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MANIPALCIGNA LIFETIME HEALTH

Prospectus

I. What are the Key Highlights of the Policy?

India Plan (Base cover)

- Hospitalization Expenses
- Pre-hospitalization
- AYUSH Treatment
- Donor Expenses
- Adult Health Check-up
- Modern and Advanced Treatments
- Mental Care Cover
- Premium Waiver Benefit
- Personal Accident Plus (Optional)
- Day Care Treatment
- Post-hospitalization
- Road Ambulance Cover
- Domiciliary Expenses
- Robotic and Cyber Knife Surgery
- HIV/AIDS and STD Cover
- Restoration of Sum Insured

Optional:

A. HEALTH+

- Air Ambulance Cover
- Medical Devices and Non- Medical Items
- Domestic Second Opinion
- Bariatric Surgery Cover
- Convalescence Benefit
- Major Illness Hospi Cash
- Chemotherapy and Radiotherapy Cash
- Accidental Hospi Cash
- Domestic Concierge Services
- Tele-Consultations

B. WOMEN+

- Breast Cancer Screening
- Cervical Cancer Screening
- Cervical Cancer Vaccination
- Ovarian Cancer Screening
- Osteoporosis Screening
- Gynaecological Consultations
- Psychiatric and Psychological Consultations

C.Deductible

D. Add On/Rider Cover

- ManipalCigna Critical Illness
- ManipalCigna Lifetime Plus
- ManipalCigna Health 360

Discounts

- Long Term policy discount
- Worksite Marketing discount
- Family discount
- Auto Renewal Discount
- Loyalty discount

The geographical scope of this policy applies to events within India and all admitted or payable claims shall be settled in India in Indian rupees.

Note:

Base Sum Insured[1] is the coverage amount that is opted at the time of inception or modified at the time of renewal whichever is later. It is the amount for which premium is computed and charged with respect to Base covers offered in this policy. It forms a part of Sum Insured[1]. Base Sum Insured[1] resets after the completion of each policy year.

Base Sum Insured[1] can be utilised only for claims under the below covers wherein medical expenses are incurred with respect to medical treatment is taken in India.

a) Hospitalisation Expenses
b) Day Care Treatment
c) Pre - hospitalization
d) Post – hospitalization
e) AYUSH Treatment
f) Road Ambulance Cover
g) Donor Expenses
h) Domiciliary Expenses
i) Robotic and Cyber Knife Surgery
j) Modern and Advanced Treatments
k) HIV/AIDS and STD Cover
l) Mental Care Cover
m) Non-Medical Items

In the event of any inconsistency in details provided in this document, the terms and conditions stated in the policy wordings shall prevail.

II. What are the Basic covers?

II.1. Hospitalization Expenses

We will indemnify the Medical Expenses of an Insured Person upto the Sum Insured[1] specified in the Policy Schedule in case of a Medically Necessary Hospitalization arising from a Disease/ Illness or Injury provided that such Medically Necessary Hospitalization is in India and such Medically Necessary Hospitalization is for more than 24 consecutive hours and the admission date of the Hospitalization is within the Policy Period.

We will indemnify Medical Expenses for Reasonable and Customary charges for Room Rent for accommodation in Hospital room up to any room category, as per the Sum Insured[1] intensive Care Unit charges, operation theatre charges, fees of Medical Practitioner or surgeon, anaesthetist, qualified nurses, specialists, cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a surgical procedure. We shall also indemnify Medical Expenses related to any admission (under In-patient Hospitalization, Day Care Treatment or Domiciliary Hospitalization) primarily for enteral feedings will be covered maximum up to 15 days in a Policy Year, provided it is Medically Necessary and is prescribed by a Medical Practitioner.

Under Hospitalization expenses, when availed under Inpatient care, we will indemnify 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.

If the Insured Person is admitted to a room category higher than that specified in the Policy Schedule, the Policyholder/Insured Person shall bear a proportionate share of the total Associated Medical Expenses (including room rent, applicable taxes and surcharge). Such proportionate share will be calculated based on the ratio of the room rent entitlement to the room rent actually incurred.Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II. 2. Day Care Treatment

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

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.3. Pre - hospitalization

We will reimburse, Pre-hospitalization Medical Expenses, upto the Sum Insured[1], incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital. The benefit is payable subject to hospitalization claim being admissible under Section II.1 'Hospitalization Expenses' or Section II.2 'Day Care Treatment' and is related to the same Illness/condition.
Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.4. Post - hospitalization

We will reimburse, Post-hospitalization Medical Expenses, upto the Sum Insured[1], incurred during the 180 days immediately post the date the Insured was discharged from the Hospital. The benefit is payable subject to hospitalization claim being admissible under Section DII.1 'Hospitalization Expenses' or Section II.2 'Day Care Treatment' and is related to the same Illness/condition.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.5. AYUSH Treatment

We will indemnify the Medical Expenses of the Insured Person in case of a Medically Necessary treatment taken during In-patient Hospitalization for AYUSH Treatment, for an Illness or Injury that occurs during the Policy Year, provided that the date of admission in the Hospital falls within a Policy Year. Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

Specific Conditions applicable to AYUSH Treatment

a. Claim under this cover is payable maximum up to the Sum Insured[1] will reduce the same.
b. Exclusion pertaining to Non-Allopathic treatments (in section E) shall be superseded to the extent of coverage provided under AYUSH Treatment

Specific Exclusions applicable to AYUSH Treatment

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

II. 6. Road Ambulance Cover:

We will indemnify the Reasonable and Customary expenses incurred towards transportation of an Insured Person by a registered healthcare or Road Ambulance service provider, to a Hospital for treatment of an Illness or Injury, covered under the Policy, necessitating the Insured Person's admission to the Hospital. Reasonable and Customary expenses shall include:

Specific Conditions applicable to Road Ambulance Cover

a. The necessity of use of aRoad Ambulance must be certified by the treating Medical Practitioner.

b. Under this benefit we shall reimburse road ambulance expenses incurred :

1. For transferring the Insured Person from site of incident to the nearest Hospital AND/OR
2. For transferring the Insured Person from one Hospital to another nearest Hospital due to the non-availability of the required treatment in the existing Hospital. AND/OR
3. For transferring the Insured Person from one Hospital to a diagnostic centre and back, if advised by the treating medical practitioner, for availing diagnostic facility not available at the existing Hospital.

Road ambulance services shall be applicable within India, and only where both the pick-up and drop-off locations fall within India. The road ambulance service must be availed during the Policy Period.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same

II.7. Donor Expenses

We will indemnify In-patient Hospitalization Medical Expenses incurred during the Policy Period, upto the Sum Insured[1], in respect of organ harvesting from the donor where an Insured Person shall be the recipient, subject to the following conditions:

a. The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, and under the following circumstances:
b. The organ donated is for the use of the Insured Person who has been prescribed to undergo an organ transplant on Medical Advice;
c. A claim is admissible under Section II.1 'Hospitalization Expenses', for the Insured Person;

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

Specific Exclusions applicable to Donor Expenses

i. Cost towards donor screening,
ii. Cost associated to the acquisition of the organ,
iii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
iv. Stem cell donation whether or not it is Medically Necessary treatment except for Bone Marrow Transplant.
v. Expenses related to organ transportation or preservation.Expenses towards any Pre or Post - hospitalization Medical Expenses towards the donor,

II.8. Domiciliary Expenses

We will reimburse the Medical Expenses of an Insured Person incurred towards treatment of a disease, Illness or Injury which in the normal course would otherwise have been covered for Hospitalization under the Policy but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a hospital transfer: or
ii. Hospital bed was unavailable provided that the treatment of the Insured Person continues at least 3 days in which case the reasonable cost of any Medically Necessary treatment for the entire period shall be payable.

