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MANIPALCIGNA SARVAH - UTTAM

(PROSPECTUS)

What are the Key Highlights of the Policy?

BASIC COVERS
- In-patient Hospitalization
- Day Care Treatment
- Pre-hospitalization Medical Expenses
- Post-hospitalization Medical Expenses
- Domiciliary Hospitalization
- Road Ambulance
- Donor Expenses
- AYUSH Treatment

OPTIONAL COVERS
- Personal Accident Cover
  - Accidental Death (AD)
  - Permanent Total Disablement (PTD)
  - Permanent Partial Disablement (PPD)
- Temporary Total Disablement (TTD)
- Health Check Up
- Air Ambulance
- Restoration of Sum Insured
- Gullak (Guaranteed Cumulative Bonus)
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  - Twin Sharing AC Room
- Maternity & New Born Hospitalization Expenses
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  - New Born Baby Expenses
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- Surplus Benefit
- Anant
- Deductible
  - Aggregate Deductible
  - Daily Deductible
- Voluntary Co-Payment
- Coverage for Non-Medical Items and Durable Medical Equipment's
  - Non-Medical Items
  - Durable Medical Equipment

VALUE ADDED COVERS
- Tele-Consultation
- Wellness Program
- Discount from Network Providers

ADD-ON/RIDER COVER
- ManipalCigna Health 360-OPD

What are the Basic covers?

1. In-Patient Hospitalization

We will cover medical expenses of an Insured Person in case of medically necessary hospitalization arising from a disease/Illness or injury when the Insured person is admitted as an In-patient for more than 24 consecutive hours provided that the admission date of the Hospitalization is within the Policy Year. The coverage will include reasonable and customary charges towards room rent for accommodation in a hospital room up the category specified in Policy Schedule, charges for accommodation in Intensive Care Unit (ICU), operation theatre charges, fees of medical practitioner and Surgeon, anaesthetist, qualified nurses, specialists, the cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner that are used intra operatively during a surgical procedure.

Room category coverage under this plan will be up to Single Private AC Room or as specified in Policy Schedule, subject to a maximum of the Sum Insured opted. For ICU accommodation, we will cover up to the Sum Insured opted.

If the Insured Person is admitted to a room category higher than the one specified in the Policy Schedule, the Policyholder/Insured Person shall bear a ratable proportion of the total Associated Medical Expenses (including surcharge or taxes) in proportion to the difference between the room rent of the entitled room category and the room rent actually incurred.

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

The following procedures will be covered (wherever medically indicated) either as In-patient or Day Care Treatment in a Hospital, up to the limit specified in the Policy Schedule within a Policy Year:

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

Medical Expenses incurred for the Medically Necessary Treatment of the Insured Person for In-patient Hospitalization arising from or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), any mutant derivative or variations thereof, Sexually Transmitted Diseases (STD), will be covered up to the Sum Insured as specified in the Policy Schedule. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, as amended from time to time. The necessity of Hospitalization must be certified by an authorized Medical Practitioner.

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

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition

F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F10	Alcohol related disorders
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

2. Day Care Treatment

We will cover the payment of medical expenses for an Insured Person in the case of medically necessary day care treatment or surgery that requires less than 24 hours of hospitalization due to advancement in technology. This treatment must be undertaken in a Hospital, Nursing Home or Day Care Centre on the recommendation of a medical practitioner. We will not cover any OPD Treatment and diagnostic service under this benefit. Coverage will also include pre and post hospitalization medical expenses as specified in Policy Schedule of this Policy.

3. Pre-hospitalization Medical Expenses

We will reimburse medical expenses incurred by an Insured person due to disease, injury or illness that occurs during the Policy Year. This reimbursement is for expenses incurred immediately prior to hospitalization, up to the limits specified in the Policy Schedule, subject to a claim being admitted as In-patient Hospitalization or Day Care Treatment, and provided the expenses are related to the same illness or condition.

4. Post-hospitalization Medical Expenses

We will reimburse medical expenses incurred by an Insured person due to disease, injury, or illness that occurs during the Policy Year, immediately following discharge from the hospital, up to the limits specified in the Policy Schedule. This is subject to a claim being admitted as In-patient Hospitalization or Day Care Treatment, and provided the expenses are related to the same illness or condition.

5. Domiciliary Hospitalization

We will cover medical expenses of an Insured person, up to the limit specified in the Policy Schedule, for the treatment of a disease, illness, or injury that would normally require hospitalization but is treated at home on the advice of the attending Medical Practitioners, where the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable, provided that the condition requires continues treatment for at least 3 days. Claims for Pre-hospitalization and Post-hospitalization medical expense are covered up to 30 days each. We shall not be liable under this policy for any claim in connection with or in respect of the following:

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

6. Road Ambulance

We will cover the reasonable and customary expenses incurred for road transportation of an Insured person by registered healthcare or ambulance service provider to the nearest hospital for the treatment of an illness or injury covered under the Policy in case of emergency. The coverage will be up to the Sum Insured as specified in Policy Schedule. This benefit will be applicable per hospitalization, and the necessity must be certified by the attending Medical Practitioner.

7. Donor Expenses

We will cover In-patient hospitalization medical expenses for the donor for harvesting the organ in the case of a major organ transplant if it is in accordance with the Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules. The organ donated must be for the use of the Insured person as per Medical Advice, and a claim must have been admitted under In-patient hospitalization. We will also cover Pre and Post hospitalization medical expenses up to 30 days each, the cost of donor screening for a successful organ transplant surgery, and any complication in respect of the donor, consequent to harvesting, which arise during hospitalization or up to 30 days from the date of discharge of the donor, up to the limits specified in the Policy Schedule for the Policy Year. However, we will not cover expenses for the donor associated with the acquisition of the organ.

8. AYUSH Treatment

We will cover the Medical Expenses incurred during the Policy Year, up to the Sum Insured as specified in the Policy Schedule, for an Insured Person in case of Medically Necessary Treatment taken as In-patient Hospitalization or Day Care Treatment for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that the Insured Person has undergone treatment in an AYUSH Hospital or AYUSH Day Care Centre.

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

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

III. What are the Value Added Covers?

1. Tele-Consultation

Insured Person may avail tele-consultations with our General Physician through our network in India for the unlimited times.

For the purpose of this benefit, tele-consultation shall mean consultation provided by a Medical Practitioner through various mode of communication available through tele/chat mode.

2. Wellness Program

You can earn reward points by participating in Our Healthy Life Management Program wherein you need to complete number of steps per day, as outlined in the table below that will help you to improve your well-being and earn rewards.

