiving the complete documents for final discharge from Network provider or Common empanelment of hospital/healthcare providers.

(v) The Company/TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

(vi) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

2. **Procedure for reimbursement of claims:** For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. **Notification of Claim:** Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:
   i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
   ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4. **Documents to be submitted:** The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

1. Duly Completed claim form
2. Photo Identity proof of the patient
3. Medical practitioner's prescription advising admission
4. Original bills with itemized break-up
5. Payment receipts
6. Discharge summary including complete medical history of the patient along with other details.
7. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
8. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
9. Sticker/Invoice of the Implants, wherever applicable.
10. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
11. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
12. KYC (Identity proof with Address) of the proposer, where claim liability is above ₹1 Lakh as per AML Guidelines
13. Legal heir/succession certificate, wherever applicable
14. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. We shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, we shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to our satisfaction.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

5. **Co-payment:** Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

6. **Claim Settlement (provision for Penal Interest)**

i. The Company shall settle or reject the claim, as the case may be, within 15 days (other than cashless) from date of submission of necessary claim documents.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from date of submission of necessary claim documents to the date of payment of claim at a

rate 2% above the bank rate.

7. **Services Offered by TPA:** Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

   The services offered by a TPA shall not include

   1. Claim settlement and claim rejection;
   2. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

   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: https://www. manipalcigna.com/our-tpas

8. **Payment of Claim:**

   All claims under the policy shall be payable in Indian currency only.

VIII. What are the plan benefits?

Name	Arogya Sanjeevani Policy, ManipalCigna
Product Type	Individual/Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis - SI shall apply to each individual family member On Floater basis - SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Eligibility Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly, half yearly and quarterly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for monthly mode of payment a fixed period of 15 days be allowed as grace period
Hospitalization Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours on Hospitalization Expenses shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalization	For 30 days prior to the date of hospitalization
Post Hospitalization	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctors fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to 2% of the sum insured subject to maximum of ₹5000/- per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/Nursing Home up to 5% of the sum insured subject to maximum of ₹10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or ₹40,000/-, whichever is lower, per eye, under one policy year .
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 3 years

Cumulative bonus	Increase in the sum insured by 5% in respect of each year subject to a maximum of 50% of SI.
Co Pay	5% co pay on all claims

Disclaimer:

This is only a summary of the product features. The actual benefits available shall be described in the policy, and will be subject to the policy terms, conditions and exclusions.

For more details on risk factors, terms and conditions read the sales brochure and speak to Your advisor before concluding a sale.

Prohibition of Rebates (Under Section 41 of the Insurance Act, 1938)

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation

IX. ANNEXURES

Illustration of Benefits

Rate Charts