Specific Conditions applicable to Domiciliary Expenses

a. We will pay for pre-hospitalization & post-hospitalization medical expenses up to 60 days and 180 days respectively.
b. All domiciliary expenses including pre-hospitalization & post-hospitalization medical expenses shall be payable ONLY if commencement of the domiciliary Hospitalization is within the Policy Period

Specific Exclusions applicable to Domiciliary Expenses

a. Asthma, bronchitis, tonsillitis, and upper respiratory tract infection including laryngitis and pharyngitis,
b. cough and cold, influenza,
c. Arthritis, gout and rheumatism,
d. Chronic nephritis and nephritic syndrome,
e. Diarrhoea and all type of dysenteries, including gastroenteritis,
f. Diabetes mellitus and insipidus,
g. Epilepsy,
h. Hypertension,
i. Pyrexia of unknown origin.
j. Any use of artificial life maintenance including life support machine use.

Benefit under this cover is payable maximum up to 10% of the Base Sum Insured[1] and any claim under this section will reduce the same.

II.9. Adult Health Check-up

If at the start of the Policy year, the Insured Person is of Age 18 years or above, then he/she may avail a comprehensive health check-up at Our Network as per the eligibility details mentioned in the table below. Health Check Ups will be arranged by Us and conducted at Our Network. This benefit will be available once a Policy Year starting from the first Policy Year.

Original copies of all reports will be provided to You.

Health Check-up list		
Base Sum Insured[1] (in INR)	**Age of the Insured Person at Policy year start date**	**List of tests**
50 Lacs/ 75 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, BUN, Sr. Creatinine, SGPT, Lipid Profile, SGOT, GGT, TSH
50 Lacs/ 75 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, BUN, Sr. Creatinine, SGPT, Lipid Profile, SGOT, GGT
50 Lacs/ 75 Lacs	>35 years (Females)	CBC-ESR, FBS, Lipid Profile, TSH, Uric acid, HbA1c, Liver Function test, Kidney Function Test, Vit D3
50 Lacs/ 75 Lacs	> 35 years (Males)	CBC-ESR, FBS, Lipid Profile, TSH, Uric acid, HbA1c, Liver Function test, Kidney Function Test, Vit D3, PSA
100 Lacs/ 150 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, BUN, Lipid Profile, TSH, Liver Function test, Kidney Function test
100 Lacs/ 150 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, BUN, Lipid Profile, Liver Function test, Kidney Function test
100 Lacs/ 150 Lacs	> 35 years (Females)	CBC-ESR, FBS, HbA1c, Lipid Profile, TSH, Uric acid, Liver Function test, Kidney Function Test, Sr. Electrolyte, Vitamin D3, Vit B12
100 Lacs/ 150 Lacs	> 35 years (Males)	CBC-ESR, FBS, HbA1c, Lipid Profile, TSH, Uric acid, Liver Function test, Kidney Function Test, Sr. Electrolyte, PSA, Vitamin D3, Vit B12
200 Lacs/ 300 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, Vitamin D3
200 Lacs/ 300 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, Kidney Profile, Lipid Profile, Liver Profile, Vitamin D3

200 Lacs/ 300 Lacs	> 35 years (Females)	CBC-ESR, FBS, HbA1C, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, Uric Acid, Sr. Electrolyte, Vitamin D3, Vitamin B12, CA-125
200 Lacs/ 300 Lacs	> 35 years (Males)	CBC-ESR, FBS, HbA1C, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, PSA, Uric Acid, Sr. Electrolyte, Vitamin D3, Vitamin B12

Full explanation of Tests is provided here: Vitals - Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth, FBS – Fasting Blood Sugar, GGT – Gamma-Glutamyl Transpeptidase, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT – Test Serum Glutamic Pyruvate Transaminase, SGOT – Serum Glutamic Oxaloacetic Transaminase, TSH – Thyroid Stimulating Hormone, TMT – Tread Mill Test, PSA – Prostate Specific Antigen, HBA1C-Hemoglobin A1C, CBC – Complete Blood Count, USG – Ultrasound/Sonography.

Coverage under this value added cover will not be available on reimbursement basis and any claim under this section will not reduce the Sum Insured[1].

II.10. Robotic and Cyber Knife Surgery

We will indemnify the Medical Expenses incurred towards Medically Necessary Robotic or Cyber knife Surgery of the Insured Person subject to the Illness/ Injury being covered under Section II.1 'Hospitalization Expenses' and the necessity being certified by an authorised Medical Practitioner.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.11. Modern and Advanced Treatments

We will indemnify the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Section D.II.1 'Hospitalization Expenses' and the necessity being certified by an authorised Medical Practitioner.

Only the below Modern and Advanced Treatment methods will be covered when availed under In-patient Hospitalization or as a Day Care Treatment:

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

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.12. HIV / AIDS and STD Cover

We will indemnify the Medical Expenses incurred for the Medically Necessary treatment, taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof or sexually transmitted diseases (STD) in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time.

Specific Conditions applicable to HIV/AIDS and STD cover

i. The purpose of Hospitalization is to avail Medically Necessary Treatment.

ii. The necessity of the Hospitalization is certified by an authorised Medical Practitioner.

iii. For conditions other than STD, the Insured Person should be a declared HIV positive.

iv. We will pay for Pre-hospitalization and Post- hospitalization medical expenses maximum up to 60 days and 180 days respectively.

v. Claim shall be payable ONLY if date of admission in the Hospital is within the Policy Period.

Benefit under this cover is payable up to Sum Insured[1] and any claim under this section will reduce the same.

II.13. Mental Care Cover

We will indemnify Medical Expenses incurred for the Medically Necessary treatment taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to with Mental illness, Stress, Anxiety, Depression or a medical condition impacting mental health in accordance with The Mental Health Care Act, 2017 as amended from time to time.

Specific Conditions applicable to Mental Care Cover

a. The Treatment is prescribed by a Medical Practitioner and the purpose of Hospitalization is to treat the Insured Person towards the Mental illness.

b. Claim shall be payable ONLY if date of admission in the Hospital is within the Policy Period.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

II.14. Restoration

In the event of complete or partial utilization of the Base Sum Insured[1] due to any claim admitted during the Policy Year, the Company shall reinstate only the utilized portion of the Base Sum Insured[1] unlimited times in the Policy Year.

Specific conditions applicable to Restoration

a. The Restored amount shall not be available for claims towards an Illness/ disease/ Injury (including its complications) for which a claim has been paid in the same Policy Year for the same Insured Person.

b. Restored amount cannot be utilized for claims falling under the purview of Any One Illness.

c. Restoration will trigger every time upon complete or partial utilization of the Base Sum Insured[1] by way of claims admissible under ONLY the below coverages.
    a) Hospitalisation Expenses
    b) Day Care Treatment
    c) Pre - hospitalization
    d) Post – hospitalization
    e) AYUSH Treatment
    f) Road Ambulance Cover
    g) Donor Expenses
    h) Domiciliary Expenses
    i) Robotic and Cyber Knife Surgery
    j) Modern and Advanced Treatments
    k) HIV/AIDS and STD Cover
    l) Mental Care Cover
    m) Non-Medical Items

d. The restored amount shall be available only for subsequent claims that may arise thereafter in the remainder of the Policy Year under the below coverages.
    a) Hospitalisation Expenses

b) Day Care Treatment
c) Pre - hospitalization
d) Post – hospitalization
e) AYUSH Treatment
f) Road Ambulance Cover
g) Donor Expenses
h) Domiciliary Expenses
i) Robotic and Cyber Knife Surgery
j) Modern and Advanced Treatments
k) HIV/AIDS and STD Cover
l) Mental Care Cover
m) Non-Medical Items

e. Any restored amount which is not utilised in a Policy Year shall not be carried forward to any subsequent Policy Year.
f. The restored amount shall be available on an Individual basis in Individual/Multi-Individual policies and on a floater basis in Family Floater policies.

