ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
Corporate Office: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151 **Call** (Toll Free): 1800-102-4462
Visit: www.manipalcigna.com **E-mail:** customercare@manipalcigna.com

ManipalCigna Health Insurance

MANIPALCIGNA PRIME SENIOR

Plans: Classic | Elite
(PROSPECTUS)

I. What are the Key Highlights of the Policy?

BASE COVERS

- In-patient Hospitalization
- Pre-hospitalization
- Post-hospitalization
- Day care Treatment
- Domiciliary Hospitalization
- Road Ambulance
- Donor Expenses
- Restoration of Sum Insured
- AYUSH Treatment
- Daily Cash for Shared Accommodation
- Air Ambulance Cover

VALUE ADDED COVERS

- Domestic Second opinion
- Tele-Consultation
- Cumulative Bonus
- Premium Waiver Benefit
- Discount from Network Providers
- Health Check-up

OPTIONAL COVERS

- Any Room Upgrade
- Premium Management
- Restoration of Sum Insured
- Deductible
- Reduction in PED Waiting Period

ADD ON/RIDER COVER

- ManipalCigna Health 360-Shield
- ManipalCigna Health 360-OPD

II. What are the Basic covers?

II.1. In-patient Hospitalization

We will cover medical expenses in case of medically necessary hospitalization of an Insured person incurred due to Disease, Illness or injury when the Insured person is admitted as an In-patient for more than 24 consecutive hours provided that the admission date of the Hospitalization due to Illness or Injury is within the Policy Year. The coverage will include reasonable and customary charges towards room rent for accommodation in a hospital, up to limits specified under the eligible Room Category under the Plan opted, charges for accommodation in Intensive Care Unit and operation theatre charges, fees of medical practitioner, anaesthetist, qualified nurses, specialists, the 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.

Room category coverage under each plan will be covered up to Single Private AC Room or as specified in the Policy Schedule, subject to maximum of Sum Insured Opted. For ICU accommodation, we will cover up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the Plan opted, then the Insured Person shall bear only the difference between the room rent of the entitled room category to the room rent actually incurred.

The Policyholder/Insured Person need not bear ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category and the room rent actually incurred.

The following are some of the instances where the Insured Person avails room category higher than the entitled room category yet, need not bear ratable proportion of the total Associated Medical Expenses:

i. Unavailability of the entitled room category

ii. Unavailability of necessary medical facility in the entitled room category for the purpose of treatment of illness/injury/condition for which the insured was admitted

iii. In case of an emergency hospitalization wherein the Insured is not in a position to select or wait for the entitled room category

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

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of day care treatment in a hospital up to the limit specified in the Policy Schedule/ Product Benefit Table of this Policy.:

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

Medical Expenses incurred for the Medically Necessary Treatment of the Insured Person for Hospitalization arising from or associated with 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, sexually transmitted diseases (STD) will be covered up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time. The necessity of the Hospitalization is to be certified by an authorised Medical Practitioner.

Medical Expenses incurred for the Medically Necessary treatment taken of the Insured Person for in-patient Hospitalization, arising from or associatedto a Mental illness or a medical condition impacting mental health will be covered up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year. This coverage is provided in accordance with The Mental Health Care Act, 2017 as amended from time to time. For the below mentioned ICD Codes, the Insured Person should have been continuously covered under this Policy for at least 24 months before availing this benefit.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders

F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

II.2. Pre - hospitalization

We will reimburse medical expenses of an Insured person due to a disease or injury or illness that occurs during the Policy Year incurred immediately prior to hospitalization, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year subject to a claim being admissible under In-patient Hospitalization and expenses are related to the same illness/condition.

II.3. Post - hospitalization

We will reimburse medical expenses of an Insured person incurred post hospitalization due to a disease or injury or illness that occurs during the Policy Year up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year subject to a claim being admissible under In-patient Hospitalization and expenses are related to the same illness/condition.

II.4. Day Care Treatment

We will cover payment of medical expenses of an Insured Person in case of medically necessary Day Care Treatment or surgery that requires less than 24 hour s hospitalization due to advancement in technology and which is undertaken in a Hospital/ Nursing Home/ Day Care Centre on the recommendation of a medical practitioner. Any treatment in an outpatient department (OPD) is not covered. Coverage will also include pre-post hospitalization expenses as available under the Plan opted.

