ManipalCigna
Health Insurance

EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS

ManipalCigna Super Top Up Customer Information Sheet

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Cover under existing policy, ManipalCigna Super Top Up, will continue to be available for the Insured person, subject to Renewal and policy terms and conditions.
#Waiting Periods here will mean initial waiting period, specific illness waiting period and pre-existing disease waiting period of base policy.
* ManipalCigna ProHealth Insurance – Protect Plan (UIN CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us.
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- Stem cell implantation/surgery.
- Dental treatment other than due to accident.
- HIV/ AIDS and related complications
- Vitamins and tonics unless forming part of treatment.
- Artificial life maintenance, including life support machine use.
- Treatment for rehabilitation measures, private duty nursing, respite care.
- Treatment from persons not registered as Medical Practitioners.
- Ailment requiring treatment due to drug abuse/ alcohol and treatment for de-addiction, or rehabilitation.
- Any illness resulting from the Insured committing any breach of law.
- Any cosmetic surgery unless forming part of treatment for accident, cancer, burns or specific disease of breast.
- Charges incurred primarily for diagnostic purposes..
- Costs of donor screening.
- Any form of Non-Allopathic treatment except treatment covered under AYUSH Cover under the policy.
- Expense for injury of insured whilst engaging in any adventure sport.
- Expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel.
- All expenses arising from foreign invasion & warlike operations, whether war be declared or not.</td><td>V</td></tr>
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Waiting Period This sections lists the applicable period (days/months) before you can make a claim for the listed diseases/treat ments	a. First 30 days from the Policy start date, for all illnesses except Accidents. b. First 24 months from the Policy start date for Specific illnesses. c. A 48 months waiting period will be applicable for any Pre-existing disease.	IV
Payout Basis This section lists the manner in which the proceeds of the Policy will be paid to you	For all covers, pay-out will be on indemnity basis either by way of Cashless to the Hospital/ Network provider when a cashless facility is availed or directly to you as a reimbursement against the bills when you have paid for the expenses.	VI.4. & VI.5.
Cancellation The section explains the Policy cancellation process in brief	Cancellations may be intimated to Us by giving 15 days' notice wherein We shall refund the premium for the unexpired term on the short period scale as mentioned in the Policy wordings enclosed in the kit. The Premium shall only be refunded only if no claim has been made under the Policy. Cover may end immediately for all Insured Persons, if there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing. This Policy can be cancelled on grounds of misrepresentation, fraud, non-disclosure of material fact, upon giving 15 days' notice without refund of premium.	VII.11.
Legal disclaimer: The information mentioned above is illustrative and not exhaustive. Information must be read in conjunction with the product brochures/prospectus and Policy document. In case of any conflict between the Prospectus and the Policy document the terms and conditions mentioned in the Policy document shall prevail.		

ManipalCigna Super Top Up
Policy Terms and Conditions

I PREAMBLE & OPERATING CLAUSE

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

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

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

BENEFITS UNDER THE POLICY

II BASIC COVERS

II.1. Inpatient Hospitalisation:

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

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

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

II.2. Pre - hospitalisation:

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

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

II.3. Post - hospitalisation:

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

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

II.4. Inpatient hospitalisation for AYUSH Cover:

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

i) The Insured Person has undergone AYUSH Treatment in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health.
ii) Teaching hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
iii) AYUSH Hospitals having registration with a Government authority under appropriate Act in the state/ UT and complies with the following as minimum criteria:

a) Has at least fifteen in-patient beds
b) Has minimum five qualified and registered AYUSH doctors
c) Has qualified paramedical staff under its employment round the clock
d) Has dedicated AYUSH therapy sections;
e) Maintains daily record of patients and makes these accessible to the insurance company's authorized personnel.

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

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

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

II.5. Day Care Treatment:

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

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

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

II.6. Non- medical expenses Cover:

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

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

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

II.7. Road Ambulance Cover:

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

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

II.8. Donor Expenses:

a. We will cover In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -
b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice.
c. A claim is admissible under Section II.1 – towards In-patient Hospitalisation
d. We will not cover expenses towards the Donor in respect of:
i. Any Pre or Post - hospitalisation Medical Expenses,
ii. Cost towards donor screening,
iii. Cost directly or indirectly associated to the acquisition of the organ,
iv. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

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

II.9. Guaranteed Cumulative Bonus:

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

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

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

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

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

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

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

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

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

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

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

III. OPTIONAL COVERS

The following optional covers are available under the product.