Healthy Life Management Program - Rewards Structure				
	No. of steps			
No. of days	**10,000 steps and above per day**	**8,000 - 9,999 steps per day**	**6,000 - 7,999 steps per day**	**Less than 6,000 steps per day**
240 days and above	20%	15%	10%	Nil
180 - 239 days	15%	10%	5%	Nil
120 - 179 days	10%	5%	Nil	Nil

Conditions under this benefit:

i. The number of days specified in the table above should fall within the first nine (9) months of each Policy Year. Activities undertaken towards this benefit during the last three (3) months of the Policy Year will not be considered for reward calculation.

ii. This wellness program is available only for the adult members aged 18 years and above. However, in a floater policy, this program shall be available only to the independent adult members and will not be available to dependent children.

iii. In an Individual Policy with one or more members, earning reward points will be at member level, where each member can earn up to 20% of their respective expiring base premium according to the applicable terms and conditions. In a floater policy, earning reward points will be at policy level, where all eligible members cumulatively can earn a maximum up to 20% of the expiring base premium according to the applicable terms and conditions.

iv. In a floater policy the above reward percentage would be divided among the eligible Adult Insured members as per the illustration below.

In a floater policy, the reward percentage would be divided as per the number of eligible Adults covered.
For Example
In a 2A+2C policy, the Healthy Life Management Program shall be applicable for 2A only. Assuming Adult 1 attains a score of 10,000 steps per day for a period of 240 days and Adult 2 attains a score of 6000 steps per day for a period of 240 days.
The reward points shall be calculated as per the below:
Adult 1: 20% / 2 = 10%
Adult 2: 10% / 2 = 5%
Hence, the total earned reward points would be 10% + 5% = 15% of the existing Policy premium (Excluding optional cover/ Rider and taxes).

v. No reward points will be allocated for any count of steps per day for a period of less than 120 days.

vi. The maximum reward points that can be earned in a single Policy Year will be limited to 20% of the premium paid (excluding premium for Optional covers other than 'Deductible' under section IV.12, 'Voluntary Co-Payment' under section IV.13 and Twin sharing room option of 'Room Rent Modification' under section IV.9, riders and taxes) in the existing Policy. In the case of 2 or 3 year policies, the maximum reward points that can be earned shall not exceed 20% of the total premium paid (excluding premium for Optional covers other than 'Deductible' under section IV.12, 'Voluntary Co-Payment' under section IV.13 and Twin sharing room option of 'Room Rent Modification' under section IV.9, riders and taxes) for 2 years or 3 years as applicable.

vii. Each earned reward point will be valued at 1 Rupee. Accrued rewards can be redeemed against payable premium (excluding premium for Optional covers, Riders and Taxes) from the 1st Renewal of the Policy.

viii. The earned reward points can be utilized as a discount in the renewal premium due immediately after accrual. Carry forward earned reward points shall not be allowed.

ix. Redemption against renewal premium will be available only at the time such renewal is due. Any earned rewards will lapse at the end of the Grace Period if the Policy is not renewed with us.

Refer Annexure- A below on the Illustration of Reward Points.

Annexure - A - Illustration of Healthy Life Management Program Rewards

Reduction of Renewal Policy Year

Policy Term - 3 years
(Premium indicated here is just for illustration purposes in case of 1 Adult policy and may not be the actual premium.)
Each earned reward point will be valued at 1 Rupee

Year	Premium (Excluding optional covers/ Rider and taxes)	Activity	No. of Days	Reward %	Reward Points Earned
Year 1	10000	10,000 and above steps/day	240 days and above	20%	2000
Year 2	11000	8,000 - 9,999 steps/day	240 days and above	15%	1650
Year 3	12000	6,000 - 7,999 steps/day	240 days and above	10%	1200
Total	33000				4850

The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium
Renewal of Policy as per below table

If Renewed Policy Term is	Renewal Premium (Excluding optional covers, Rider and taxes)	Reward discount utilized	Renewal Premium Payable after adjusting Reward discount

	1 Year Policy	13000	1617 (4850*1/3 as Insured is renewing 3 Year policy to 1 Year Policy)			11383
	2 Years Policy	27000	3233 (4850*2/3 as Insured renewing 3 Year policy to 2 Year Policy)			23767
	3 Years Policy	42000	4850 (Insured renewing to the same policy tenure of 3 years)			37150
Increase of Renewal Policy Year	**Policy Term - 1 year** (Premium indicated here is just for illustration purposes and may not be the actual premium.) Each earned reward point will be valued at 1 Rupee					
	Year	Premium paid (Excluding optional cover, Rider and taxes)	Activity	No. of Days	Rewards %	Points Earned
	Year 1	10000	6,000 - 7,999 steps / day	180 - 239 days	5%	500
	Total	10000				500
	The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium **Renewal of Policy as per below table**					
	If Renewed Policy Term is	Renewal Premium (Excluding optional cover, Rider and taxes)	Rewards discount utilized			Renewal Premium Payable after adjusting Rewards discount
	1 Year Policy	11000	500 (as Insured is renewing 1 Year policy to 1 Year Policy)			10500
	2 Year Policy	21000	500 (as Insured is renewing 1 Year policy to 2 Year Policy)			20500
	3 Year Policy	33000	500 (as Insured is renewing 1 Year policy to 3 Year Policy)			32500

Notifications related to wellness program will be communicated via SMS, email and the program- specific phone/ web application. Details about reward points will be available on the program app (if any) or would be shared through SMS and/or Renewal Notice which would be sent to customers.

3. Discount from Network Providers

The Insured Person can avail discounts on diagnostics, pharmacy and health supplements offered through our Network Providers.

IV. What are the Optional Covers?

1. Personal Accident Cover

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and if such Injury solely and directly results in the Insured Person's death or disablement within 365 days of the Accident, We will pay the corresponding benefits as specified below to You, the Insured Person, or the Nominee, as applicable.

1.1. Accidental Death

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and if such Injury results in the death of the Insured Person within 365 days from the date of the Accident, We will pay:

- 100% of the opted Sum Insured as specified in the Policy Schedule.
- 200% of the opted Sum Insured if such death occurs while the Insured Person is a fare-paying passenger on a common carrier.

Once a claim has been accepted and paid under this benefit, cover will automatically terminate for that Insured Person.

1.2. Permanent Total Disablement (PTD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Total Disablement as specified in the table below within 365 days from the date of the Accident, We will pay:

- 100% of the opted Sum Insured as specified in the Policy Schedule.
- 200% of the opted Sum Insured if such Permanent Total Disablement occurs while the Insured Person is a fare-paying passenger on a common carrier.

Type of Permanent Total Disablement
i. Total and irrecoverable loss of sight of both eyes
ii. Loss by physical separation or total and permanent loss of use of both hands or both feet
iii. Loss by physical separation or total and permanent loss of use of one hand and one foot
iv. Total and irrecoverable loss of sight of one eye and loss of a Limb
v. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
vi. Total and irrecoverable loss of hearing of both ears and loss of speech
vii. Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
viii. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment, occupation, or business for remuneration or profit, resulting in "Loss of Independent Living" (Refer section C.II.14 of Policy Wordings)

For the purpose of this benefit:

- **"Limb"** means a hand at or above the wrist or a foot above the ankle.
- **"Physical separation of one hand or foot"** means separation at or above wrist and/or at or above ankle, respectively.