II.5. Domiciliary Hospitalization

We will cover medical expenses, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year, of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalization or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable. This is provided that the condition would otherwise have been covered for hospitalization under the Policy and for which treatment is required continues for at least 3 days and is on the advice of a medical practitioner. Claims for pre-hospitalization expenses, post-hospitalization up to 30 days each. We shall not be liable under this policy for any claim in connection with or in respect of the following:

i. Asthma, COPD, bronchitis, tonsillitis and upper and lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,
ii. Arthritis, gout and rheumatism including the rheumatism of bones, joints and also rheumatic heart disease,
iii. Chronic nephritis and nephritic syndrome,
iv. All types of Diarrhea and dysenteries, including gastroenteritis,
v. Diabetes mellitus and Diabetes Insipidus,
vi. Epilepsy / Seizure disorder,
vii. Hypertension,
viii. Pyrexia of unknown origin.

II.6. Road Ambulance

We will cover the reasonable and customary expenses incurred for transportation of an Insured person by an ambulance service provider to the hospital for treatment covered under the Policy following an emergency, requiring the Insured Person's admission to a Hospital. The coverage will be up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year. This benefit will be applicable per Hospitalization and necessity must be certified by the attending Medical Practitioner.

II.7. Donor Expenses

We will cover In-patient hospitalization medical expenses towards the donor for harvesting the organ in case of major organ transplant if it is in accordance with the Transplantation of Human Organs Act 1994 (amended and other applicable laws and rules. The organ donated is for the use of the Insured person as per Medical Advice and a claim has been admitted under In-patient hospitalization.

We will also cover Pre-Post hospitalization expenses towards the donor, cost towards donor screening for successful organ transplant surgery and any complication in respect of the donor, consequent to harvesting, which arise during hospitalization or up to 30 days from the date of discharge of the donor, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year.

However, we will not cover towards cost associated to the acquisition of the organ for the donor consequent on the harvesting will not be covered.

II.8. Restoration of Sum Insured

In case the Sum Insured inclusive of earned cumulative bonus (if any) is insufficient due to claims paid or accepted as payable during the policy year, then we will restore 100% of the Sum Insured for any number of times as per the plan opted in a policy year. This restored amount can be used for all future claims related and/or not related to the illness/disease/injury for which a claim has been made in the particular policy year for the same Insured Person. Restoration will not trigger on the first claim.

Restoration of the Sum Insured will only be provided for coverage under II.1. 'In-patient Hospitalization', II.2. 'Pre-Hospitalization', II.3. 'Post-Hospitalization', II.4. 'Day Care Treatment', II.6. 'Road Ambulance', II.7'Donor Expenses', II.9. 'AYUSH Treatment' Non-Medical Items (if Section IV.6 'ManipalCigna Health 360 - Shield' is opted and applicable)

In case the Restored Sum Insured is not utilised in a policy year, it shall not be carried forward to subsequent policy year. Any restored Sum Insured will not be used to calculate the Cumulative Bonus. For Individual policies restored Sum Insured will be available on individual basis whereas in case of a floater it will be available on floater basis.

For any single Claim during a Policy Year the maximum Claim amount payable shall be sum of:

a. The Sum Insured
b. Cumulative Bonus (if earned)
c. Restored Sum Insured

II.9. AYUSH Treatment

We will pay the Medical Expenses incurred during the Policy Year in case of Medically Necessary Treatment taken during In-patient Hospitalization/ Day Care Centre for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

The Insured Person has undergone treatment in an AYUSH Hospital/AYUSH Day Care Centre.

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

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

II.10. Daily Cash for Shared Accommodation

We will pay a daily cash amount up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year for the Insured Person for each continuous and completed period of 24 hours of

Hospitalization provided that,

a. We have accepted claim under Section II.1 In-patient Hospitalization during the Policy Year
b. The Insured Person has occupied a shared room accommodation during such Hospitalization
c. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

What is not covered:

This benefit will not be payable if the Insured Person stays in an Intensive Care Unit or High Dependency Units / wards.