III.1 Guaranteed Continuity on Deductible

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

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

Conditions:

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

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

* ManipalCigna ProHealth Insurance – Protect Plan (UIN CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us.

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

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

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

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

UIN: IRDA/NL-HLT/CTTK/P-H/V-I/390/Add on (CI)13-14

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

IV. WAITING PERIODS

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

IV.1. Pre-existing Disease Waiting Period

All Pre-existing Diseases / Illness / Injury / conditions as defined in the Policy, until 48 (as specified in the Schedule) months of continuous covers have elapsed since inception of the first Policy with Us. This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 48 months, prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break. For insured persons who have opted for 'Reduction in Pre – existing waiting period', the waiting period will be reduced to 24 months as mentioned in Section III.2.

IV.2. 30 days Waiting Period

Any disease contracted and/or Medical Expenses incurred in respect of any disease/illness by the Insured Person during the first 30 days from the inception date of the Policy will not be covered.

This exclusion doesn't apply for Insured Person having any health insurance indemnity policy in India at least for a period of 30 days prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

IV.3 Two year waiting period

A waiting period of 24 months shall apply to the treatment of the following except if arising out of an accident or proven malignancy (as specified against the ailments),whether medical or surgical, for all Medical Expenses along with their complications on treatment towards:

i. Cataract,

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

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

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

malignancy.

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

IV.4 Personal Waiting period:

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

V. PERMANENT EXCLUSIONS

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

1. Stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells.
2. Dental treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalisation or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
3. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception, surrogate or vicarious pregnancy.
5. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, cochlear implants, vaccinations except post-bite treatment or for new born baby up to 90 days, any physical, psychiatric or psychological examinations or testing , any treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall treatment & products, issue of medical certificates and examinations as to suitability for employment or travel.
6. Laser Surgery for treatment of focal error correction other than for focal error of +/- 7 or more and is medically necessary.
7. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
8. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
9. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
10. 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.
11. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
12. Treatment for developmental problems, learning difficulties, behavioural problems.
13. Treatment for general debility, ageing, convalescence, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, run down condition or rest cure, congenital external anomalies or defects, sterility, fertility, infertility including IVF and other assisted conception procedures and its complications, subfertility, impotency, venereal disease, or intentional self-injury, suicide or attempted suicide(whether sane or insane).
14. Certification / Diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven, or any form of clinical trials or any kind of self-medication and its complications.
15. Ailment requiring treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation unless arising out of use of drugs prescribed by a Medical Practitioner.
16. Any illness or hospitalisation arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
17. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics.
18. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
19. 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.
20. Any cosmetic surgery, aesthetic treatment unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/morbid obesity (unless certified to be life threatening) or treatment/surgery /complications/illness arising as a consequence thereof.
21. Any robotic, remote surgery or treatment using cyber knife.
22. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital.
23. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
24. Any form of Non-Allopathic treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine except Inpatient hospitalisation under AYUSH covered specifically under Section II.4
25. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
26. Insured Person whilst flying or taking part in aerial activities (including cabin) except as an authorised passenger in a regular scheduled airline or air Charter Company.
27. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
28. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
29. All non-medical expenses including convenience items for personal comfort, except the items covered under 'List of Non-Medical Cover' under the policy or not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized, Ambulatory devices, walker, crutches, collars, and any medical equipment that is subsequently used at home except when they form part of room expenses.

    For complete list of Non-medical expenses, Please refer to the Annexure III “List of Non-Medical Expenses”.
30. Non-Medical Expenses including RMO charges, night charges, levied by the hospital under whatever head, registration/admission charges except the items listed under 'List of Non-Medical Expenses' under the Policy.
31. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.

VI. CLAIM PROCESS & MANAGEMENT

VI.1. Condition Preceding

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

Completed claim forms and processing documents must be furnished to Us within the stipulated timelines for all reimbursement claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if You can satisfy Us that it was not reasonably possible for You to

submit / give proof within such time.