The benefits specified above will be payable provided that:

a. The Permanent Total Disablement is proven to Our satisfaction; and a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and

b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement, and We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

c. If the Insured Person dies before a claim has been admitted under this benefit, then no amount will be payable under this benefit; however, it will be payable under 'Accidental Death' under section IV.1.1 above, provided it is payable as per the coverage under section IV.1 and such intimation of death has been made to Us.

d. If We have admitted a claim for Permanent Total Disablement in accordance with this benefit, then We shall not be liable to make any payment under

the Policy on the death of the Insured Person if the Insured Person subsequently dies.

e. Once a claim has been accepted and paid under this benefit, cover under this Policy shall immediately and automatically cease for that Insured Person.

1.3. Permanent Partial Disablement (PPD)

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and such Injury results in Permanent Partial Disablement as specified in the table below within 365 days from the date of the Accident, We will pay the amount specified in the table below:

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

The benefits specified above will be payable provided that:

a. The Permanent Partial Disablement is proven to Our satisfaction; and a disability certificate issued by a Civil Surgeon or the equivalent appointed by the District/State or Government Board; and

b. The Permanent Partial Disablement continues for a period of at least 180 days from the commencement, and We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

c. If the Insured Person dies before a claim has been admitted under this benefit, then no amount will be payable under this benefit; however, it will be payable under 'Accidental Death' under section IV.1.1 above, provided it is payable as per the coverage under section IV.1 and such intimation of death has been made to Us.

d. In case the Insured Person suffers a loss not mentioned in the table above, then Our medical advisors will determine the degree of disablement and the amount payable, if any.

e. We will not make any payment under Permanent Partial Disability if We have already paid or accepted any claims under 'Permanent Total Disability' under section IV.1.2 and 'Permanent Partial Disability' under section IV.1.3 in respect of the Insured Person, and the total amount paid or payable under those claims is cumulatively greater than or equal to the opted Sum Insured for that Insured Person.

f. Once a claim has been accepted and paid under this benefit, cover under this Policy shall be reduced to the extent of payment made under Permanent Partial Disability for that Insured Person.

Notes:

i. At least one earning member must be covered if Personal Accident cover is opted.

ii. Selection of this cover will be available at member level on an individual basis.

iii. Claims under Accidental Death, Permanent Total Disablement, and Permanent Partial Disablement shall be subject to claims within India.

iv. In the event of death or discontinuation of the earning member, 'Personal Accident Cover' would be allowed to continue for non-earning member at the time of Renewal.

v. If non-earning spouse and/or dependent children or dependent parents or dependent parent-in-law of the Proposer are covered under this Optional Cover, then the coverage amount for them will be as follows:

   a) For non-earning spouse/live-in partner: 60% of the coverage amount chosen for the Proposer.

   b) For per dependent child/dependent parents/dependent parent-in-law: 30% of the coverage amount chosen for the Proposer, subject to maximum of ₹30 Lacs.

2. Temporary Total Disablement (TTD)

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and if such injury solely and directly results in the Temporary Total Disablement of the Insured Person immediately after the Accident, We will pay a fixed benefit amount as specified in the Policy Schedule of this policy per week. This benefit will be paid for the duration of the Temporary Total Disablement.

For the purpose of this benefit, 'Temporary Total Disablement' means a disablement of an Insured Person such that he or she is totally disabled from engaging in any employment, occupation, or business for remuneration or profit, or unable to perform his or her duties of any description whatsoever on a temporary basis and a disability certificate is issued by the treating Doctor or Civil Surgeon or the equivalent appointed by the District/State or Government Board.

Note:

i. TTD benefit can only be opted if the 'Personal Accident Cover' (Section IV.1) is opted.

ii. TTD benefit is available only for the earning member in the Policy.

iii. We shall not be liable to make payments under this benefit for more than a total of 100 weeks in respect of any one Injury, calculated from the date of commencement of the Temporary Total Disablement.

iv. If the Insured Person is disabled for part of the week, then only a proportionate part of the weekly benefit will be payable.

3. Health Check-up

We provide a comprehensive Health Check-Up to all Insured Persons covered as adults (excluding dependent children in floater policy), as listed in the eligibility table below. Health Check-Ups are available irrespective of their claim status under the Policy and will be arranged by us at our Network Providers.

In the case of an individual policy covering more than one member, upon each member attaining 18 years of age, they become eligible for a health check-up with our Network Provider.

Health Check Up				
			List of tests - Cashless	
Package	**Sum Insured**	**Age group**	**Compulsory Tests**	**Optional Tests (Any one)**
1	₹5 Lacs	Upto 40 Years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring – ECG or B2 - Liver screening - SGOT and SGPT
		Above 40 years	CBC-ESR, FBS, Lipid Profile, Sr. Creatinine	B1 - Heart monitoring – ECG or B2 - Liver screening - SGOT and SGPT or B3 - Thyroid Screening - Thyroid profile or B4 - Diabetes screening - HbA1c
2	₹7.5 Lacs, ₹10 Lacs,	Upto 40 Years	ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, USG - Abdomen & pelvis	
		Above 40 years	ECG, FBS, Lipid Profile, Sr. Creatinine, CBC-ESR, SGOT, SGPT, GGT, TSH, HbA1c, USG Abdomen & Pelvis, PSA (for Males), Mammogram/ PAP Smear (for females)	
3	> ₹10 Lacs	Upto 40 Years	FBS, Kidney Profile, ECG, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, USG Abdomen & Pelvis, Vitamin D3, Vitamin B12	
		Above 40 years	FBS, ECG, HbA1C, Kidney Profile, CBC-ESR, Lipid Profile, Liver Profile, Thyroid Profile, 2D-Echo, PSA (for Males)/ Mammogram/ PAP Smear (for females), USG Abdomen & Pelvis, Vitamin D3, Vitamin B12	

Full explanation of Tests is provided here:

FBS – Fasting Blood Sugar, ECG – Electrocardiogram, CBC-ESR – Complete Blood Count-Erythrocyte Sedimentation Rate, Sr. Creatinine – Serum Creatinine, HbA1c – Glycosylated Hemoglobin, SGOT – Serum Glutamate oxaloacetate transaminase, SGPT – Serum Glutamate Pyruvate Transaminase, GGT – Gamma Glutamyl Transferase, TMT – Tread Mill Test, PSA – Prostate Specific Antigen, USG – Ultrasound Sonography, TSH – Thyroid Stimulating Hormone, CBC – Complete Blood Count.

Note:

i. This benefit is available once in a Policy Year, including the first Policy Year.

ii. All the tests must be conducted on the same date.

iii. Original copies of all reports will be provided to You.

iv. We shall cover health check-up on a cashless basis only.

v. This benefit will not be available during the free look period of the Policy.