II.11. 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, provided that:

i. Air Ambulance is used in case of an Emergency life threatening health condition of the Insured Person which requires immediate and rapid ambulance transportation to the hospital or a medical centre which ground transportation cannot provide;
ii. The Illness/ Injury, causing Emergency, is covered under the Section II.1 In-patient Hospitalization;
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. Restoration of Sum Insured shall not be available under this benefit.
v. Air Ambulance service is offered by a Registered Ambulance service provider;
vi. 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;
vii. Payment under this cover is subject to a claim being admissible under Section II.1 'In-patient Hospitalization' or under Section II.4 'Day Care Treatment', for the same Illness/Injury;

Benefit under this cover is payable up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy subject to maximum up to Rs.10 Lacs in a policy year and this is over and above the Sum Insured.

What is not covered: Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.

III. What are the Value Added Covers?

III.1. Domestic Second Opinion

You may choose to secure a second opinion from Our Network of Medical Practitioners in India, if an Insured Person is diagnosed with/ advised a treatment listed and defined under Critical Illness during the Policy Year. The expert opinion would be directly sent to the Insured Person.

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 the Insured Person that will be shared with the Medical Practitioner
c. 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.
d. 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.
e. 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.
f. The expert opinion under this Policy shall be limited to covered Critical 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. This benefit can be availed by each Insured Person only once during a Policy Year for one Critical Illness. However, one can avail this benefit for multiple critical illnesses in a year.

i. Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus.

For the purpose of this benefit covered Critical Illnesses shall include -

1. Cancer of Specified Severity
2. Myocardial Infarction (First Heart Attack of Specific 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
12. Primary (Idiopathic) Pulmonary Hyperte sion
13. Aorta Graft Surgery
14. Deafness
15. Blindness
16. Aplastic Anemia
17. Coronary Artery Disease
18. End Stage Lung Failure
19. End Stage Liver Failure
20. Third Degree Burns
21. Fulminant Hepatitis
22. Alzheimer's Disease
23. Bacterial Meningitis
24. Benign Brain Tumor
25. Apallic Syndrome
26. Parkinson's Disease
27. Medullary Cystic Disease
28. Muscular Dystrophy
29. Loss of Speech
30. Systemic Lupus Erythematous
31. Loss of Limbs
32. Major Head Trauma
33. Brain Surgery
34. Cardiomyopathy
35. Creutzfeldt-Jacob Disease (CJD)
36. Terminal Illness

III.2. Tele-Consultation

Insured Person may avail tele-consultations including specialists with our Medical Practitioner(s) through our network in India. These consultations would be available through tele/chat mode.

Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus.

III.3. Cumulative Bonus

We will increase Your Sum Insured at the rate, as specified in the Policy Schedule/ Product Benefit Table of this Policy, on the Base Sum Insured, at the end of the Policy Year if the Policy is renewed with Us without any break.

a) No Cumulative Bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.

b) If you have opted for 'Classic' Plan or 'Elite' Plan, the Cumulative Bonus shall be accumulated irrespective of claim in the preceding Policy Year.

c) The Cumulative Bonus will not be accumulated in excess of 100% of the Sum Insured under the current Policy with Us under any circumstances.

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

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

f) Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis

and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy. Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.

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

h) Cumulative bonus shall not be available for claims made under III. Value Added Covers, II.11 Air Ambulance Cover and II.10 Daily Cash for Shared Accommodation.

i) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section F.I.6 and F.I.7 under Policy Terms and Condition.

III.4. Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers Death due to an injury caused by an Accident within 365 days from the date of the event or he/she is diagnosed with a Critical Illness, listed under this section, We will pay the next one full Policy Year's Renewal Premium (including premium for Optional covers, Riders and Taxes) of the Policy, for a policy tenure of 1 year. The premium shall be waived towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.

In case of any change in Policy benefits, complete premium will be paid by the Policyholder.

The cover is available subject to below conditions:

- If only one person is covered under the Policy, policy will not be renewed in case of death of the Policyholder.
- The Policyholder is not added in the Policy in the middle of the Policy Year. There is no change in covers, Sum Insured, benefit structure, limits and conditions applicable under the Policy, at the time of renewal.
- No new member is being added under the renewed Policy.
- 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.

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

a) Cancer of Specified Severity
b) Myocardial Infarction (First Heart Attack of Specific Severity)
c) Open Chest CABG
d) Open Heart Replacement or Repair of Heart Valves
e) Coma of Specified Severity
f) Kidney Failure Requiring Regular Dialysis
g) Stroke Resulting in Permanent Symptoms
h) Major Organ/Bone Marrow Transplant
i) Permanent Paralysis of Limbs
j) Motor Neuron Disease with Permanent Symptoms
k) 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.