II.15. Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers any of the below, we will pay the next Renewal Premium of the Policy, for a policy tenure of 1 year.

a) Permanent Partial Disablement, OR
b) Permanent Total Disablement, OR
c) Death due to an injury caused by an Accident within 365 days from the date of the Injury caused by an accident OR
d) He/she is diagnosed with a Critical Illness, listed under this section

Specific Conditions applicable to Premium Waiver Benefit

a) The premium shall be paid towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.
b) If only one person is covered under the Policy, policy will not be renewed in case of death of the Policyholder.
c) The Policyholder is not added in the Policy in the middle of the Policy Year.
d) There should be no change in covers, Sum Insured, benefit structure, limits and conditions applicable under the Policy, at the upcoming renewal.
e) No new member should be added under the renewed Policy.
f) In case of a policy with existing tenure of 2 or 3 years, it will be renewed only for one year, provided all the terms and conditions, benefits and policy limits remain same.
g) Once a claim has been accepted and paid under this Benefit, this cover will automatically terminate in respect of that Insured Person.
h) Claims under this section will not reduce the Sum Insured[1].
i) In case of any change in Policy benefits, complete premium will be paid by the Policyholder. For the purpose of this benefit, Critical Illnesses shall include –

For the purpose of this benefit, Critical Illnesses shall include –

1. Cancer of specific severity
2. Myocardial Infarction (First Heart Attack of specified severity)
3. Open Chest CABG

4. Open Heart Replacement or Repair of Heart Valves
5. Coma of specified severity
6. Kidney Failure requiring regular dialysis
7. Stroke resulting in permanent symptoms
8. Major Organ/Bone Marrow Transplant
9. Permanent Paralysis of Limbs
10. Motor Neuron Disease with permanent symptoms
11. Multiple Sclerosis with persisting symptoms

Once a claim has been accepted and paid under this Benefit, this cover will automatically terminate
in respect of that Insured Person.

Claims under this section will not reduce the Sum Insured[1].

II.16. Personal Accident Plus (Optional Cover)

The Policyholder will have the option to choose from any one of the following options below either at policy inception or any renewal. The details pertaining to the selected option will be specified on the Policy Schedule:

- Option 1: Accidental Death Cover (AD) only [II.16.A.]
- Option 2: Permanent Disablement Cover (includes Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD)) only [II.16.B.i and II.16.B.ii]. Herein Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD) will be covered upto a common sum insured
- Option 3: Accidental Death Cover [II.16.A.] AND Permanent Disablement Cover (includes Permanent Total Disablement & Permanent Partial Disablement) [II.16.B.i and II.16.B.ii] covered upto a common sum insured

Specific Conditions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. In the lifetime of this policy, our maximum liability in respect of an Insured Person under Personal Accident Plus (which includes AD, PTD and PPD) shall never exceed 100% of the Benefit Amount applicable to the Insured Person
b. In the lifetime of this policy, if we pay a claim equal to our maximum liability then the entire Personal Accident Plus shall terminate for that Insured Person in respect of whom such claim has been paid.
c. Choice to opt out from this cover or change the coverage option is available only at renewals. The choice of opting in again after opted out shall be subject to underwriting.
d. The geographic scope of Personal Accident Plus (which includes AD, PTD and PPD) cover is restricted to India
e. In case there is a change in occupation of any Insured Person post inception of this benefit, the same should be communicated to us in writing at the immediate upcoming renewal.
f. The Minimum entry age of any Individual at the time of opting for this cover cannot be less than 18 years
g. The Maximum entry age of any Individual at the time of opting for this cover cannot be greater than 65 years
h. All eligible insured persons opting for the Personal Accident Plus cover shall have the same Sum Insured and cover option.
i. If any insured person is above 75 years of age at the time of renewal, then for all future policy years maximum payout under Personal Accident Plus for that insured person will be limited to ₹10 lakh or the applicable Benefit Amount, whichever is lower. Premium shall be charged according to such applicable Benefit Amount.

II.16.A Accidental Death Cover (AD)

If an Insured Person sustains an injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in the Death or Disappearance of the Insured Person within

365 days from the date of the Accident, we will pay the Nominee in Lumpsum 100% of the Benefit Amount stipulated against Accidental Death cover in the Policy schedule.

Disappearance Clause

If the Insured Person's body cannot be located within 365 days post happening of the below event it shall be deemed as disappearance

a. Forced landing, stranding, sinking or wrecking of a common carrier in which the insured person were travelling as a fare paying passenger OR
b. Catastrophic event in which the insured person was a victim

To process a claim pertaining to disappearance we will require a missing-person police report and/or any other documents we reasonably request to support the claim. If it was later established that the Insured Person is alive, the settled amount must be repaid to us in full.

II.16.B. Permanent Disablement Cover

II.16.B.i Permanent Total Disablement (PTD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a Permanent Total Disablement, as listed in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum 100% of the Benefit Amount stipulated against Permanent Total Disablement benefit in the Policy schedule

	Listed Permanent Total Disablement (PTD) covered
i.	Total and irrecoverable loss of sight of both eyes
ii.	Loss by physical separation or total and permanent loss of use of both hands or both feet
iii.	Loss by physical separation or total and permanent loss of use of one hand and one foot
iv.	Total and irrecoverable loss of sight of one eye and loss of a Limb
v.	Total and irrecoverable loss of hearing of both ears and loss of onGe Limb/loss of sight of one eye
vi.	Total and irrecoverable loss of hearing of both ears and loss of speech
vii.	Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye

Specific Conditions applicable to Permanent Total Disablement (PTD)

i. Claim pertaining to Permanent Total Disablement is admissible only with confirmatory diagnosis of Permanent Total Disablement while the Insured Person is alive.
ii. The Permanent Total Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
iii. The Permanent Total Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.

II.16.B.ii Permanent Partial Disablement (PPD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a listed Permanent Partial Disablement, as specified in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum the Benefit Amount stipulated against Permanent Partial Disablement benefit in the Policy schedule in accordance with

details specified in the table given below

	Listed Permanent Partial Disablement (PPD) covered	% of Benefit Amount payable
i.	Total and irrecoverable loss of sight of one eye	50%
ii.	Loss of one hand or one foot	50%
iii.	Loss of all toes - any one foot	10%
iv.	Loss of great toe - any one foot	5%
v.	Loss of toes other than great, if more than one toe lost, each	2%
vi.	Total and irrecoverable loss of hearing in both ears	50%
vii.	Total and irrecoverable loss of hearing in one ear	15%
viii.	Total and irrecoverable loss of speech	50%
ix.	Loss of four fingers and thumb of one hand	40%
x.	Loss of four fingers	35%
xi.	Loss of thumb-both phalanges	25%
xii.	Loss of thumb - one phalanx	10%
xiii.	Loss of index finger - three phalanges - two phalanges - one phalanx	 10%, 8%, 4%
xiv.	Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	 6%, 4%, 2%

Specific Conditions applicable to Permanent Partial Disablement (PPD)

i. Claim pertaining to Permanent Partial Disablement is admissible only with confirmatory diagnosis of a Permanent Partial Disablement while the Insured Person is alive.
ii. The Permanent Partial Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
iii. The Permanent Partial Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.
iv. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Benefit Amount shown in the Permanent Disablement Table. The cumulative sum in such cases shall be capped at 100%.
v. If in a policy year we pay a claim equal to 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, the entire Personal Accident Plus section shall automatically terminate for the respective Insured Persons.
vi. If in a policy year we pay a claim of less than 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, then at the end of such Policy Year only the remaining Benefit Amount shall replenish for the next policy year or the renewed policy if the cover is opted. In such an event the eligible premium shall be paid in full. For any claims that arise in the subsequent policy years, percentage shall be applied on the original benefit amount and the resultant amount shall be deducted from the Benefit amount that was remaining.