4. Air Ambulance

We will reimburse the Reasonable and Customary expenses incurred for the transportation of an Insured Person to the nearest Hospital or for moving the Insured Person to and from healthcare facilities within India by an Air Ambulance, provided that:

i. The Air Ambulance is used in the case of an Emergency life threatening health condition of the Insured Person, which requires immediate and rapid ambulance transportation to the Hospital or a medical centre that ground transportation cannot provide;

ii. The Illness/ Injury causing the Emergency is covered under Section II.1 'In-patient Hospitalization';

iii. The transportation is provided by a medically equipped aircraft that can provide medical care in flight and should have medical equipment to monitor vitals and treat the Insured Person suffering from an Illness/Injury, including but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;

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

v. The Air Ambulance service is offered by a Registered Ambulance service provider;

vi. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the need for an Air Ambulance;

vii. Payment under this cover is subject to a claim being admissible under Section II.1 'In-patient Hospitalization' or Section II.2 'Day Care Treatment', for the same Illness/Injury.

The benefit under this cover is payable up to the limits specified in the Policy Schedule, subject to a maximum of ₹10 Lacs in a Policy Year, and this is over and above the Sum Insured.

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

5. Restoration of Sum Insured

We will provide a 100% restoration of the Sum Insured any number of times in a Policy Year, whether the illness/condition is unrelated or the same, provided that:

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted & earned), is insufficient as a result of previous claims in that Policy Year.

ii. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under section II of the Policy and shall not apply to the first claim in the Policy Year. Restoration of the Sum Insured will only be provided for coverage under section II.1 'In-patient Hospitalization', section II.2 'Day Care Treatment', section II.3 'Pre-Hospitalization Medical Expenses', section II.4 'Post-Hospitalization Medical Expenses', section II.6 'Road Ambulance', section II.7 'Donor Expenses', section II.8 'AYUSH Treatment' and section IV.13 'Coverage overage for Non-Medical Items and Durable Medical Equipment's' (if opted).

iii. The Restored Sum Insured will not be considered while calculating the Guaranteed Cumulative Bonus (Gullak if opted).

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

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

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

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

a) Sum Insured

b) Guaranteed Cumulative Bonus (Gullak if opted and earned)

c) Surplus Benefit (Applicable for 1st Claim if opted)

d) Restored Sum Insured (if opted)

6. Gullak (Guaranteed Cumulative Bonus)

We will increase Your Sum Insured by 100% as specified in the Policy Schedule at the end of the Policy Year, provided the Policy is renewed with Us without any break.

Note:

i. No Guaranteed Cumulative Bonus (Gullak Amount) will be added if the Policy is not renewed with us by the end of the Grace Period.

ii. The Guaranteed Cumulative Bonus (Gullak Amount) will not exceed 1000% of the Sum Insured under the Current Policy with Us under any circumstances.

iii. Any Guaranteed Cumulative Bonus (Gullak Amount) accrued for a Policy Year will be credited at the end of that Policy Year if the Policy is renewed with Us within the Grace period. It will be available for claims made in the subsequent Policy Year.

iv. Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and the expiring Policy is renewed with Us on a Family Floater basis, the Guaranteed Cumulative Bonus (Gullak Amount) carried forward to the renewed policy will be lowest percentage of the Guaranteed Cumulative Bonus (Gullak Amount) applicable to the lowest Sum Insured of the last policy year amongst all the expiring polices being merged.

v. Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies, the Guaranteed Cumulative Bonus (Gullak Amount) will be apportioned to the Renewed Policies in proportion to the Sum Insured of each Renewed Policy.

vi. Reduction in Sum Insured: If the Sum Insured is reduced at the time of Renewal, the applicable Guaranteed Cumulative Bonus (Gullak Amount) will be calculated on the revised Sum Insured on pro-rata basis.

vii. Increase in Sum Insured: If the Sum Insured under the Policy is increased at the time of Renewal, the Guaranteed Cumulative Bonus (Gullak Amount) will be calculated on the Sum Insured of the last completed Policy Year.

viii. If You choose to opt out from this Optional Cover at the time of Policy renewal, then the accumulated Guaranteed Cumulative Bonus balance (Gullak balance Amount) under the expiring Policy shall be forfeited.

ix. This Guaranteed Cumulative Bonus (Gullak Amount) shall not be available for claims made for Value Added Covers (Section III), for coverage under section IV.7 'Maternity & New Born Hospitalization Expenses' if opted and coverage under section IV.4 'Air Ambulance Cover' if opted.

7. Maternity & New Born Hospitalization Expenses

7.1. Maternity Expenses

We will cover Maternity Expenses up to the Maternity Sum Insured as specified in the Policy Schedule for the delivery of a child and/ or Maternity Expenses incurred during the Policy Year, related to a Medically Necessary and lawful termination of pregnancy, up to maximum 2 deliveries or terminations during the lifetime of an Insured Person.

You understand and agree that:

i. Our maximum liability per delivery or termination is subject to the Maternity Sum Insured specified in the Policy Schedule.

ii. The female adult Insured Person should have been continuously covered under the Policy for at least 36 months before availing this benefit.

iii. Payment towards any admitted claim under this benefit for any complication arising out of or as a consequence of maternity or child birth will be restricted to Maternity Sum Insured specified in the Policy Schedule. Any restored amount will not be available for coverage under this section.

iv. Pre or post-natal Maternity Expenses will be covered within the Maternity Sum Insured under this benefit.

v. The Maternity Sum Insured available will be in addition to the base Sum Insured.

vi. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.

vii. The following expenses will not be covered under Maternity Benefit:

   a. Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.

   b. Medical Expenses for ectopic pregnancy, however, these expenses will be covered under the 'In-patient Hospitalization' of base cover under section II.1.

viii. Exclusion VII.i.15 shall not apply to this cover subject to terms and conditions under this benefit.

ix. For the purpose this benefit, the birth of twin children shall be considered as single event.

In Individual policies, we can offer Maternity Expenses to an Adult Insured Male member as well. However, a claim under this benefit shall be payable to the female spouse upon adding them as an Insured in the Policy. In such cases, the applicable waiting period shall be as per the first inception of the policy.

7.2. New Born Baby Expenses

Subject to a claim being admitted under Maternity Cover under Section IV.7.1, We will cover:

i. Medical Expenses for the treatment of the New Born Baby while the Insured Person is hospitalized as an In-patient for delivery.

ii. The Reasonable and Customary Charges incurred on the New Born Baby during and post birth, up to 90 days from the date of delivery, within the limits specified in the Policy Schedule under Maternity Expenses without payment of any additional premium.

iii. Any restored Sum Insured will not be available for coverage under this section.

iv. Subject to the underwriting and the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days upon payment of requisite premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

v. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.