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

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

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

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

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

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

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

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

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

VI.3. Claim Intimation

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

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

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

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

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

VI.4. Cashless Facility

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

(a) For Planned Hospitalisation:

i. The Insured Person should at least 3 days prior to admission to the Hospital approach the Network Provider for Hospitalisation for medical treatment.

ii. The Network Provider will issue the request for authorization letter for Hospitalisation in the pre-authorization form prescribed by the IRDA.

iii. The Network Provider shall electronically send the pre-authorization form along with authorisation letter of the primary Insurer (with whom the insured person has availed cashless) & all the relevant details to the 24 (twenty-four) hour authorization/cashless department along with contact details of the treating Medical Practitioner and the Insured Person. The Network Provider will also send details of the policy by other Insurers.

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.

v. Wherever the information provided in the request is sufficient to ascertain the authorisation, We shall issue the authorisation Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 4 hours from the receipt of last complete documents.

vi. The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any co-pays or deductibles and non-medical items if applicable.

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

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

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

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

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

At the time of discharge:

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

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

(b) In case of Emergency Hospitalisation

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

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

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

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

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

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

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

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

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

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

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

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

VI.5. Claim Reimbursement Process

(a) Collection of Claim Documents

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

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

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

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

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

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

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

VI.6. Scrutiny of Claim Documents

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

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

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

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

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

VI.7. Claim Assessment

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

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

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

I) Deductible

ii) Sum Insured

iii) Cumulative Bonus

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

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

VI.8. Claims Investigation

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

VI.9. Pre and Post-hospitalisation claims

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

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

VI.10. Settlement including Repudiation of a claim

We shall settle or reject the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.

In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

In case of delay beyond stipulated 45 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

VI.11 Representation against Rejection:

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

VI.12. Payment Terms

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

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

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

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

VI.13. Deductible

a) Any claim towards hospitalisation during the Policy Period must be submitted to Us for assessment in accordance with the claim process laid down under Section VI.4 and Section VI.5. towards cashless or

reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the deductible, We will assess and pay such claim in accordance with Section VI.6. and VI. 7.b).

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

VII. GENERAL TERMS AND CONDITIONS

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by You or any one acting on Your behalf, under this Policy. You further understand and agree that We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

2. Material Change

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

3. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by You or any of the Insured Persons, shall be the condition precedent to Our liability under this Policy.

4. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us.

5. Change of Policyholder

The policyholder may be changed only at the time of Renewal of the Policy. The new policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The renewed Policy shall be treated as having been renewed without break.

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

6. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

7. Geography

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

8. Multiple Policies

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, We shall make the claim payments independent of payments received under other similar polices.

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

- In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- Claims under other policy/ies may be made irrespective of the exhaustion of Sum Insured in the earlier chosen policy / policies. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.
- If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
- Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalisation costs in accordance with the terms and conditions of the chosen policy.

9. Records to be maintained

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

10. Free Look period

All new individual health insurance policies issued by Us, except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and

The insured will be allowed a period of at least 15 days from the date of receipt of the policy and a period of 30 days in case of electronic policies and policies obtained through distance mode, to review the terms and conditions of the policy and to return the same if not acceptable.

If the insured has not made any claim during the free look period, the insured shall be entitled to

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

b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or; Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

11. Cancellation

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

Premium shall be refunded only if no claim has been made under the Policy and full premium has been received.

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

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

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

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

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

Cancellation of the Super Top Up policy in order to align it with the base policy will be processed on request from the Policyholder and irrespective of claim. Premium shall be refunded on pro-rata basis for the balance Policy Period. The policy, with aligned date, will be issued subject to payment of premium

applicable for Age of Insured Person as on alignment effective date. Continuity with respect to Cumulative bonus and Waiting periods shall be passed on to the policy issued, post alignment.

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

Cover may end immediately for all Insured Persons, if there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

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

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

12. Grace Period

The Policy may be renewed by mutual consent and in such an event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy for, Single, Yearly, Half-yearly and Quarterly mode of payment. Grace period of 15 days is allowed for monthly mode of payment. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

13. Renewal Terms

a. The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium

b. The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous policy expiry date and current Policy start date. We, however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.