Specific Exclusions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority
b. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof
c. Involvement of Insured person in any unlawful/Criminal activity.
d. Intentional self-injury or attempted suicide.
e. Any Injury sustained while working, storing or transporting explosives.
f. Injury caused due to
   1. Insect bites or
   2. Animal bites or
   3. Animal attacks or
   4. Serpant (snake) bites or attacks
g. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.
h. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand
i. Claims arising out of Non-accidental Injuries: Injuries emanating from participation in Adventure Sports (Hazardous Sports, action sports, aggro sports, extreme sports or any such name) irrespective whether the Insured Person is trained or not and also irrespective whether the Insured is a professional or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighing / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving, gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, luging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkeling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weightlifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing

and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

III. What are the Optional Covers?

The following optional packages are available under the product.

A. HEALTH+:

This optional package is available to all Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only.

If opted, benefits under the package will be available for each Insured Person on individual basis, for individual as well as family floater policies. . The geographical scope of all cover of this package is restricted to India ONLY. Any expenses made outside or benefit availed outside India will not be payable.

1. Air Ambulance Cover

We will reimburse the Reasonable and Customary expenses incurred towards transportation of an Insured Person, to the nearest Hospital or to move the Insured Person to and from healthcare facilities within India, by an Air Ambulance

Specific Conditions applicable to Air Ambulance Cover

i. Air Ambulance is used during medical Emergency of the Insured Person;
ii. The Illness/Injury, causing Emergency, is covered under the Policy (under base cover). ;
iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment to monitor vitals and treat the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;
iv. Air Ambulance service is offered by a Registered Ambulance service provider;
v. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the Insured Person's requirement for Air Ambulance;
vi. Payment under this cover is subject to a claim being admissible under Section II.1 'Hospitalization Expenses', for the same Illness/Injury;
vii. The benefit is available once in a Policy year for each Insured Person;

Benefit under this cover is payable maximum up to Rs.10 Lacs and claim under this section will not reduce the Sum Insured[1].

2. Medical devices and Non-Medical items:

We will indemnify the expense towards

a. Non-Medical items, listed under list I of Annexure III of this Policy Wording AND
b. Cost of buying or renting medical devices, prescribed to the Insured Person by the treating Medical Practitioner for a Medically Necessary treatment.

Specific Conditions applicable to Medical Devices and Non-Medical Items

1. Hospitalization claim must admissible under Section II.1 Hospitalization Expenses' and the expenses on Non-medical items or Medical devices should be related to the same Illness/ Injury.
2. The need for Medical device is prescribed by an authorised Medical Practitioner during hospitalization or within 180 days of the post-hospitalization period. Any purchase of the medical device should be done within 30 days of such recommendation.

3. Our maximum liability for Medical Devices is upto ₹2 Lacs once in 3 Policy Years. For the purpose of this benefit 'once' means one or more claims for Medically Prescribed medical device/s (listed above) provided that it is related to one Hospitalization. Claim under Medical Devices will not reduce the Sum Insured[1] and any balance amount, if not utilised will not be carried forward.
4. Our maximum liability for Claims under Non-Medical items shall never exceed Sum Insured[1] in a Policy Year. Claim paid under Non-Medical items will reduce the Sum Insured[1].
5. Exclusion pertaining to Non-Medical items (in section E) shall be superseded to the extent of coverage provided herein

For the purpose of this benefit, medical devices shall mean -

- Artificial limb,
- Cannula,
- Catheter,
- Colostomy bag,
- CPAP machine,
- Feeding tube,
- Glucose meter,
- Heating pad,
- Hospital bed,
- Infusion pump,
- Nebulizer,
- Oxygen concentrator,
- Traction splint,
- Ventilator,
- Wheelchair,
- Ankle Rehabilitation,
- Back Support Belts,
- Gel Heel Pads,
- Heel And Elbow Suspension,
- Hernia and Abdominal Support,
- Hot and Cold Therapy Wraps,
- Lancets And Lancing Devices,
- Nebulizer Accessories,
- Nebulizers,
- Orthopedic Supports and Braces,
- Rollators,
- Urinary Bag Holders
- Urinary Bags,
- Prosthetic device,
- Pulse oximeter,
- Insulin Aids,
- Insulin Pen Needles,
- Insulin Syringes

Claim under this section will not reduce the Sum Insured[1].

3. Domestic Second Opinion:

If an Insured Person is diagnosed with advised a treatment listed and defined under Major Illness/es, You may choose to avail a second medical opinion from Our Network of Medical Practitioners in India. The expert opinion would be directly sent to You.

You understand and agree that You can exercise the option to secure an expert opinion, provided:

a. We have received a request from You to exercise this option.
b. That the expert opinion will be based only on the information and documentation provided by You that will be shared with the Medical Practitioner.
c. This benefit can be availed by each Insured Person once during a Policy Year for one major illness and multiple times for different Major Illness/es.
d. This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
e. The Insured Person is free to choose whether or not to obtain the expert opinion and if obtained then whether or not to act on it.
f. The expert opinion under this Policy shall be limited to Major Illnesses and not be valid for any medico legal purposes.
g. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
h. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

For the purpose of this benefit, covered Major Illnesses shall include as below:

1. Cancer Treatment
2. Coronary Artery By-Pass Surgery
3. Heart Valve Replacement
4. Lung Transplant Surgery in case of End Stage Lung Disease
5. Kidney Transplant Surgery in case of End Stage Renal Failure
6. Liver Transplant Surgery in case of End Stage Liver Disease
7. Heart Transplant
8. Cardiac arrest (excluding angioplasty)
9. Bone Marrow Transplant
10. Neurosurgery
11. Surgical Treatment for Benign Brain Tumour
12. Pulmonary artery graft surgery
13. Aorta Graft Surgery
14. Stroke Treatment
15. Surgical treatment of Coma
16. Skin Grafting Surgery for Major Burns
17. Surgery for Pheochromocytoma
18. Permanent Paralysis of Limbs
19. Motor Neuron Disease with Permanent Symptoms
20. Multiple Sclerosis with Persisting Symptoms
21. Fulminant Viral Hepatitis
22. Bacterial meningitis
23. Alzheimer's Disease
24. Cerebral aneurysm – with surgery or radiotherapy
25. Parkinson's disease – resulting in permanent symptoms
26. Pneumonectomy – Removal of an entire lung
27. Surgical removal of an eyeball

Claims under this section will not reduce the Sum Insured[1].

4. Bariatric Surgery Cover:

We will indemnify the Medical Expenses incurred towards Medically Necessary Hospitalization of the Insured Person for Bariatric Surgery and its complications.