7.3 First Year Vaccinations

We will cover Reasonable and Customary charges for vaccination expenses for the New Born Baby as per National Immunization Scheme (India) listed below, until the baby completes 1 year (12 months) within the limits specified in the Policy Schedule under Maternity Expenses without payment of any additional premium. In case the Policy ends before the New Born Baby has completed 1 year (12 months), the coverage under this benefit shall continue subject to the Policy being renewed in the subsequent year. Any restored Sum Insured will not be available for coverage under this section.

Time Interval	Vaccinations to be done (Age)	Frequency
0 - 3 months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2

3 - 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis - B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

8. Sarathi

If the Insured Person has opted for this Optional Cover, any condition, illness, complication or ailment arising out of any of the below mentioned conditions declared and accepted as part of a Pre-Existing Disease shall not be subject to the Pre-Existing Disease waiting period. These condition will be covered after the first 30 days from the Inception Date of the first policy with Us.

i. Asthma
ii. Diabetes
iii. Dyslipidemia
iv. Obesity
v. Hypertension

Note - This optional cover is available only during the first Policy Year and cannot be availed during renewal. Once this optional cover is opted for, it cannot be opted out in the subsequent renewal.

9. Room Rent Modification

We offer the option to modify the room category limit covered under 'In-patient Hospitalization' to either "Any Room" or "Twin Sharing AC room" as per your choice. This coverage will be provided up the Sum Insured specified in the Policy schedule of this Policy.

For ICU accommodation, coverage will continue to be provided up the Sum Insured.

10. Surplus Benefit

We offer an option to avail an additional amount equal to the opted Sum Insured as specified in the Policy Schedule for the first claim in every Policy Year, provided that:

i. The Sum Insured, inclusive of Guaranteed Cumulative Bonus (Gullak if opted and earned) is insufficient for the first claim in every Policy Year.
ii. The Surplus Benefit will not be considered while calculating Guaranteed Cumulative Bonus (Gullak if opted and earned).
iii. If the Policy is issued on a floater basis, the Surplus Benefit will also be available on floater basis.
iv. Any unutilized Surplus Benefit after the first claim of every Policy Year shall not be carried forward to subsequent claims in the same Policy Year or next Policy Year.

11. Anant

If the Insured person opts for this optional cover, in the event of any hospitalization related to Cancer, Heart, Stroke, or Major Organ/Bone Marrow Transplant, as defined in the Policy Wordings, we will cover all medical expenses incurred under section II.1 "Inpatient Hospitalisation", Section II.2 "Day Care Treatment", and Section II.8 "AYUSH Treatment" without any Sum Insured limit.

Note:

i. This optional cover can be opted at the first policy purchase with Us and cannot be opted at subsequent renewal.
ii. Available with Base Sum Insured ₹10 Lacs and above.
iii. Once this optional cover is opted, it cannot be opted out in subsequent renewal, irrespective of any claim made in the expiring policy.
iv. This benefit will be applied at the policy level irrespective of policy type.
v. This optional cover will be available once in a policy year for a floater policy and once in a policy year for each insured under an Individual or Multi Individual policy.
vi. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.
vii. Sequence of utilization will be as follows:
    a. Base Sum Insured
    b. Guaranteed Cumulative Bonus (Gullak if opted and earned)
    c. Surplus Benefit (If Opted)
    d. Restoration of Sum Insured(If Opted)
    e. Anant (Utilized toward balance claim amount incurred towards II.1 "Inpatient Hospitalization", Section II.2 "Day Care Treatment", and Section II.8 "AYUSH Treatment")

12. Deductible

You can opt for a Deductible as specified in the Policy Schedule. There are 2 types of Deductible options available:

a. Aggregate Deductible - When an Aggregate Deductible is selected, the deductible amount will be applied for each Policy Year on the aggregate of all claims in that Policy Year.

b. Daily Deductible - When a Daily Deductible is selected, the deductible amount will be applied per day of Hospitalization on all admissible claims.

Note:

i. The Deductible can be opted-in or opted out at Inception or during Renewal of the Policy.
ii. Opting out of the Deductible may be subject to underwriting.
iii. For Aggregate deductible other than ₹10,000 or ₹25,000, if the insured opt out during any renewal, a fresh waiting period will be applied for this enhanced limit from the effective date of such enhancement.
iv. Any Voluntary Co-Payment shall not apply to plans with Deductible options.
v. Deductible opted shall apply on all claims other than mentioned under section IV.1 'Personal Accident Cover', section IV.2 'Temporary Total Disablement', section IV.3 Health Check-up, section IV.4 'Air Ambulance' and Value Added Cover (section III).

13. Voluntary Co-Payment

Irrespective of the Age and number of claims made by the Insured Person and subject to the Co-payment option chosen by You, it is agreed that We will only pay 90% or 80% or 70% of any amount that We assess (payable amount) for the payment or reimbursement in respect of any claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.

Voluntary Co-payment shall apply to all sections other than mentioned under section IV.1 'Personal Accident Cover', section IV.2 'Temporary Total

Disablement', section IV.3, 'Health Check-Ups' section IV.4 'Air Ambulance' and Value Added Cover (section III).

Voluntary Co-Payment if opted shall apply in addition to any other co-payment applicable in this Policy.

14. Coverage for Non-Medical Items and Durable Medical Equipment's

14.1.Non-Medical Items

The cover is available subject to the claim being admissible under 'In-patient Hospitalization' under section II.1 or 'Day Care Treatment' under section II.2 or 'Domiciliary Hospitalization' under section II.5, and the expenses on Non-Medical Items are related to the same illness/injury.

Note:

i. Exclusion with respect to any of the Non-Medical Items listed in Annexure III List-1 shall not be applicable for this benefit.

ii. Any claim made under this cover will reduce the Sum Insured of the Policy.

iii. Exclusion under section VII.v.28 shall not apply to this cover subject to terms and conditions under this benefit

14.2. Durable Medical Equipment

We will cover the expenses towards the cost of buying or renting Durable Medical Equipment as listed below, provided the same is prescribed to the Insured Person by the treating Medical Practitioner during or after Hospitalization for medically necessary treatment.

The cover is available subject to below conditions:

i. The Hospitalization claim is admissible under section II.1 'In-patient Hospitalization' or under section II.2 'Day Care Treatment' or under section II.5 'Domiciliary Hospitalization' under the base Policy, and the expenses on Durable Medical Equipment are related to the same Illness/ Injury.

ii. The need for Durable Medical Equipment is prescribed by an authorised Medical Practitioner during Hospitalization or within 30 days post discharge of the insured from the hospital.

iii. Any purchase/renting of the Durable Medical Equipment should be done within 30 days of such recommendation.

iv. Exclusion VII.v.19 shall not apply to this cover subject to terms and conditions under this benefit.

v. For the purpose of this benefit, Durable Medical Equipment shall mean -

Sr. No	List of Durable Medical Equipment
1	CPAP machine
2	BPAP machine
3	Ventilator
4	Wheelchair
5	Prosthetic device
6	Suction Machine
7	Commode Chairs
8	Infusion pump
9	Continuous Passive motion devices in case of Knee Replacement
10	Oxygen concentrator

Note:

i. For this cover, a Prosthetic device means an externally applied device used to replace wholly or partly an absent or deficient body part (limited to arm or leg or auditory system).

ii. Benefit under this cover is payable up to a maximum of ₹1 Lac in a Policy Year.

iii. Any claim made under this cover will reduce the Sum Insured of the Policy.

