ManipalCigna Health Insurance Company Limited
(Formerly known as CignaTTK Health Insurance Company Limited)
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IRDAI Registration No. 151 **Call** (Toll Free): 1800-102-4462
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SECUREHEALTH, MANIPALCIGNA

Prospectus

I. What are the key highlights of the product?

- Inpatient Care and Day Care Treatment
- AYUSH Treatment
- Pre-Hospitalization Medical Expenses
- Post-Hospitalization Medical Expenses
- Emergency Ground Ambulance
- Cataract Treatment
- Modern Treatment

II. What are the basic covers?

1. Inpatient Care

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/Nursing Home up to maximum of 1% of the Sum Insured per day.

ii. Intensive Care Unit (ICU)/Intensive Cardiac Care Unit (ICCU) expenses up maximum of to 2% of Sum Insured per day.

iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/surgeon or to the hospital

iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.

ii. Dental treatment necessitated due to disease or injury (for Inpatient care only).

iii. Plastic surgery necessitated due to disease or injury.

iv. All day care treatments

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.
3. 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 a 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 to the room rent actually incurred.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for Inpatient care/day care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 100% of sum insured as specified in the policy schedule in any AYUSH Hospital/AYUSH Day Care Centre.

3. Pre-Hospitalization Medical Expenses

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period of 30 days prior to the date of admissible

Hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 1 (Inpatient Care) or Section 2 (AYUSH Treatment) or Section 7 (Modern Treatments) in respect of that Insured Person.

ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

4. Post-Hospitalization Medical Expenses

The Company shall indemnify Post-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 1 (Inpatient Care) or Section 2 (AYUSH Treatment) or Section 7 (Modern Treatments) in respect of that Insured Person.

ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

5. Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization as per the limit mentioned in Policy Schedule.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

i. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.

ii. Expenses incurred on road Ambulance subject to a maximum of ₹2000/- per hospitalization.

iii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

iv. The original Ambulance bills and payment receipt is submitted to the Company.

v. The Company has accepted a claim under Section 1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 2 (AYUSH Treatment) or Section 7 (Modern Treatments).

vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

6. Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of ₹40,000/-, per each eye in one policy year.

7. Modern Treatment

The following procedures will be covered (wherever medically indicated) either as Inpatient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period.

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy - Monoclonal Antibody to be given as injection.

f. Intra Vitreal injections

g. Robotic surgeries

h. Stereotactic radio Surgeries
i. 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.

III. What are the features of the product?

i. Eligibility

The minimum entry age under this policy is New born (0 days) for children and 18 years for adults. The maximum age of entry under this policy is 17 years for children and 65 years for adults.

Coverage for children: Children will only be covered if one of the parents is the proposer.

ii. Policy Type

The policy can be purchased on an Individual basis only. This 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.

iii. Policy Period

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

iv. Sum Insured Options

You have the option to choose from the below range of Sum Insured's available: ₹4 Lacs and ₹5 Lacs

v. Discounts under the Policy

o Employee Discount - of 10% discount on the premium.

vi. Underwriting Loading and Special Conditions

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

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

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

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

vii. Premiums

The Premium charged on the policy will depend on Sum Insured, Age and Pre-existing HIV/AIDS/Disability Additionally, the health status of the individual will also be considered.

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

viii. Premium payment mode

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

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

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

Premium payment mode	% Loading on premium
Monthly	5.5%
Quarterly	3.5%
Half yearly	2.5%

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

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

ix. Grace Period and Premium Payment in Installments

For Yearly, half yearly and quarterly payment of mode, a fixed period of 30 days will be allowed as Grace Period and for monthly mode of payment a fixed period of 15 days will be allowed as Grace Period.

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

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

x. Renewal Terms

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

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

xi. Portability

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

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

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

xii. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

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

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

xiii. Income Tax Benefit

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

xiv.Free Look Period

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

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

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

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

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

xv. Cancellations

i. 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 policy period 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.

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

xvi. Endorsements

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

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

xvii. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

xviii. Grievance Redressal

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

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at,

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

or

Email - headcustomercare@manipalcigna.com.

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

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

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

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

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

xix.Pre-Policy Medical Check-Up

All the proposed Insured members are required to undergo mandatory Pre Policy Medical Check-up and/or Tele/Video MER across all ages and Sum Insured as per grid mentioned below.

Category	Medical Test
For person with disability	Tele / Video UW
For person with HIV/ AIDS and without/with Disability	Pre Policy Medical Checkups For Males: SET-15 - MER, CBC-ESR, ECG, Hb1Ac, Urine Routine, Lipid Profile, FBS, Liver Function Test, Renal Functioning Test, CEA and HIV, HbsAg, PSA For Females: SET-16 - MER, CBC-ESR, ECG, Hb1Ac, Urine Routine, Lipid Profile, FBS, Liver Function Test, Renal Functioning Test, CEA and HIV, HbsAg

Full explanation of Tests is provided here: MER – Medical Examination Report, FBS – Fasting Blood Sugar, RBS – Random Blood Sugar, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, S Creatinine – Serum Creatinine, RUA – Routine Urine Analysis, HbA1c – Glycosylated Hemoglobin, SGOT – Serum Glutamate oxaloacetate transaminase, SGPT – Serum Glutamate Pyruvate Transaminase, GGT – Gamma Glutamyl Transferase, TMT – Tread Mill Test, HBsAg – Hepatitis B Surface Antigen, PSA – Prostate Specific Antigen, LFT – Liver Function Tests, CEA – Carcinoembryonic Antigen

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/or Tele/Video underwriting 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 revised offer is not accepted by the customer we will bear the cost for such tests.