Specific Conditions applicable to Bariatric Surgery Cover

1. Surgery must be Medically Necessary and should be certified by an authorised Medical Practitioner
2. Date of admission in Hospital must be within the Policy Year.
3. The Insured Person must satisfy the following criteria as devised by NIH (National Institute of Health):

a. The BMI should be greater than 37.5 without any co-morbidity; or greater than 32 with co-morbidity and

b. Is unable to lose weight through traditional methods like diet and exercise.

4. This cover is available ONLY after a Waiting Period of 2 years from the inception of 'Health+ ' with Us, with respect to the Insured Person.
5. Benefit under this cover is payable maximum up to Rs. 5 Lacs and claim under this section will not reduce the Sum Insured[1].
6. Exclusion pertaining to Obesity / Weight control (in section E) shall be superseded to the extent of coverage provided under Bariatric Surgery cover

5. Convalescence benefit:

If the Insured Person is hospitalised for 10 consecutive days or more and the Hospitalization claim is admissible under Section D.II.1 Hospitalization Expenses, We will pay in lump sum an amount of ₹50,000 towards convalescence, provided that the Hospitalization is Medically Necessary for at least 10 consecutive days.

Claims under this section will not reduce the Sum Insured[1].

6. Major Illness Hospi cash :

If the Insured Person is hospitalised for a Medically Necessary treatment of a Major Illness, listed under the Policy (under domestic second opinion), We will pay daily cash benefit of ₹2,500 per day for each continuous and completed period of 24 hours of Hospitalization, for a maximum of 10 days per hospitalization event.

Claims under this section will not reduce the Sum Insured[1].

7. Chemotherapy and Radiotherapy Cash

If the Insured Person undergoes Medically Necessary Chemotherapy or Radiotherapy as a Day Care Treatment without 24 hours of Hospitalization, We will pay a cash benefit of ₹2,500 for each session of Chemotherapy or Radiotherapy for maximum of a total of 12 sessions in a Policy Year.

Claims under this section will not reduce the Sum Insured[1].

8. Accidental Hospi Cash:

If the Insured the Person is hospitalised for Medically Necessary treatment of an Injury sustained due an Accident that occurred during the Policy Period, We will pay a daily cash benefit of ₹2,500 for each continuous and completed 24 hour period of Hospitalization, for a maximum of 10 days per hospitalization .Claims under this section will not reduce the Sum Insured[1].

9. Domestic Concierge Services:

If an Insured Person is hospitalised for a Medically Necessary treatment of an Illness or Injury covered under the Policy, concierge services may be provided at our sole discretion, subject to prior request and availability of the services. Such services are purely facilitative in nature, optional, and not mandatory for us to provide in every claim or hospitalisation.

This benefit is only a value added service provided by Us and if availed, will not reduce the Sum Insured[1].

The benefit is available only once in a Policy year for each Insured Person.

These services shall be available only on pre-intimation of a planned Hospitalization and intimation of an Emergency Hospitalization as per the process defined under Section G.I.3.

For availing this service kindly connect with our customer care services at customercare@manipalcigna.com or write to us at headcustomercare@manipalcigna.com.

10. Tele-Consultations:

Insured Persons may be eligible to avail tele-consultations with Medical Practitioners from our empaneled network only, through telephonic or chat mode, subject to availability and prior appointment. Such consultations shall be limited to select medical specialities as determined by us and shall not be available for all conditions or treatments. Any claim under this section will not reduce the Sum Insured[1].

B. WOMEN+

This optional package is available to female of Age 12 years and above at the commencement of Policy with Us with respect to the Insured Person. Selection of this package is allowed at Policy level only. For cases where female child turns 12 years of Age after the commencement of the Policy, selection of 'Women+' shall be allowed at the first renewal immediately after this instance. If opted, benefits under the package will be applicable to each eligible female on individual basis, for Individual as well as family floater policies. The geographical scope of all cover of this package is restricted to India ONLY. Any expenses made outside or benefit availed outside India will not be payable.

1. Breast Cancer Screening:

A Mammography screening once in a policy year will be available to each Insured female. The screening will be arranged by Us and conducted at Our Network. Original copy of the report will be provided to You.

Claim under this Section will not reduce the Sum Insured[1].

2. Cervical Cancer Screening:

A papanicolaou screening, commonly known as pap smear will be available to each Insured female once in policy year. The screening will be arranged by Us and conducted at Our Network. Original copy of the report will be provided to You.

Claim under this section will not reduce the Sum Insured[1].

3. Cervical Cancer Vaccination:

We will pay the Reasonable and Customary Charges incurred towards Cervical Cancer vaccination availed in India by the Insured Person, on the advice of the treating Medical Practitioner. Cost of each dose of the vaccine will be limited up to ₹2,500.

Claims under this section will not reduce the Sum Insured[1].

4. Ovarian Cancer Screening:

An Ovarian Cancer screening known as Ultrasound and CA 125 will be available to each Insured female once in a policy year. The screening will be arranged by Us and conducted at Our Network Original copy of the report will be provided to You

Claims under this section will not reduce the Sum Insured[1].

5. Osteoporosis Screening:

An Osteoporosis screening known as Dexa scan will be available to each Insured female once in a policy year. The screening will be arranged by Us and conducted at Our Network. Original copy of the report will be provided to You.

Claims under this section will not reduce the Sum Insured[1].

6. Gynaecological Consultations:

Each Insured female may avail maximum up to 15 out-patient gynaecological consultations in a policy year. These consultations will be arranged by Us and conducted at Our Network. For the purpose of this benefit, 'Gynaecological Consultations' shall mean consultation with a gynaecologist to assess well-being and functioning of the female reproductive system and determine the presence of diseases and infections. It may also relate to hormonal imbalance, fertility and to a certain extent preconception, prenatal, and maternal care. Follow up consultations shall also be covered under this benefit.

Claims under this section will not reduce the Sum Insured[1]

7. Psychiatric and Psychological Consultations:

Each Insured female may avail maximum up to a total of 5 out-patient psychiatric/ psychological consultations and psychotherapy session in a policy year. These consultations/ sessions will be arranged by Us and conducted at Our Network.

Claims under this section will not reduce the Sum Insured[1].

C. Deductible

A deductible is an amount you agree to pay each policy year before certain policy benefits become active for that policy year. Deductible in this policy shall be on an annual aggregate basis. The deductible amount opted by the policy holder shall be specified in the Policy Schedule. For a claim to be payable in a policy year, the applicable deductible must first be exhausted for that Policy year as per Policy Type. Once the deductible is exhausted, the claim will be eligible for payment as per the policy. Such deductible amount shall be calculated on an annual aggregate basis taking into consideration only claims that are admissible under the below coverages and made during that Policy Year..

i. Hospitalisation Expenses
ii. Day Care Treatment
iii. Pre - hospitalization
iv. Post – hospitalization
v. AYUSH Treatment
vi. Road Ambulance Cover
vii. Donor Expenses
viii. Domiciliary Expenses
ix. Robotic and Cyber Knife Surgery
x. Modern and Advanced Treatments
xi. HIV/AIDS and STD Cover
xii. Mental Care Cover
xiii. Non-Medical Items

<u>Specific Conditions applicable to Annual Aggregate Deductible</u>

a) The Deductible can be opted either at Policy inception or at the time of renewal at policy level (on all or none basis).
b) The opted deductible can be reduced OR increased OR waived at renewals subject to underwriting. If deductible amount of ₹25,000 was opted and was waived at a subsequent

renewal, then, no afresh waiting period shall apply in such case. However, if deductible amount greater than ₹25,000 was opted and the same was reduced or waived at a subsequent renewal, then, all waiting period applicable under the policy shall apply afresh for such reduced amount.