V. Add-on/Rider Cover

ManipalCigna Health 360-OPD

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

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

VI. What are Features of the Policy?

1. Eligibility

The minimum entry age under this policy is 91 days for children and 18 years for adults. There is no maximum limit for entry under this policy.

Coverage for children:

a. Children from 91 days to 17 years will only be covered if one of the parents is the proposer.

b. Children up to 30 years can be covered under the floater.

c. Children beyond 30 years can be covered under an individual policy.

2. Individual and Family Floater

The policy can be purchased on an Individual/ Multi-Individual basis or a Family floater basis.

a. In case of an Individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, legally wedded spouse, live-in partner, children, father, mother, father-in-law, mother-in-law, Son-in-law, Daughter-in-law, Grand-parents, Grandchildren, Uncle, Aunt, Nephew, Niece, Brother, Sister, Sister in-law, Brother in-law.

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, legally married spouse or live-in-partner, dependent children (naturally/legally adopted) up to the age of 30 years, parents or parents-in-law. A floater cover can cover a maximum of 2 adults and 3 children's under a single policy.

3. Policy Period option

You can buy the policy for 1, 2 or 3 continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the inception date of the policy.

4. Plan & Sum Insured Options

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

Plan Name	Sum Insured
UTTAM	₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs, ₹100 Lacs, ₹200 Lacs, ₹300 Lacs

5. Discounts under the Policy

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

Lifetime Discounts		
a.	Early Renewal Discount OR Standing Instruction Discount	Early Renewal Discount - You can receive a 2.5% discount on the Renewal premium if the Policy is renewed 30 days before the Policy expiry date. OR Standing Instruction Discount - 2.5% discount on the renewal premium, if the renewal premium is received through standing instruction. **Note -** Early Renewal Discount and Standing Instruction Discount are mutually exclusive, only one of these discount can be applied at given point in time.
b.	Long Term Policy Discount	Long term discount of 7.5% for selecting a 2 year Policy and 10% for selecting a 3 year Policy. This discount is available only with 'Single' Premium Payment mode.
c.	Family Discount	10% discount on the premium is applicable for covering 2 members under the same individual Policy on Multi-Individual basis.
d.	Website Discount	5% discount would be offered if the policy is purchased directly from the insurer website without any intermediary involved.
e.	Employee Discount	10% discount on the premium
Short Term Discounts		
a.	1st Policy Renewal Discount	5% discount on your first policy renewal premium.
a.	Worksite Marketing Discount	A discount of 10% will be available on polices which are sourced through worksite marketing channel. Discount would be applicable once only at inception of the Policy.
b.	Discount in lieu of Commission	Maximum discount up to 15% will be provided on premium once only at inception of the Policy, in case the intermediary forgoes their commission.
Note - i. Website Discount, Employee Discount, Worksite Marketing Discount and Discount in lieu of commission are mutually exclusive. ii. Maximum discount in a single policy shall not exceed 40%.		

6. Underwriting Loading & Special Conditions

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

We may apply a specific sub-limit on a medical condition/ailment depending on your medical history and declarations or an additional waiting periods (a maximum of 36 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.

We will inform you about the applicable risk loading or special condition through a counter offer letter or through an electronic mode, as the case may be. We will only issue the Policy once we receive your consent and the applicable premium within the duration specified in the counter offer letter.

7. Premium Calculation and Premium Payment Mode

Premium will be calculated based on the Sum Insured opted, Age, risk classification, optional cover selected, family combination and zone classification. Zone classification will be based on Proposer's city-location pin code as mentioned in CKYC document.

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

Premium can be paid on Single, Half yearly, Quarterly and Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy by sending a request at least one month in advance.

Change in premium payment mode is subject to:

i. Payment of premium and loading, if any.

ii. Minimum premium requirement for the requested premium payment mode, if any.

iii. Availability of the requested premium payment mode on the day of implementation of request.

iv. 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.

Note - Instalment facility shall not be available for the policy tenure more than 1 year.

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

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

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

<u>Zone Classification</u>

Identification of Zone will be based on Proposer's city-location pin code as mentioned in CKYC documents.

Zone	Region / District / State
Zone 1	**Delhi & NCR** **Districts in Gujarat:** Ahmedabad, Gandhinagar, Surat, Vadodara **Districts in Maharashtra:** Mumbai, Thane, Navi Mumbai **Districts in Andhra Pradesh /Telangana:** Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal **Districts in Uttar Pradesh:** Mathura, Jyotiba Fule Nagar (Amroha), Aligarh **Districts in Punjab:** Amritsar, Gurdaspur **Others:** Kolkata, Rewari, Jind, Jhunjhunu, Patna

Zone 2	**Rest of the Bihar State** **Districts in Andhra Pradesh / Telangana:** Ananthapur, Bapatla, Gadwal, Guntur, Jagtial, Kamareddy, Karimnagar, Kurnool, Mahabubnagar, Mancherial, Medak, Nalgonda, Nellore, Nizamabad, Peddapalli, Rangareddy, Suryapet, Wanaparthy **Districts in Punjab:** Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, Mohali, Patiala **Districts in Maharashtra:** Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad **Districts in Uttar Pradesh:** Banda, Fatehpur, Kanpur **Others: C**hennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad
Zone 3	**Assam State, Daman & Diu UT, Dadara & Nagar Haveli UT, Rest of Andhra Pradesh State, Rest of Telangana State, Rest of Gujarat State, Rest of Haryana State** **Districts in Karnataka:** Chikkamagaluru, Dakshina kannada, Chikkaballapur, Kolar, Tumakuru, Udupi **Districts in Rajasthan:** Ajmer, Dausa, Dholpur, Jaipur, Karauli, Sawai madhopur, Tonk, **Districts in Tamilnadu:** Coimbatore, Erode, Kanchipuram, Karur, Krishnagiri, Tiruppur, Tiruvallur **Others:** Dehradun, Raipur
Zone 4	**Rest of India**

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

8. Renewal of Policy

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

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

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the grace period of 30 days, to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

A. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.

b. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.

c. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure of material facts by You.

d. Where We have discontinued or withdrawn this product/plan You will have the option to 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.

e. Insured Person shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

f. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

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

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

i. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 36 consecutive months as applicable to the relevant waiting periods of this Policy.