Revival Period: For Policies other than 'Single' Premium payment modes.

Policies issued on other than single premium payment mode may be revived by mutual consent and in such an event; the revival premium should be paid to us within 15 days (for monthly mode) / 30 days for (Quarterly, Half yearly and Yearly mode).

Wherever premium is not received within the revival period of the policy, the policy will be terminated and all claims that fall beyond such instalment due date 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 instalment premium due date.

You may pay the premium through National Automated Clearing House i i i I (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.

c. Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.

d. Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.

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 approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

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

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 48/24 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 IV.1 to IV.4 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.

l. In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits in the policy will remain intact. Guaranteed Cumulative Bonus earned on the Policy will stay with the Insured under the original policy.

14. Premium calculation

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

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

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

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

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

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

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

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

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

1. Payment of premium and loading, if any.
2. Minimum premium requirement for the requested premium payment mode, if any.

3. Availability of the requested premium payment mode on the day of implementation of request.
4. Premium rates/ tables applicable for the changed premium payment mode will be the same as the premium rates/ tables applicable on the date of commencement of policy.

15. Loadings & Special Conditions

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

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

We shall inform You about the applicable risk loading or special condition through a counter offer letter and You would need to revert with consent and additional premium (if any), within 7 working days of the issuance of such counter offer letter.

In case, You neither accept the counter offer nor revert to Us within 7 working days from the last communication date, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

16. Communications & Notices

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

a. The policyholder's, at the address as specified in Schedule
b. To Us, at the address specified in the Schedule.
c. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
d. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

17. Electronic Transactions

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

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

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

18. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

19. Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

20. Portability & Continuity Benefits

You can port Your existing health insurance policy from another company to ManipalCigna Super Top Up Insurance, provided that:

a. You have been covered under an Indian retail health insurance policy from a Non-life Insurance or Health Insurance company registered with IRDAI without any break in the immediate previous policy.
b. We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of Insurance
c. If the Sum Insured under the previous Policy is higher than the Sum Insured chosen under this Policy, the applicable waiting periods shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the Eligible Cumulative Bonus under the expiring health insurance policy.
d. In case the proposed Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of sum insured and Eligible Cumulative Bonus under the expiring health insurance policy;
e. All waiting periods shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
f. If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the Eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.
g. If You were covered on an individual basis in the expiring Policy then the Eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, Eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been Renewed with the existing insurance company.

It is further agreed and understood that -

a. Portability benefit will be offered to the extent of sum of previous sum insured and accrued cumulative bonus (if opted for), and Portability shall not apply to any other additional increased Sum Insured.
b. We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in in line with our Board approved underwriting policy.
c. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation
d. We should have received the database and claim history from the previous insurance company for Your previous policy.

The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. All benefits under the Policy will terminate on successful porting of the Policy.

In case You have opted to switch to any other insurer under portability provisions and the outcome of acceptance of the portability request is awaited from the new insurer on the date of renewal,

a. We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis.
b. If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately, We may deduct the premium for the balance period and pay the balance claim amount if any and issue the Policy for the remaining period.

21. Complete Discharge

We will not be bound to take notice or be affected by any Notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to You/Insured Person or to Your Nominee/Legal Representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

22. Dispute Resolution

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

23. Grievances Redressal Procedure

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

Toll Free : 1800-102-4462

Contact No.: + 91 22 61703600

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

You may also approach the grievance cell at any of Our branches with the details of the grievance during Our working hours from Monday to Friday.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at The Grievance Cell, ManipalCigna Health Insurance Company Limited, 401/402,

Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063 or email headcustomercare@manipalcigna.com.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

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

VIII Definitions

1. **Accident** or Accidental means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** or Aged is the age last birthday, and which means completed years as at the Inception Date
3. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Annexure** means a document attached and marked as Annexure to this Policy
5. **Any one Illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment may have been taken.
6. **Associated Medical Expenses** shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/ surgeon/ anesthetist/ Specialist and diagnostic tests, excluding cost of medicine, conducted within the same Hospital where the Insured Person has been admitted.
7. **AYUSH** treatment refers to the medical and /or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.
8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
9. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.
10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