c) The aggregate deductible shall apply only to hospitalization related claims made under the below benefits

i. Hospitalisation Expenses
ii. Day Care Treatment
iii. Pre - hospitalization
iv. Post – hospitalization
v. AYUSH Treatment
vi. Road Ambulance Cover
vii. Donor Expenses
viii. Domiciliary Expenses
ix. Robotic and Cyber Knife Surgery
x. Modern and Advanced Treatments
xi. HIV/AIDS and STD Cover
xii. Mental Care Cover
xiii. Non-Medical Items

d) In case of an Individual/Multi Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.

e) In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year.

f) For the purpose of applying the Aggregate Deductible and assessing claim admissibility, all claims must be submitted in accordance with Sections G.I.4 and G.I.5 of the Claims Process. All other terms, conditions, waiting periods, and exclusions of the Policy shall apply

D. ADD ON S/Riders:

For in-depth details of the below add-ons / rider kindly refer to prospectus / policywordings of the same available on our website. Any other Add-ons as launched from time to time may also be available.

1) ManipalCigna Critical Illness Add on Cover

You can also avail the ManipalCigna Critical Illness Add On Cover and get a lumpsum amount upon the first diagnosis of a listed critical illness.

2) ManipalCigna Health 360

You can opt for this Add-on cover which helps modify you room rent limit and also provides coverage for expenses incurred on air ambulance, non-medical items and durable medical equipment, unlimited restoration and OPD.

3) ManipalCigna Lifetime Plus

You can opt for this Add-on cover which helps you to modify your Cumulative bonus and also provides coverage for expenses incurred on Maternity, infertility, oocyte donor and worldwide medical emergency hospitalizations.

IV. What are Features of the Policy?

In the event of any inconsistency in details provided in this document, the terms and conditions stated in the policy wordings shall prevail.

i) Eligibility

The minimum entry Age under this policy is 91 days for children and 18 years for adults. The maximum entry Age under this policy is 30 years for children and is 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 Age 30 years can be covered under the floater.
c. Children beyond Age 30 years can be covered under an individual policy.

Renewals will be available for lifetime.

ii) Individual and Family Floater

The policy can be purchased on an individual basis or a family floater basis.

a. In case of an individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, lawfully wedded spouse (same or opposite gender), children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, uncle, aunt, nephew and niece.
b. In case of a floater cover, one family will share a single Sum Insured, as opted. A floater plan can cover self, lawfully wedded spouse (same or opposite gender), children up to the age of 30 years, parents or parent in laws. A floater cover can cover a maximum of 2 adults and 3 children under a single policy. Combinations allowed under 2 Adults are: Self & Spouse or Father & Mother or Father-in-law & Mother-in-law.

iii) Policy Period option

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

iv) Sum Insured Options

You have an option to choose from a wide range of Sum Insureds available:

- Sum Insured[1]: Sum Insured[1] is coverage available under benefits from II.1 to II.15.
  ₹ 50 Lacs / ₹ 75 Lacs / ₹100 Lacs / ₹ 150 Lacs / ₹ 200 Lacs / ₹ 300 Lacs

v) Deductible Options (Optional)

You have an option to choose deductible as below:

₹ 25K / 50K / 1L / 2L / 3L / 4L/5L/10L

vi) Discounts under the Policy

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

a. Long Term policy discount - Long term discount, of 7.5% on the premium for selecting a 2 year policy term and 10% on the premium for selecting a 3 year policy term. The discount is available only with 'Single' premium payment mode.
b. Worksite Marketing Discount - A discount of 10% will be available on policies which are sourced through worksite marketing channel.
c. Family Discount – A discount of 15% on the premium for covering 2 or more members in the same Policy with individual policy option. The discount is not available on the premium of Health+ and

Women+ optional packages.

d. Auto Renewal discount: A 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).

e. Loyalty discount – A discount of 5% on the entire Policy premium from 4th Policy Year to 7th Policy Year and discount of 10% on the premium of the entire Policy from 8th Policy Year onwards.

All discounts under v (a), (b), (d) and (e) are available to both individual as well as floater policies and (c) is available for Individual policies only.

All applicable discounts are multiplicative and will be calculated on the total Policy premium, irrespective of Policy type (individual or family floater).

vii) Underwriting Loading & Special Conditions

We may apply a risk loading on the premium payable (excluding Statutory Levis & Taxes as applicable) or Special Conditions on the Policy based on your 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 history and declarations or additional waiting periods (a maximum of 36 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 premium, within the duration specified in the counter offer.

viii) Premiums

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

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

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

ix) Premium payment mode

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

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

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

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

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.

5. Zone Classification

Identification of Zone will be based on Proposer's city-location pin code as mentioned in KYC documents. The residential address provided by You should be true, correct and complete. Any discrepancy or mismatch identified during claim adjudication may lead to delays, disputes or denial of claim settlement. The policyholder is required to promptly inform the company of any changes to the residential address to ensure uninterrupted communication and smooth claim processing.

Zone	Region/District/State
Zone 1	Delhi & NCR Districts in Gujarat: Ahmedabad, Gandhinagar, Surat, Vadodara Districts in Maharashtra: Mumbai, Thane, Navi Mumbai Districts in Andhra Pradesh /Telangana: Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal Districts in Uttar Pradesh: Mathura, Jyotiba Fule Nagar (Amroha), Aligarh Others: Rewari, Jind, Jhunjhunu, Patna
Zone 2	Rest of the Bihar State Districts in Andhra Pradesh / Telangana: Ananthapur, Bapatla, Gadwal, Guntur, Kamareddy, Kurnool, Mahabubnagar, Medak, Nalgonda, Nellore, Nizamabad, Rangareddy, Suryapet, Wanaparthy Districts in Punjab: Amritsar, Gurdaspur Districts in Maharashtra: Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad Others: Chennai, Bangalore, Kolkata, Dhanbad, Bokaro
Zone 3	Rest of India

Note

i. Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts.

ii. No Zonal Co-payment shall apply if person from a lower zone avails treatment in a higher zone. Example: No Zonal Co-payment shall apply if person from a Zone 3 avails treatment in Zone 2 or Zone 1.

x) Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation, non-disclosure of material facts by the insured person.

i. The Company shall give notice for renewal at least 30 days in advance from the Policy due date.
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 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.

I. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium
b. We, shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and

date of inception of subsequent policy.

c. 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.

d. Insured Person shall disclose to Us in writing of or 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.

e. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are 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 45 days prior to date of such revision or modification.

f. Alterations like increase/decrease in Sum Insured[1]/Deductible or Change in Plan/Product, addition/deletion of members, addition/deletion of optional covers/riders, 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[1] on renewal. The terms and conditions of the existing policy will not be altered.

g. Any enhanced Sum Insured[1] and/or amount of reduction in Deductible 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.

h. Wherever the Sum Insured[1] is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured[1] of the last 24 consecutive months as applicable to the relevant waiting periods under the product.

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

j. In case of floater policies, children attaining 31 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.

k. In case there is any enhancement of risk by way of opting for optional covers, add-ons/riders, upgradation of plan, extension of geographical scope etc. all waiting periods under this policy shall apply afresh to the enhanced portion of the risk.

II. 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 Your Policy Schedule, 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. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.

iii. Instalment facility shall not be available for the Policy Tenure more than 1 year.

iv. 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.

v. No interest will be charged if the instalment premium is not paid on due date.