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 VII.(i) to VII (iv) will be applicable considering such Policy Year as the first year of Policy with the Company.

j. Applicable Guaranteed Cumulative Bonus (Gullak If opted and earned) shall be accrued at the end Policy year as per eligibility under the Policy.

k. In case of floater policies, children attaining 31 years at the time of Renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Guaranteed Cumulative Bonus (Gullak if opted and earned) on the Policy will stay with the floater cover

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

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

- Grace Period of 15 days for Monthly mode and 30 days for Half-Yearly & Quarterly mode would be given to pay the instalment premium due for the Policy.
- If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.
- The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- No interest will be charged if the instalment premium is not paid on due date.
- Wherever premium is not received within the grace period of the policy, the policy will be terminated from the date on which such grace period is over to pay the premium and all claims that fall beyond such grace period shall not be covered as part of the policy. However, we will be liable to pay in respect of all claims where the treatment/admission/accident has commenced/occurred before the expiry of such grace period for the payment of instalment premium.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

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

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

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

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

v. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination

of the policy.

9. Income Tax benefit

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

10. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

11. Free-look Period

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

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

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

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

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

12. Cancellations

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

A. Policy Tenure of 1 Year:

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

Illustration:

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

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

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

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

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

B. If Policy Tenure is more than 1 year:

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

Illustration:

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

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

Premium Refund	88.92 (100*650/731)

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

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

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

13. Endorsements

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

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

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not change Zone)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer
- Change in Nominee Details

b) Financial Endorsements - which result in alteration in premium

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

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

14. Redressal of Grievance

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

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

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

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

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

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

or

Email: headcustomercare@manipalcigna.com.

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

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

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

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

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

15. Pre-Policy Medical Check-up

Pre-policy medical check-up may be required based on optional cover(s) chosen, Sum Insured, Age and/or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. Full cost of all such tests will be borne by Us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer We will bear only 50% of the cost for such tests.

16. Migration:

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

17. Portability:

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire Policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Portability.

18. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

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

19. Moratorium Period

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

VII. What are the Waiting Period and Exclusions?

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

i. Pre-existing Disease - Code - Excl. 01

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Policy with Insurer.

b. In case of enhancement of Sum Insured, the exclusion shall apply afresh to the extent of Sum Insured increase.

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

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

ii. Specified disease/procedure Waiting Period - Code - Excl. 02

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

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

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

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

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

f. List of specific diseases/procedures:

a) Cataract,

b) Endometriosis, Dilatation and curettage, Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus or myomectomy for fibroids unless necessitated by malignancy,

c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal, Removal of Implants and all diseases of Ligament, tendon, meniscal tear (other than caused by accident or malignancy).

d) Varicose Veins and Varicose Ulcers,

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

f) Benign Prostate Hypertrophy, all types of Hydrocele,

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

h) 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.

i) 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,

j) 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 Policy Schedule shall apply.

iii. 30 Days Waiting Period - Code - Excl. 03

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

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

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

iv. Personal Waiting period:

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

v. Permanent Exclusions

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

1. Investigation & Evaluation- Code- Excl 04

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

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

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

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

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

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

3. Obesity/ Weight Control: Code - Excl 06

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

a) Surgery to be conducted is upon the advice of the Doctor

b) The surgery/Procedure conducted should be supported by clinical protocols

c) The member has to be 18 years of age or older and

d) Body Mass Index (BMI);

   a. greater than or equal to 40 or

   b. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:

      i. Obesity-related cardiomyopathy

      ii. Coronary heart disease

      iii. Severe Sleep Apnea

      iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: Code - Excl 07

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

5. Cosmetic or Plastic Surgery: Code - Excl 08

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

6. Hazardous or Adventure sports: Code - Excl 09

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

7. Breach of law: Code - Excl 10

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

8. Excluded Providers: Code - Excl 11

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

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

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

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

12. Refractive Error: Code - Excl 15

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

13. Unproven Treatments: Code - Excl 16

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

14. Sterility and Infertility: Code - Excl 17

Expenses related to sterility and infertility. This includes:

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

15. Maternity: Code - Excl 18

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

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

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

18. Multifocal lens for cataract.

19. 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.

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

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

22. 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

23. Treatment received outside the geographical limits of India.

24. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body subject to conditions mentioned in II.7 'Organ Donor'.

25. Any form of Non-Allopathic treatment (except AYUSH Treatment), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

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

27. All expenses 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), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

28. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized-belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment. For complete list of Non-medical expenses, please refer to the Annexure III List - I "Items for which Coverage is not available in the Policy" of Policy Wordings subject to conditions mentioned in section IV.14 'Coverage for Non-Medical Items and Durable Medical Equipment's'.

29. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Policy Schedule.

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

VIII. How can I buy the Policy?

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

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

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

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

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

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

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

IX. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable

and necessary. The cost of such examination will be borne by Us.

- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

b) Claim Process

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

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

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

For a Cashless Claim -

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

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

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

For a Reimbursement Claim -

The following claim documents should reach us not later than 15 days from the date of discharge from Hospital -

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

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

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

X. What are the Plans Benefit Details?

The benefit details are as mentioned below:

<table>
<tr><td>Title</td><td colspan="2">Description
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></td><td>Relationship Covered</td><td>Individual: Self, legally married spouse or live-in partner, son, daughter, father/ mother/ father-in-law/ mother-in-law/ son-in-law/ daughter-in-law/ grand-parents/ grandchildren/ uncle/ aunt/ nephew/ niece/ brother/ sister/ sister in-law/ brother in-law.
Floater: Self, legally married spouse or live-in partner, dependent children (natural / legally adopted), dependent parents/ parents-in-law</td></tr>
<tr><td>Your Coverage Details:</td><td>Identify your Plan</td><td>ManipalCigna Sarvah - Uttam</td></tr>
<tr><td rowspan="10">Basic Cover

This section lists the Basic benefits available on your plan
Basic Cover</td><td>Identify your Opted Sum Insured (in ₹)</td><td>₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs, ₹100 Lacs, ₹200 Lacs, ₹300 Lacs</td></tr>
<tr><td>In-patient Hospitalization (When you are hospitalized)</td><td>Covered up to Sum Insured
Room Rent: Covered up to Single Private AC Room
For ICU - Covered up to Sum Insured
This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments: Up to Sum Insured
b. HIV/AIDS & STD: Up to Sum Insured
c. Mental Illness: Up to Sum Insured
For ICD Codes mentioned below: Waiting Period of 24 months shall apply
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F10</td><td>Alcohol related disorders</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table></td></tr>
<tr><td>Day Care Treatment</td><td>All Day Care Procedure related to specified disease/illness, covered up to Sum Insured.</td></tr>
<tr><td>Pre - hospitalization Medical Expenses</td><td>Medical Expenses covered up to 90 days before the date of hospitalization; covered up to the Sum Insured</td></tr>
<tr><td>Post - hospitalization Medical Expenses</td><td>Medical Expenses covered up to 180 days post discharge from the hospital; covered up to the Sum Insured</td></tr>
<tr><td>Domiciliary Hospitalization (Treatment at Home)</td><td>Covered up to the Sum Insured
Pre and Post Hospitalization Expenses: 30 days each</td></tr>
<tr><td>Road Ambulance (Reimbursement of Ambulance Expenses)</td><td>Covered up to the Sum Insured</td></tr>
<tr><td>Donor Expenses (Hospitalization Expenses of the donor providing the organ)</td><td>Covered up to the Sum Insured
• Pre & Post Hospitalization expenses (Up to 30 days each) of the donor
• Cost towards donor screening once in a Policy year for successful transplant
• Complications arising during hospitalization or up to 30 days from date of discharge - Covered up to 25% of SI subject to maximum of ₹2 Lacs, Over and above SI
We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.</td></tr>
<tr><td>AYUSH Treatment</td><td>Covered up to the Sum Insured</td></tr>
</table>