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

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

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

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

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

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

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

a. has qualified nursing staff under its employment

b. has qualified medical practitioner (s) in charge

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

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

16. **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.
17. **Dental Treatment** is a treatment carried out by a dental practitioner including examinations, fillings, (where appropriate), crowns, extractions and surgery.
18. **Disclosure to Information Norm** means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
19. **Emergency** shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a medical practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the insured person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
20. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
21. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Inception Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Period.
22. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
23. **Hospital** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:

i. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least

ii. 15 in-patient beds in all other places;

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

iv. has qualified medical practitioner(s) in charge round the clock;

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

vi. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

24. **Hospitalisation or Hospitalised** means admission in a hospital for a minimum period of 24 consecutive 'In-patient' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

25. **Illness** means sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a) **Acute condition-** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

b) **Chronic condition-** A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics:-

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups,
2. and/or tests
3. it needs on-going or long term control or relief of symptoms
4. it requires your rehabilitation or for you to be specially trained to cope with it
5. it continues indefinitely
6. it comes back or is likely to come back.

26. **Inception Date** means the Inception date of this Policy as specified in the Schedule.
27. **Injury** means accidental physical bodily harm excluding illness or

disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

28. **In-patient** means an Insured Person who is admitted to hospital and stays for at least 24 consecutive hours for the sole purpose of receiving treatment.
29. **In-patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.
30. **Insured Person** means the person(s) named in the Schedule to this Policy, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.
31. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
32. **Medical Advice** means any written consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.
33. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
34. **Medical Practitioner** - A Medical practitioner is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by Government of India or a State Governement and is and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
35. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. Is required for the medical management of the Illness or injury suffered by the Insured;
b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
c. Must have been prescribed by a Medical Practitioner.
d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the insurance company.

46. **Pre-existing Disease** Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
47. **Pre-hospitalisation Medical Expenses** Pre-hospitalisation Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:

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

48. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
49. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
50. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

i. In case where the Policy Period for 2/3 years, the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted will be available for the second/third year.
ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

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

Annexure I – Ombudsman

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, JJeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:- bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Email:- bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Fax: 0141 -Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@ecoi.co.in	West Bengal, Bihar, Sikkim, Jharkhand and Andaman and Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:- 0522-2231310 Email:- bimalokpal.lucknow@ecoi.co.inmailto:ioblko@sancharnet.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106552/6960 Fax:- 022-26106052 Email:- bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure – II:

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

Add on cover (Rider) This section lists the Add on cover available under your plan	Critical Illness UIN: IRDA/NL-HLT/CTTK/P-H/V-I/390/Add on (CI)13-14	Lump sum payment of an additional 100% of Sum Insured Opted.