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.

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

payable.

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

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

- NACH/Standing Instruction Mandate form is completely filled & signed by You.
- The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.
- 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.
- 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.

xi) 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 30 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 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 per IRDAI guidelines on portability.

xii) Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 126 as per the Income Tax Act 2025. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

xiii) Free-look Period

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

- The insured shall be allowed a period of at least 30 days from the 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 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.

xiv) Cancellation

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:

A. Policy Tenure of 1 Year:

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.

B. If Policy Tenure is more than 1 years:

1. If no claim has been made in the policy year, a proportionate refund of the premium on cancellation will be issued based on the number of unexpired days. The date of the cancellation will be considered as the expiry date of coverage.
2. If a claim has been made in the current policy year, the premium for the remaining complete policy year(s) will be refunded on cancellation.
3. If a claim has been made in active policy but in previous policy year, a proportionate refund of the premium on cancellation will be issued based on the number of unexpired days. The date of the cancellation will be considered as the expiry date of coverage.

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

2. Where the Policyholder has made a **claim** during the Policy Period.

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure	2
Latest Claim Date	11-05-2024
Cancellation Request Date	11-06-2025
Premium Collected	100.00
Unexpired Period (in Days)	19
Premium Refund	2.60 (100*19/731)

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non- disclosure of material facts, established 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.

xv) Endorsements

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.

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

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not impact the premium)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer
- Change in Nominee Details
- Change in Claim Status (for cases where claims are reported post issuance of renewal notice and renewal policy issued before expiry date).

b) Financial Endorsements - which result in alteration in premium

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

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

xvi) Redressal of Grievance

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.: 022-61703600

Courier: Any of Our Branch office or corporate office during business hour, 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,

401/402, 4th Floor, Raheja Titanium,

Western Express Highway, Goregaon (East),

Mumbai - 400063, Maharashtra, 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.

xvii) Pre-Policy Medical Check-up

We will require You to undergo a medical check-up based on Your Age, Gender, Optional package and the Sum Insured opted, as per underwriting guidelinesz. 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/Gender/Optional Cover or Plan opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You

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

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

xviii) Migration:

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

person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

xix) Moratorium Period:

After completion of 60 continuous months of coverage (including Portability and Migration) in health insurance policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of 60 continuous months is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of Sums Insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

xx) Revival of Policy:

If your Policy has passed the stipulated grace period due to non-payment of premium, you may be allowed for revival of your policy, subject to certain specific terms and conditions.

Specific conditions applicable to revival of policy

a. The policy could be revived maximum within 180 days from lapse of the first payment due date
b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):

1. Special conditions,
2. Assessment of current health status or Good health declaration
3. Undergoing medical examinations
4. Payment of all the premium (inclusive of applicable taxes) that was due and unpaid

c. Any claim/medical expense incurred during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.
d. If a 'Good Health Declaration' is sought by us and is later proven to be fraudulent, the entire policy shall be cancelled, and no claims shall be payable.
e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

xxi) Coverage Standard & Protocols

Medicine is an evidence-based science. Clinical diagnosis supported by positive investigation test findings are its founding principles. Treatment in Medicine are given as per well-defined protocols.

Our goal is to deliver care that is appropriate, effective, and safe. Equally important is avoiding treatments that are not medically necessary, as this helps safeguard patient well-being. Insurance, by design, is to support healthcare needs and not to change treatment choices. Furthermore, a key principle in insurance suggests that having coverage should not influence healthcare decisions. Patients naturally consider the benefits of treatment along with its cost and choose care that offers the best value and medical results. This approach supports responsible, value-based care that focuses on what is truly needed for recovery and long-term health.

A. Medical Protocols

We are committed towards supporting safe, effective, and evidence-based medical care. To help

bring clarity and consistency, we will be referring to trusted and widely accepted sources such as leading medical textbooks, All India Institutes of Medical Sciences

(AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and
National Institute for Health and Care Excellence (NICE).

These guidelines are designed to help explain:

a. When hospitalization is needed, including guidance on the appropriate level of care (for example: admission in an ICU or non-ICU room)
b. What treatments and procedures are considered appropriate, based on the medical condition and its severity, including recommended medicines and procedures

To ensure patient safety and quality of care, coverage under this policy shall be aligned with treatments and medicines that are approved by recognized regulatory authorities such as the Central Drugs Standard Control Organisation (CDSCO), Food and Drug administration (FDA), and other relevant bodies in India. Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India shall not be covered under the policy.

We also follow official guidance provided by manufacturers and regulatory authorities regarding how medicines and procedures should be used, including their approved indications and precautions. Treatments or medications used outside their approved purpose (often called “off-label” or extra usage) shall not be covered under the policy, as these fall outside established approval and safety guidelines.

Our approach is focused on transparency, safety, and supporting care that is medically appropriate and widely accepted, helping customers make informed healthcare decisions with confidence.

B. Position statements

Medicine is constantly evolving, wherein, new technologies and treatment approaches are emerging regularly. While many innovations offer promise, not all deliver outcomes that are meaningfully better when considered alongside their costs and established alternatives.

As a responsible insurer, we believe in being transparent and clear with our customers. Therefore, our decision on the coverage of illnesses or injury shall be basis texts and medical protocols published/recognised by globally trusted establishments like All India Institutes of Medical Sciences (AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and
National Institute for Health and Care Excellence (NICE). Our evaluations will be based on comprehensive Health Technology Assessments, health economic evaluations, cost-benefit and cost-efficiency analyses, along with other well-regarded global research published in reputable medical journals. Any research found to have conflicts of interest will be excluded from consideration.

Medical protocols published by these establishments will outline how we assess different medicines, treatments, procedures, investigations, and therapies. Depending on the clinical and scientific evaluation, we may either cover the Reasonable and Customary charge incurred on a treatment wholly or partially or may recommend suitable alternatives or may seek additional review or in some cases may be unable to provide coverage under this product.

Importantly, if our medically-informed assessment results in no coverage or partial coverage for a particular treatment, we will still ensure payment at least up to the cost of the most widely accepted and commonly used alternative treatment currently available for that condition.

C. Prolonged Hospitalization extending beyond 10 days

a. It is important that you inform us in a timely manner. If we do not receive intimation within 10 days from the date of admission, we may apply an additional cumulative co-payment of 10% on the final admissible claim amount.
b. We may request for indoor case papers, treatment sheets, and daily monitoring records to help us understand and support the medical need for the extended stay.
c. If the medical records indicates that the insured's health parameters have stabilized and yet the hospitalization continues, expenses related to the extended period of stay may not be payable under this policy.

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.
b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.
c. For all Kidney, liver and pancreas transplants, a biopsy of the recipient's organ may be required as part of the medical evaluation process.
d. If treatment is taken at a non-network hospital and we do not receive the required intimation or the biopsy report as outlined above, an additional 20% co-payment may be applicable on the admissible claim amount.

xxii) Switching between Plans

There are 2 plans under Lifetime Health product ie India Plan and Global Plan. Policyholders are allowed to switch from one plan to another only at renewals. This shall be subject to Underwriting. If the Policyholder switches from India Plan to Global Plan then all waiting periods shall apply afresh to the enhanced part of the risk ie. Waiting periods shall apply afresh to the Global covers that would come into force.

xxiii) Personal Data and Privacy

Personal and health data will be processed only for policy issuance, servicing and claims, and may include ABDM/ABHA-enabled services where consented; you can withdraw such consent at any time (see Policy T&C).