III.5. Discount from Network Providers

The Insured Person can avail discounts on Diagnostics, Pharmacy, Medical Devices, Health Supplements and other health-related services offered through our Network Providers.

III.6. Health Check-up

i. The Insured Person may avail a comprehensive Health Check Up with Our Network Provider as per the details mentioned in the table below.
ii. The Insured member shall choose to undergo Health Check Ups of Insured member's choice on Cashless

basis with Our Network Provider, subject to the maximum limits as specified against the applicable Sum Insured.

iii. All the tests must have been done on the same date.

iv. Original Copies of all reports will be provided to You.

v. We shall cover Health Check Up only on cashless basis.

vi. This benefit shall be over and above the Sum Insured.

vii. Restoration of Sum Insured shall not be available under this benefit

IV. What are the Optional Covers?

The following optional covers shall be available under the Policy and shall apply to all Insured Persons under a single policy without any individual selection.

IV.1. Any Room Upgrade

We will upgrade the Room category coverage under Section II.1 Inpatient hospitalization up to 'Any Room Category' subject to maximum of Sum Insured Opted and as specified in the Policy Schedule.

IV.2. Premium Management

We will limit the Room category coverage under Section II.1 In-patient hospitalization up to the limits and plan opted and as specified in the Policy Schedule. For ICU accommodation, we will cover up to the opted Sum Insured and as specified in the Policy Schedule.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the Policy Schedule, then the Policyholder/Insured Person shall bear only the difference between the room rent of the entitled room category and the room rent actually incurred.

The Policyholder/Insured Person need not bear ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category and the room rent actually incurred.

The following are some of the instances where the Insured Person avails room category higher than the entitled room category yet, need not bear ratable proportion of the total Associated Medical Expenses:

i. Unavailability of the entitled room category

ii. Unavailability of necessary medical facility in the entitled room category for the purpose of treatment of illness/injury/condition for which the insured was admitted

iii. In case of an emergency hospitalization wherein the Insured is not in a position to select or wait for the entitled room category

This Optional Cover is available only under Classic Plan.

IV.3. Restoration of Sum Insured

We will provide for a 100% restoration of the Sum Insured for any number of times in a Policy Year, provided that:

a. The Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year.

b. This restored amount can be used for all future claims related and/or not related to the illness/disease/injury for which a claim has been made in the particular policy year for the same Insured Person.

c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section II of the Policy and shall not apply to the first claim in the Policy Year. Restoration of the Sum Insured will only be provided for coverage under Section II.1 'In-patient Hospitalization', Section II.2 'Pre-Hospitalization', Section II.3 'Post-Hospitalization', Section D.I.4 'Day Care Treatment', Section II.6 'Road Ambulance', Section II.7 'Donor Expenses', Section II.9 'AYUSH Treatment', Non-Medical Items (if Section IV.6 'ManipalCigna Health 360 - Shield' is opted and applicable)

d. The Restored Sum Insured will not be considered while calculating the Cumulative Bonus

e. Such Restoration of Sum Insured will be available for any number of times, during a Policy Year to each insured in case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

f. If the Policy is issued on a floater basis, the Restored Sum Insured will also be available on a floater basis.

g. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

h. For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:

   i. The Sum Insured

   ii. Cumulative Bonus (if earned)

   iii. Restored Sum Insured

This benefit shall be available only under Classic Plan on opting Sum Insured 5 Lacs and above.

IV.4. Reduction in PED Waiting Period

We will provide an option to reduce the pre-existing disease waiting period under this Policy to 90 days, on payment of applicable premium for this cover.

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

IV.5. Deductible

You can opt for a Deductible, as specified in the Policy Schedule/ Product Benefit Table of this Policy. Wherever a Deductible is selected such amount will be applied for each Policy Year on the aggregate of all Claims in that Policy Year other than for claims under fixed benefit covers and Health Check Ups. Deductible shall apply to all sections other than II.10 Daily Cash for Shared Accommodation, III. Value added covers and IV.7 ManipalCigna Health 360-OPD if opted.

For Deductible of ₹10,000, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal.