Annexure III

List of Non-Medical Expenses

SNO	Item	SNO	Item
I	**TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS/SIMILAR EXPENSES**	55	HAND HOLDER
1	HAIR REMOVAL CREAM	56	HANSAPLAST/ADHESIVE BANDAGES
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	57	INFANT FOOD
3	BABY FOOD	58	SLINGS
4	BABY UTILITES CHARGES	59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES
5	BABY SET	60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.
6	BABY BOTTLES	61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
7	BRUSH		
8	COSY TOWEL	62	HORMONE REPLACEMENT THERAPY
9	HAND WASH	63	HOME VISIT CHARGES
10	MOISTURISER PASTE BRUSH	64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE
11	POWDER	65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY
12	RAZOR		
13	SHOE COVER	66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS
14	BEAUTY SERVICES	67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR
15	BELTS/ BRACES	68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES
16	BUDS	69	DONOR SCREENING CHARGES
17	BARBER CHARGES	70	ADMISSION/REGISTRATION CHARGES
18	CAPS	71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
19	COLD PACK/HOT PACK	72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED
20	CARRY BAGS		
21	CRADLE CHARGES	73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY
22	COMB		
23	DISPOSABLES RAZORS CHARGES (for site preparations)		
24	EAU-DE-COLOGNE / ROOM FRESHNERS	74	STEM CELL IMPLANTATION/ SURGERY and STORAGE
25	EYE PAD	75	WARD AND THEATRE BOOKING CHARGES
26	EYE SHEILD	76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
27	EMAIL / INTERNET CHARGES	77	MICROSCOPE COVER
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER
29	FOOT COVER	79	SURGICAL DRILL
30	GOWN	80	EYE KIT
31	LEGGINGS	81	EYE DRAPE
32	LAUNDRY CHARGES	82	X-RAY FILM
33	MINERAL WATER	83	SPUTUM CUP
34	OIL CHARGES	84	BOYLES APPARATUS CHARGES
35	SANITARY PAD	85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
36	SLIPPERS	86	ANTISEPTIC or DISINFECTANT LOTIONS
37	TELEPHONE CHARGES	87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
38	TISSUE PAPER	88	COTTON
39	TOOTH PASTE	89	COTTON BANDAGE
40	TOOTH BRUSH	90	MICROPORE/ SURGICAL TAPE
41	GUEST SERVICES	91	BLADE
42	BED PAN	92	APRON
43	BED UNDER PAD CHARGES	93	TORNIQUET
44	CAMERA COVER	94	ORTHOBUNDLE, GYNAEC BUNDLE
45	CLINIPLAST	95	URINE CONTAINER
46	CREPE BANDAGE	**II**	**ELEMENTS OF ROOM CHARGE**
47	CURAPORE	96	LUXURY TAX
48	DIAPER OF ANY TYPE	97	HVAC
49	DVD, CD CHARGES	98	HOUSE KEEPING CHARGES
50	EYELET COLLAR	99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
51	FACE MASK	100	TELEVISION & AIR CONDITIONER CHARGES
52	FLEXI MASK	101	SURCHARGES
53	GAUSE SOFT	102	ATTENDANT CHARGES
54	GAUZE	103	IM IV INJECTION CHARGES

104	CLEAN SHEET	154	MICROSHEILD
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	155	ABDOMINAL BINDER
		V	**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**
106	BLANKET/WARMER BLANKET	156	BETADINE \HYDROGEN PEROXIDE \ SPIRIT \ DISINFECTANTS ETC
III	**ADMINISTRATIVE OR NON-MEDICAL CHARGES**	157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
107	ADMISSION KIT	158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
108	BIRTH CERTIFICATE		
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	159	SUGAR FREE TABLETS
110	CERTIFICATE CHARGES	160	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
111	COURIER CHARGES		
112	CONVENYANCE CHARGES	161	DIGESTION GELS
113	DIABETIC CHART CHARGES	162	ECG ELECTRODES
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	163	GLOVES
115	DISCHARGE PROCEDURE CHARGES	164	HIV KIT
116	DAILY CHART CHARGES	165	LISTERINE/ ANTISEPTIC MOUTHWASH
117	ENTRANCE PASS / VISITORS PASS CHARGES	166	LOZENGES
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	167	MOUTH PAINT
119	FILE OPENING CHARGES	168	NEBULISATION KIT
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	169	NOVARAPID
121	MEDICAL CERTIFICATE	170	VOLINI GEL/ ANALGESIC GEL
122	MAINTENANCE CHARGES	171	ZYTEE GEL
123	MEDICAL RECORDS	172	VACCINATION CHARGES
124	PREPARATION CHARGES	**VI**	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**
125	PHOTOCOPIES CHARGES	173	AHD
126	PATIENT IDENTIFICATION BAND / NAME TAG	174	ALCOHOL SWABES
127	WASHING CHARGES	175	SCRUB SOLUTION/STERILLIUM
128	MEDICINE BOX	**VII**	**OTHERS**
129	MORTUARY CHARGES	176	VACCINE CHARGES FOR BABY
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	177	AESTHETIC TREATMENT / SURGERY
IV	**EXTERNAL DURABLE DEVICES**	178	TPA CHARGES
131	WALKING AIDS CHARGES	179	VISCO BELT CHARGES
132	BIPAP MACHINE	180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT
133	COMMODE		
134	CPAP/ CAPD EQUIPMENTS	181	EXAMINATION GLOVES
135	INFUSION PUMP - COST	182	KIDNEY TRAY
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	183	MASK
137	PULSEOXYMETER CHARGES	184	OUNCE GLASS
138	SPACER	185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
139	SPIROMETRE	186	OXYGEN MASK
140	SP 02 PROBE	187	PAPER GLOVES
141	NEBULIZER KIT	188	PELVIC TRACTION BELT
142	STEAM INHALER	189	REFERAL DOCTOR'S FEES
143	ARMSLING	190	ACCU CHECK (Glucometery/Strips)
144	THERMOMETER	191	PAN CAN
145	CERVICAL COLLAR	192	SOFNET
146	SPLINT	193	TROLLY COVER
147	DIABETIC FOOT WEAR	194	UROMETER, URINE JUG
148	KNEE BRACES (LONG/ SHORT/ HINGED)	195	AMBULANCE
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	196	TEGADERM / VASOFIX SAFETY
150	LUMBOSACRAL BELT	197	URINE BAG
151	NIMBUS BED OR WATER OR AIR BED CHARGES	198	SOFTOVAC
152	AMBULANCE COLLAR	199	STOCKINGS
153	AMBULANCE EQUIPMENT		