V. What are the Waiting Period and Exclusions?

We shall not be liable to make any payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless otherwise covered or specified under the Policy or any Cover opted under the Policy. All the waiting periods and exclusions shall be applicable individually for each Insured Person and claims shall be assessed accordingly. Section 'E. Exclusions' is applicable to all benefits under this policy except the below

a. Adult Health Check-Up
b. Breast Cancer Screening
c. Cervical Cancer Screening
d. Cervical Cancer Vaccination
e. Ovarian Cancer Screening
f. Psychiatric and Psychological Consultations

g. Osteoporosis Screening
h. Gynaecological Consultations
i. Tele-consultations
j. Personal Accident Plus

i. 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 24 months of continuous coverage after the date of inception of the first policy with us.

b. In case of enhancement of Sum Insured[1] the exclusion shall apply afresh to the extent of Sum Insured[1] 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 for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

ii. 30 days waiting period – Code – Excl 03

a. Expenses related to the treatment of any illness within 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[1] in the event of granting higher Sum Insured[1] subsequently.

iii. Specified disease/procedure waiting periods - 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[1] the exclusion shall apply afresh to the extent of Sum Insured[1] increase.

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

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

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

f. List of specific diseases/procedures:

i. Cataract,

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

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of 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-genito 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.

iv. Personal Waiting period:

A special Waiting Period not exceeding 36 months, may be applied to individual Insured Persons for the list of acceptable Medical Ailments listed under the Underwriting manual of the product depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

VI. Permanent Exclusions

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

1. Investigation & Evaluation - Code - Excl 04

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

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

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

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

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

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

3. Obesity/ Weight Control: Code- Excl 06

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

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

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

16. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

17. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

18. Prostheses, corrective devices and/or Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised, unless opted.

19. Treatment received outside India.

20. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack or in any other sequence to the loss..

21. All All expenses caused by or arising from war or war-like situation or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

22. For complete list of non-medical items, please refer to the Annexure III, list I of “Non-Payable Items” and also on Our website.

23. Any form of Non-Allopathic Treatments except AYUSH treatment.

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

25. 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.

26. Out-patient treatment expenses.

27. Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

28. Preventive care, vaccination, inoculation, or immunization, except when administered as part of hospitalization required for post-animal bite treatment.

29. Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.

30. Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.

31. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.

32. Drugs or treatments which are not supported by a prescription.

33. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

34. Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre.

35. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

36. Dental Treatment, orthodontic treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the Policy.

37. Instrument used for Sleep Apnea Syndrome (C.P.A.P.),Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pumps, or other external devices used during or after treatment.

38. Costs of donor screening or organs Transplants involving organs not harvested from a human body

39. Expenses for Multi-Focal Lenses, Multi-Focal Toric lenses, and Femto Laser-Assisted surgeries for cataract treatment.

40. Expenses related to any Modern & Advanced Treatments other than those covered under this Policy

VI. How can I buy the Policy?

Step 1: Please read and understand the product brochure, policy benefits, exclusions and premium details thoroughly before buying the policy. Any queries or concerns you have can be discussed with your advisor/ Company representative.

Step 2: Once the benefits of the policy are understood, fill the Proposal Form. This form will capture the details of the prospective Insured Persons including their medical information. Please ensure the information provided is as accurate as possible. This will help the evaluation of your case as well as ease the process of claims, in the future.

Step 3: : Submit the proposal form along with the required documents and premium.

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured, Age band or any medical declaration, we would arrange the medical check-ups at Our network of diagnostic centres.

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

Once you submit your proposal for processing, we will write back to you within 7 days with the decision on the proposal or any additional requirements that we may have from 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 or fail to provide the consent/ requirement within the defined time period, we will cancel your proposal.

VII. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.
- In the event of any Illness or Injury or occurrence of any other contingency including availing of Domestic Concierge Services 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.
- For more information on the claim intimation process, please refer the Policy Terms and Conditions.

b) Claim Process

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

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

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

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

In case of planned hospitalization - at least 48 hours prior to the planned date of admission.

In case of Emergency Hospitalization - within 24 hours of such admission.

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

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

The following claim documents should reach us not later than 30 days from the date of discharge from Hospital –

- Duly completed claim form.
- Photo Identity proof of the patient.
- Medical practitioner's prescription advising admission
- Bills with itemized break-up
- Payment receipts
- Discharge summary including complete medical history of the patient along with other details
- Investigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
- Sticker/Invoice of the Implants, wherever applicable
- MLR (Medico Legal Report) copy if carried out and FIR (First Information Copy) if registered, where ever applicable
- NEFT details (to enable direct credit of amount in bank account) and original cheque of the proposer with pre printed name
- KYC (Identity proof with Address) of the proposer, where claim liability is above Rs1 Lakh as per AML guidelines
- Legal heir / succession certificate, wherever applicable
- Any other relevant document required by Company / TPA for assessment of the claim

For more information on documents to be submitted for claim raised for Optional packages, please refer the Policy Terms & Conditions.

For more information on documents to be submitted for claim raised for Optional packages, please refer the Policy Terms & Conditions.

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

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

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

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on our website as also provided to you along with the Policy documents. The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on Our 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.

VIII. What are the Plan Benefit Details?

The policy is available as detailed below:

ManipalCigna Lifetime Health (Plan Benefit Structure)

Sr.no.	What am I covered for	India Plan

i	Sum Insured[1] (INR)	□
ii	Sum Insured[2] (INR)	□
iii	Deductible (Optional) (INR)	₹25K / 50K / 1L / 2L / 3L / 4L/5L/10L
Sr.no.	**Cover/s**	**India Plan**
1	Hospitalization Expenses	□
2	Day Care Treatment	□
3	Pre - hospitalization	□
4	Post - hospitalization	□
5	AYUSH Treatment	□
6	Road Ambulance Cover	□
7	Donor Expenses	□
8	Domiciliary Expenses	□
9	Adult Health Check-up	□
10	Robotic and Cyber Knife Surgery	□
11	Modern and Advanced Treatments	□
12	HIV/AIDS and STD Cover	□
13	Mental Care Cover	□
14	Restoration of Sum Insured	□
15	Premium Waiver Benefit	□
16	Personal Accident Plus *(Optional; coverage is available only if opted)* – If opted coverage will be restricted to India only	□
		Optional Packages
I	**Health+ (Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under Health+ is over and above that of Base Plan (India Plan), as opted.	□
II	**Women+ (Available to female of age 12 years and above) (Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under the Women+ is over and above that of Base Plan (India Plan), as opted.	□
Add on cover (Rider) This section lists the Add on cover available under your plan		
ManipalCigna Critical Illness Add on Cover		Lump sum payment of Sum Insured, upon diagnosis of a Critical Illness.

ManipalCigna Lifetime Plus	This add-on provides following benefits: 1. Maternity Expenses a. Maternity Cover b. New Born Baby Cover c. First Year Vaccination: d. Infertility Cover 2. Surrogacy Cover 3. Oocyte Donor Cover 4. Cumulative Bonus (Applicable only on India SI – SI1 of Lifetime Health) 5. Worldwide Medical Emergency Hospitalization
ManipalCigna Health 360	This add-on provides following benefits: 1. Health 360 – OPD 2. Health 360 – Advance 3. Health 360- Shield

Disclaimer:

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

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

Prohibition of Rebates (under section 41 of Insurance Act, 1938):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 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 prospectus or tables of the insure₹
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

Annexures:

Illustration of Benefits

Rate Chart