For Deductible of ₹25,000 and above, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. On opting out of deductible of ₹25,000 and above, the enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as applicable under the base policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of the insured member at renewal.

All other terms, conditions, waiting periods and exclusions shall apply.

IV.6. Add on - ManipalCigna Health 360-Shield

Along with this Product You can also avail the ManipalCigna Health 360-Shield Add On Cover (UIN: MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider will apply.

For the purpose of this Benefit, coverages are listed under the ManipalCigna Health 360 Add on Cover Policy documents.

IV.7. Add on - ManipalCigna Health 360-OPD

Along with this Product You can also avail the ManipalCigna Health 360-OPD Add On Cover (UIN: MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All exclusions and terms and conditions of applicable rider will apply.

For the purpose of this Benefit, coverages are listed under the ManipalCigna Health 360 Add-on Cover Policy documents.

V. What are Features of the Policy?

V.1. Eligibility

The minimum entry age under this policy is 56 years and above. The maximum entry Age under this policy is 75 years. In case of Family Floater, spouse less than 56 Years are allowed to be part of the policy. In case of Multi-individual, every insured member has to be aged 56 Years or more.

Renewals will be available for lifetime.

V.2. Individual and Family Floater

The policy can be purchased on an Individual/ Multi-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, children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, sister in-law, brother in-law, uncle, aunty, nephew & niece.

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover Insured and his/her lawfully wedded spouse. A floater cover can cover a maximum of 2 adults under a single policy.

V.3. Policy Period option

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

V.4. Plan & Sum Insured Options

You have the option to choose from a wide range of Sum Insured's available under different plans.

Plan Name	Sum Insured (Lacs)
Classic Plan	₹3 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs
Elite Plan	₹5 Lacs, ₹ 7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs

V.5. Discounts under the Policy

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

i. Lifetime Discounts

a. Employee Discount: 15% discount on the premium

b. Standing Instruction Discount: 3% discount on the renewal premium, if the renewal premium is received through standing instruction.

c. Long Term policy discount - Long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy. This discount is available only with 'Single' Premium Payment mode

d. Family discount: (Applicable only with cover on individual basis) 10% discount on the premium is applicable for covering 2 members under the same individual Policy on Multi-Individual basis.

ii. Short Term Discounts

a. **ManipalCigna Existing Customer Discount:** 5% discount will be applicable to customers (Proposers/ Insured) of ManipalCigna who are already covered under Group/ Retail Products. Discount would be applicable once, only at inception and shall not be offered to Portability/ Migration related proposals wherein the customer does not have any other Policy from ManipalCigna apart from the Ported or Migrated Policy.

b. **Worksite Marketing Discount** - A discount of 10% will be available on polices which are sourced through worksite marketing channel. Discount would be applicable once only at inception of the Policy.Discount under V.v.i (d) is applicable only to individual policies. All other discounts mentioned above are available to both individual as well as floater policies. Maximum discount in a single policy shall not exceed 40%. Family Discount, Long Term Discount and Worksite Marketing Discount is applied on the total Policy premium which is sum total of individual premium for Family policies.

Employee Discount and Worksite Marketing Discount/ ManipalCigna Existing Customer Discount are mutually exclusive.

V.6. Loading & Special Conditions

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levis & taxes) based on your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

We may apply a specific sub-limit on a medical condition/ailment depending on Your medical 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 will 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 We will only issue the Policy once We receive your consent and applicable premium within the duration specified in the counter offer letter.

V.7. Mandatory Co-payment

A mandatory co-payment of 20%, as mentioned in the Policy Schedule/ Product Benefit Table, is applicable on all claims irrespective of Age of entry in to the Policy. This mandatory co-payment shall be applied on the admissible claim amount.

You shall have an option to reduce or increase the mandatory co-payment, up to the rate as mentioned in the Product Benefit Table and as specified in the Policy Schedule, which shall supersede the mandatory co-payment rate mentioned above.

Any modification of co-payment option is available during inception of the first Policy and/or subsequent renewals and may be subject to Underwriting.

V.8. Premiums

The Premium charged on the Policy will depend on the Plan, Sum Insured, Policy Tenure, Age, Policy Type, Gender, Zone of Cover, Optional Covers and Add On Benefits opted. Additionally the health status of the individual will also be considered. All Premiums are age based and will vary each year as per the change in age group.