ManipalCigna Critical Illness Add On Cover

Terms and Conditions

I. General Provisions

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

II. Definitions

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

a) Cancer of Specified Severity

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

The following are excluded -

1. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
2. Any skin cancer other than invasive malignant melanoma
3. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
4. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
5. Chronic lymphocytic leukaemia less than RAI stage 3
6. Microcarcinoma of the bladder
7. All tumours in the presence of HIV infection.

b) First Heart Attack of Specified Severity

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

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

The following are excluded:

1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
2. Other acute Coronary Syndromes
3. Any type of angina pectoris.

c) Open Chest CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

Excluded are:

1. Angioplasty and/or any other intra-arterial procedures
2. Any key-hole or laser surgery.

d) Open Heart Replacement or Repair of Heart Valves

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

e) Coma of Specified Severity

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

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

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

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

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

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

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

i) Permanent Paralysis of Limbs

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

j) Motor Neurone Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

1. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

3. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

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

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

III. Coverage

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

i. Cancer of specific severity

ii. First Heart Attack of specified severity

iii. Open Chest CABG

iv. Open Heart Replacement or Repair of Heart Valves

v. Coma of specified severity

vi. Kidney Failure requiring regular dialysis

vii. Stroke resulting in permanent symptoms

viii. Major Organ/Bone Marrow Transplant

ix. Permanent Paralysis of Limbs

x. Motor Neurone Disease with permanent symptoms

xi. Multiple Sclerosis with persisting symptoms

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

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

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

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

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

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

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

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

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

IV. Waiting Periods

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

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

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

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

V. Survival Period

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

VI. Cancellations

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

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

1 Year		2 year	
Policy in force upto	Premium Refund %	Policy in force upto	Premium Refund %
1 Month	75%	1 Month	87.5%
3 months	50%	3 months	75%
6 months	25%	6 months	62.5%
More than	NIL	12 months	50%
6 months		15 months	37.50%
		18 months	25%
		Above 18 months	NIL

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

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

VII. Permanent Exclusions

1. We shall not be liable to make any payment under this Add On Cover, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:
2. Any Illness, sickness or disease, other than specified as Critical Illness, as mentioned in the Schedule;
3. Any Critical Illness directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases/ illness/ injury caused by and/or related to HIV;
4. Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen;
5. Any Critical Illness directly or indirectly caused due to Intentional self-injury, suicide or attempted suicide.
6. Any treatment/ surgery for change of sex or any cosmetic surgery or treatment/ surgery/ complications/ illness arising as a consequence thereof;
7. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power;
8. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
9. Congenital anomalies or any complications or conditions arising therefrom;
10. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation;
11. Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy;

12. Any Critical Illness based on Certification/ Diagnosis/ Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven or any kind of self-medication and its complications;
13. Cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs, or treatment of an optional nature;
14. Any critical illness arising or resulting from the Proposer or any of his family members committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion;
15. In the event of death of the Insured within the stipulated survival period applicable under each category.

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

VIII Claim Process:

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

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

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

   In the unfortunate event of the death of the insured person post the survival period, someone claiming on his behalf must inform us in writing immediately.

Manipal Cigna
Health Insurance

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

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