IV. What are the Waiting Periods and Exclusions?

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

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

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for pre-existing disability/36 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.

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 number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

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

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

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

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

iii. Specific Waiting Period (Code - Excl 02)

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

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

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

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

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

i. 24 Months waiting period

1. Benign ENT disorder
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments

10. Gastric/Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers

iv. PERMANENT EXCLUSIONS

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

1. Investigation & Evaluation (Code - Excl 04)

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

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

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/Weight Control (Code - Excl 06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      - Obesity related cardiomyopathy
      - Coronary Heart Disease
      - Severe sleep apnea
      - Uncontrolled Type^2 diabetes

4. Change of Gender treatments (Code - Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are excluded, except for sex reassignment surgery for transgender persons.

5. **Cosmetic or plastic Surgery (Code - Excl 08)**

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

6. **Hazardous or Adventure sports (Code - Excl 09)**

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

7. **Breach of law (Code - Excl 10)**

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

8. **Excluded Providers (Code - Excl 11)**

   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations 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 - Excl14)**

12. **Refractive Error (Code - Excl 15)**

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

13. **Unproven Treatments (Code - Excl 16)**

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

14. **Sterility and Infertility (Code - Excl 17)**

    Expenses related to sterility and infertility. This includes:

    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

15.Maternity Expenses (Code - Excl 18)

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

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

16. Any medical treatment taken outside India.

17. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

18. Nuclear damage caused by, contributed to, by or arising from ionizing radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);

c. nuclear weapons material.

d. nuclear equipment or any part of that equipment.

19. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection,military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

20. Injury or Disease caused by or contributed to by nuclear weapons/materials.

21. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.

22. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.

23. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

24. Vaccination or inoculation except as post bite treatment for animal bite.

25. Convalescence, general debility, “Run-down” condition, rest cure, Congenital external illness/disease/defect.

26. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.

27. Dental treatment or Surgery of any kind unless requiring Hospitalization as a result of accidental Bodily Injury.

28. Venereal/ Sexually Transmitted disease (excluding HIV/AIDS)

29. Stem cell storage.

30. Any kind of service charge, surcharge levied by the hospital.

31. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

32. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II of the Policy Wording

33. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

V. How can I buy the Policy?

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

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

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

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

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

In case we are unable to accept Your proposal We will intimate the same to You.

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

VI. What is the claim process?

1. Procedure for Cashless claims

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

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

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

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

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

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

2. Procedure for reimbursement of claims

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

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

3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4. Documents to be submitted

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

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

Note:

1. We shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, we shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to our satisfaction.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.
4. Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

5. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

6. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject the claim, as the case may be, within 15 days (other than cashless) from date of submission of necessary claim documents.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from date of submission of necessary claim documents to the date of payment of claim at a rate 2% above the bank rate.

7. Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

1. Claim settlement and claim rejection;
2. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company. Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on the Health Card issued by Us as well as on our website: https://www. manipalcigna.com/our-tpas.

8. Payment of Claim

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

VII. What are the plan benefits?

Name	SecureHealth, ManipalCigna
Coverage Basis	Individual basis only
Category of Cover	Indemnity
Sum insured	On Individual basis - Sum insured shall apply to each individual member
Sum insured available(in ₹)	₹4 lacs and ₹5 lacs
Policy Period	1 Year
Eligibility	Policy can be availed by availed on Individual basis. Age eligibility for adults: 18 years to 65 years Age eligibility for Children: Newborn (0 days) to 17 years
Grace Period	For Yearly, half yearly and quarterly payment of mode, a fixed period of 30 days is to be allowed as Grace. Period and for monthly mode of payment a fixed period of 15 days be allowed as grace period.
Hospitalization Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. Time limit of 24 hrs shall not apply in respect of Day Care Treatment.
Pre-Hospitalization	For 30 days prior to the date of hospitalization
Post-Hospitalization	For 60 days from the date of discharge from the hospital
Sublimit for Room/ Medical Practitioner's fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/ Nursing Home up to maximum of 1% of the sum per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/Nursing Home up to maximum of 2% of the sum insured per day.
Cataract Treatment	Up to ₹40,000/-, per each eye in one policy year
Modern Treatment	Covered for listed procedures up to 100% of sum insured available for Inpatient Hospitalization Care

Emergency Ground Ambulance	Expenses covered up to ₹2000 per hospitalization
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to 100% of sum insured, during each Policy year as specified in the policy schedule
Pre-Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered.
Initial Waiting period	30 days for all claims except resulting from Accident
PED waiting period	36 months (For pre-existing diseases other than the pre-existing Disability and HIV/ AIDS covered)
Specific Disease/ Illness waiting period	24 months
Waiting Period and specific Sublimit for HIV AIDS Cover	For HIV/AIDS cover: a. Initial waiting period of 30 days will be applicable for Indemnity basis cover b. Sum Insured would be available for Hospitalization Expenses as per terms and conditions of the policy.
Waiting Period and specific Sublimit for Disability Cover	For Disability Cover: 24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.
Co-pay	20% on all claims made under the policy

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 insurers.
2. Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.
3. 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

VIII. ANNEXURES

Rate Charts