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.For the purpose of calculating premium, the country has been divided into 3 Zones. Identification of Zone will be based on the City-Location of the correspondence address of the proposed Insured persons and premiums will be calculated accordingly.

Zone Classification

Zone I: Mumbai, Thane & Navi Mumbai, Gujarat, Kolkata and Delhi & NCR

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Pune

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the City of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any zonal co-pay.

(b) Persons paying Zone II premium

i) Can avail treatment in Zone II and Zone III without any zonal co-pay.

ii) Availing treatment in Zone I will have to bear 10% of each and every claim.

(c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any zonal co-pay

ii) Availing treatment in Zone II will have to bear 10% of each and every claim.

iii) Availing treatment in Zone I will have to bear 20% of each and every claim.

Option to select a Zone higher or lower than that of the actual Zone is available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals. Aforesaid Co-payments for

claims occurring outside of the Zone will not apply in case of Hospitalization due to an Accident.

The aforesaid Co-payments applicable are in addition to the Co-payment under Section V.7 (if applicable) and will be applied in conjunction to Section V.7 of the Policy

V.9. 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, 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, 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.

V.10. 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.

a. The Company shall give notice for renewal at least 30 days in advance from the Policy due date.
b. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d. At the end of the policy period, the policy shall terminate and can be renewed within the grace period of 30 days, to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e. No loading shall apply on renewals based on individual claims experience.

V.11. 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. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure of material facts by You.
d. Where We have discontinued or withdrawn this product/plan You will have the option to renew under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy.
e. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of

seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

f. 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 90 days prior to date of such revision or modification.

g. Alterations like increase/ decrease in Sum Insured 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, on renewal. The terms and conditions of the existing policy will not be altered.

h. Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

i. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.

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

k. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.

Premium Payment in Instalments: For Policies other than 'Single' Premium payment modes.

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

- Grace Period of 15 days for Monthly mode and 30 days for Half-Yearly & Quarterly mode would be given to pay the instalment premium due for the Policy.
  - If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.
- The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged if the instalment premium is not paid on due date.
- 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.
  - In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
  - The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

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

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

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions

whether or not leading to change in Premium.

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

v. 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.

V.12. 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 policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

V.13. Income Tax benefit

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

V.14. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

V.15. Free-look Period

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

The insured person shall be allowed a free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

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

V.16. Cancellations

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 7 days' notice in writing. We shall refund the premium for the unexpired term as mentioned 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.

1. 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)

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

V.17. Endorsements

The Policy will allow the following endorsements during the term of the Policy. Any request for endorsement must be made by You in writing. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later other than for change in Date of Birth or Gender which will be with effect from inception.

a) Non-Financial Endorsements shall include but not limited to

- 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 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 caregiver 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 shall include but not limited to

- 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 (Newly Wedded Spouse)
- Change in Address (resulting in change in Zone)
- 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.

V.18. 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.: + 91 22 71781300

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

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

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

Email: headcustomercare@manipalcigna.com.

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

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

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

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

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

V.19. Pre-Policy Medical Check-up

No mandatory pre-policy medical check-up is required irrespective of Your age, Plan and the Sum Insured opted. However, proposals with Sum Insured greater than ₹15 lacs may be required to undergo Tele/Video MER across all ages. wherever any pre-existing disease or any other adverse medical history is declared on the proposal form / Tele/Video MER, we may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age, Sum Insured and 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

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.

If a non-disclosure/misrepresentation of material facts is noted post inception either in welcome calling or at claims stage, it will be subjected to underwriting evaluation and may result in termination of the policy.

V.20. 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.

V.21. Withdrawal of Policy

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

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

V.22. 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.

VI. What are the Waiting Period and Exclusions?

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

VI.1. Pre-existing Disease - 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 the exclusion shall apply afresh to the extent of sum insured increase.

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

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

VI.2. Specified disease/procedure Waiting Period - Code- Excl. 02

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

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

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

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

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

f. List of specific diseases/procedures:

   i. Cataract and other disorders of lens and Retina,

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

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, 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, ,

iv. Varicose Veins and Varicose Ulcers,

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

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/ throat disorder or surgery,

ix. gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/ Benign tumors including internal tumors and skin tumors, and type of breast lumps,

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

xi. Congenital Internal diseases

xii. Rheumatism including the rheumatism of bones, joints and also rheumatic heart disease

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

VI.3. 30 Days Waiting Period - Code- Excl. 03

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

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

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

VI.4. 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.5. Mental Illness Cover Waiting Period

Any treatment arising out of a condition caused by or associated to a Mental illness or a medical condition under below mentioned ICD Codes impacting mental health, shall not be covered until 24 months of continuous coverage has elapsed for the particular Insured Person since the inception of the first Policy with Us.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders

F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

VI.6. 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 comorbidities 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.

6. **Hazardous or Adventure sports: Code- Excl 09**

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

7. **Breach of law: Code- Excl 10**

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

8. **Excluded Providers: Code- Excl 11**

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

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

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

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

12. **Refractive Error: Code- Excl 15**

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

13. **Unproven Treatments: Code- Excl 16**

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

14. **Sterility and Infertility: Code- Excl 17**

    Expenses related to sterility and infertility. This includes:

    (i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15.Maternity: Code Excl 18

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

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

16. Dental Treatment, 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.

17. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

18. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

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

20. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalized.

21. 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.

22. Treatment taken outside the geographical limits of India

VII. How can I buy the Policy?

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

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

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

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured and Age band, 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.

We shall process the proposals and the decision on the proposal thereof, shall be communicated in writing to You within a reasonable period but not exceeding 7 days from the date of receipt of proposals or any requirements called for by Us.

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

VIII. What is the Claim Process?

VIII.1. 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.

VIII.2. 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 15 days from the date of discharge from Hospital -

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

- Payment receipt.

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's 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.

IX. What are the Plan wise Benefit Details?

The Plan wise benefit details are as mentioned below:

<table>
<tr><th>Title</th><th colspan="3">Description
Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief</th></tr>
<tr><td>Your Coverage Details:</td><td>Identify your Plan</td><td>Classic</td><td>Elite</td></tr>
<tr><td rowspan="2">Basic Cover

This section lists the Basic benefits available on your plan</td><td>Identify your Opted Sum Insured (in ₹)</td><td>₹3 Lacs, ₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs</td><td>₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs</td></tr>
<tr><td>In-patient Hospitalization (When you are hospitalised)</td><td colspan="2">Room Rent: Covered up to Single Private A/C Room
For ICU - Covered up to Sum Insured
This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments: Up to Sum Insured
b. HIV/AIDS & STD: Up to Sum Insured
c. Mental Illness: Up to Sum Insured
For below mentioned ICD Codes: Waiting Period of 24 months shall apply.
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table></td></tr>
</table>

	Pre - hospitalization	Medical Expenses Covered up to 30 days before the date of hospitalization; Covered up to the Sum Insured	Medical Expenses Covered up to 60 days before the date of hospitalization; Covered up to the Sum Insured
	Post - hospitalization	Medical Expenses Covered up to 60 days post discharge from the hospital; Covered up to the Sum Insured	Medical Expenses Covered up to 90 days post discharge from the hospital; Covered up to the Sum Insured
	Day Care Treatment	Covered up to the Sum Insured	
	Domiciliary Hospitalization (Treatment at Home)	Covered up to of the Sum Insured Pre and Post Hospitalization Expenses: 30 days each	
	Road Ambulance (Reimbursement of Ambulance Expenses)	Covered up to the Sum Insured	
	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to the Sum Insured including: • Pre & Post Hospitalization expenses (Up to 30 days each) of the donor • Cost towards donor screening once in a Policy year for successful transplant • Complications arising during hospitalization or up to 30 days from date of discharge - Up to 25% of SI subject to maximum of ₹2 Lacs, Over and above SI We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.	
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Not Available	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, in addition to the Sum Insured Applicable for below covers only II.1 – In-patient Hospitalization II.2 – Pre - hospitalization II.3 – Post - hospitalization II.4 – Day Care Treatment II.6 – Road Ambulance II.7 – Donor Expenses II.9 – AYUSH Treatment Non-Medical Items (if ManipalCigna Health 360 Shield is opted and applicable) Restoration shall not get triggered for the 1st claim The maximum liability under a single claim shall not be more than Base Sum Insured + Cumulative Bonus + Restored Sum Insured
	AYUSH Treatment	Covered up to the Sum Insured	

	Daily Cash for Shared Accommodation	Not Available	Daily Cash benefit for occupying shared accommodation while hospitalized of ₹800 per day up to maximum of ₹5,600 per hospitalization Payable for each continuous and completed 24 Hours of Hospitalization during the Policy Year This benefit gets triggered post 48 hours of In-patient hospitalization and shall be payable from 1st day onwards.
	Air Ambulance Cover	Not Available	Covered up to sum insured subject to maximum of ₹10 Lacs in addition to the Sum Insured for expenses incurred on Air Ambulance
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Domestic Second Opinion	Not Applicable	Available for 36 listed Critical Illnesses
	Tele-Consultation	Unlimited Tele-consultation including specialist during the Policy Year	
	Cumulative Bonus	A guaranteed bonus of 10% of Sum Insured for every completed Policy Year, subject to a maximum accumulation up to 100% of the Sum Insured.	
	Premium Waiver Benefit	Not Applicable	Waives off one year Policy Premium (including premium for optional covers, rider and taxes) upon occurrence of any of the listed contingencies (Accidental death/ listed Critical Illnesses) to the Policyholder who is also an Insured Person in the Policy
	Discount from Network Provider	Discount on Pharmacy, Diagnostics, Medical Devices, Health Supplements and other health-related services offered by the Network Providers of ManipalCigna Health Insurance Company Limited	
	Health Check Up	Once after every claim free year For Sum Insured up to 10 Lacs: Up to ₹2,000 per insured member For Sum Insured above 10 Lacs: Up to ₹2,500 per insured member Available from 2nd policy year onwards. The Health Check-up shall be offered on cashless basis only. However, the eligible insured may avail health check from the MCHI Network of Health Check Up Center up to the limit specified	Available each policy year For Sum Insured up to 10 Lacs: Up to ₹3,500 per insured member For Sum Insured above 10 Lacs: Up to ₹5,000 per insured member Annually from 1st policy year onwards The Health Check-up shall be offered on cashless basis only. However, the eligible insured may avail health check from the MCHI Network of Health Check Up Center up to the limit specified

Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Any Room Upgrade	The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to "Any Room Category" in a Hospital.	
	Premium Management (Not available on Opting 'Any Room Upgrade' Optional Cover)	Room Rent - Covered up to ₹3000 per day. ICU - Upto Sum Insured.	Not Available
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims) (Applicable for Sum Insured 5 Lacs and above)	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same in addition to the Sum Insured Applicable for below covers only II.1 – In-patient Hospitalization II.2 – Pre - hospitalization II.3 – Post - hospitalization II.4 – Day Care Treatment II.6 – Road Ambulance II.7 – Donor Expenses II.9 – AYUSH Treatment Non-Medical Items (if ManipalCigna Health 360 Shield is opted and applicable) Restoration shall not get triggered for the 1st claim The maximum liability under a single claim shall not be more than Base Sum Insured + Cumulative Bonus + Restored Sum Insured	Not Available
	Reduction in PED waiting period	Option to reduce the Pre-Existing Disease waiting period to 90 Days	
Loss Sharing This sections lists the various circumstances under which you will bear some portion of the claim out of your pocket	Co-payment	Mandatory Co-payment of 20% shall be applicable on all claims Co-payment is applicable on all claims irrespective of Age of entry in to the Policy The insured shall have the option to reduce the co-payment to 0% or 10% or increase the co-payment to 30% Any modification of Co-Payment option is available during renewal and may be subject to Underwriting	

	Deductible	Deductible of ₹10,000, ₹25,000, ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 or ₹5,00,000 can be opted at the inception or during any Renewal of the Policy. For Deductible of ₹10,000, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. For Deductible of ₹25,000 and above, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. On opting out of deductible of ₹25,000 and above, the enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as applicable under the policy shall apply afresh for this enhanced limit from the effective date of such enhancement.
Add on cover (Rider) This section lists the Add on cover available under your plan	ManipalCigna Health 360-Shield	Coverage available for NME and DME NME: Covered up SI as part of base SI DME: Listed DME covered up to ₹1 Lac
	ManipalCigna Health 360-OPD	Coverage available for OPD as per package opted

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 or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is a subject matter of solicitation

Annexures:

Benefit Illustration

Rate Charts