<table>
<tr><td rowspan="3">Value Added Covers

This section lists the additional value added benefits that are available along with your plan</td><td>Tele-Consultation</td><td>Unlimited Tele-consultation with General Physician during the Policy Year</td></tr>
<tr><td>Wellness Program</td><td>Rewards can be earned by completing activities specified under Our Healthy Life Management Program up to maximum of 20% of expiring base Premium (excluding Premium for optional covers other than Deductible, Voluntary Co-Payment, Twin Sharing, Rider and taxes).
These earned Reward Points can be used as premium discount from 1st Renewal of the Policy.
Carry forward of earned Reward Points shall not be allowed.</td></tr>
<tr><td>Discount from Network Provider</td><td>Discount on Pharmacy, Diagnostics and Health Supplements offered by the Network Providers of ManipalCigna Health Insurance Company Limited</td></tr>
<tr><td rowspan="6">Optional Covers

This section lists the available optional covers under your plan and the limits under each of these options</td><td>Personal Accident Cover</td><td>Coverage under this option is available on Individual and Family Basis.
Min Age at Entry - 5 Years, Max Age at Entry 65 Years.
Relationships Covered - Self, Lawfully Wedded Spouse/Live-in Partner, Dependent Children, Dependent Parents/Parent in laws
Individual Sum Insured - ₹10L, ₹15L, ₹20L, ₹25L, ₹30L, ₹40L, ₹50L, ₹1Cr, ₹2Cr, ₹3Cr
Family Cover Sum Insured Eligibility
<table><tr><td>Earning Member</td><td>As per the Sum Insured Opted</td></tr><tr><td>Non-earning Spouse/ Live-in Partner</td><td>60% of the Sum Insured of Earning member</td></tr><tr><td>Dependent Children /Parents/Parents-in-Laws</td><td>30% of the Sum Insured, max up to ₹30Lacs</td></tr></table><table><tr><td>Age wise</td><td>Eligibility of Sum Insured will be up to a maximum times of Annual Income of the Proposer or Earning member to be Insured. (as detailed below)</td></tr><tr><td>18-45</td><td rowspan="2">Max 20 times of the Gainful Annual Income</td></tr><tr><td>46- 60</td></tr><tr><td>>60 above</td><td>Max 10 times of the Gainful Annual Income</td></tr></table>Note:
i. At least one earning member must be covered if Personal Accident Cover is opted.
ii. Coverage of 200% of the opted Sum Insured if such Accidental Death or Permanent Total Disablement occurs while the Insured Person is a fare-paying passenger on a common carrier.
iii. In the event of death or discontinuation of the earning member, Personal Accident coverage would be allowed to continue for non-earning member at the time of Renewal.</td></tr>
<tr><td>Temporary Total Disablement (TTD)</td><td>If the Insured Person suffers an injury due to an accident that occurs during the policy period and such Injury results in the Temporary Total Disablement of the Insured Person immediately after an Accident, We will pay fixed weekly benefit for the duration of the TTD.
<table><tr><td>Coverage Options</td></tr><tr><td>₹5K, ₹10K, ₹15K, ₹20K, ₹25K, ₹50K, ₹1L per week.</td></tr></table>Note:
ii. Max No. of Weeks Covered - 100 in respect of any one Injury calculated from the date of commencement of the Temporary Total Disablement.
iii. Available only if Personal Accident Cover is opted.
iv. TTD Cover is available only for the earning members in the Policy.</td></tr>
<tr><td>Health Check Up</td><td>Available each policy year (including the first year), to all Adult insured persons who have completed 18 years of Age.
• For Sum Insured of ₹5 lacs: Package 1
• For Sum Insured ₹7.5 lacs and ₹10 lacs: Package 2
• For Sum Insured above ₹10 lacs: Package 3
The packages shall be offered on cashless basis only.</td></tr>
<tr><td>Air Ambulance</td><td>Covered up to Sum Insured subject to maximum of ₹10 Lacs in addition to the base Sum Insured, for expenses incurred on Air Ambulance</td></tr>
<tr><td>Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)</td><td>Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, in addition to the base Sum Insured
Applicable for below covers only
1. D.I.1 - In-patient Hospitalization
2. D.I.2 - Day Care Treatment
3. D.I.3 - Pre - hospitalization Medical Expenses
4. D.I.4 - Post - hospitalization Medical Expenses
5. D.I.6 - Road Ambulance
6. D.I.7 - Donor Expenses
7. D.I.8 - AYUSH Treatment
Restoration shall not get triggered for the 1st claim.</td></tr>
<tr><td>Gullak (Guaranteed Cumulative Bonus)</td><td>We will provide an option to policyholder to get Guaranteed increase 100% of Sum Insured for each policy year up to the maximum of 1,000% of Sum Insured irrespective of any claim made in the previous Policy Year.</td></tr>
</table>

	Maternity & New Born Hospitalization Expenses	**Maternity & New Born Hospitalization Expenses** **a. Maternity Cover** (up to maximum 2 deliveries or terminations) - Covered up to 20% of Sum Insured opted subject to a maximum of ₹5 Lac in addition to the Sum Insured opted. **b. New Born Baby** Coverage for the In-patient Hospitalization expenses of a new born up to the limit provided under Maternity Expenses. **c. First Year Vaccination** Covered as per national immunization program, up to the limit provided under Maternity Expenses. In Individual policies, we will offer Maternity Expenses to Adult Insured Male member as well. However, claim under this benefit shall be payable to the female spouse upon adding them as an Insured in the Policy. In such cases the applicable waiting period shall be as per the first inception of the Policy. **Note:** i. The female adult Insured Person should have been covered under the base Policy & Maternity Expenses for at least 36 months before availing this benefit. ii. The payment towards any admitted claim will be restricted to Maternity Sum Insured however any restored amount (if applicable) will not be available for coverage under this section. iii. Voluntary Co-Payment or Deductible (if opted) shall also apply to this benefit.
	Sarathi	If the Insured Person has opted for this optional cover and for any condition or illness, complication or ailment arising out of any of the below mentioned conditions declared and accepted as a part of Pre-existing disease, the same shall not be considered as part of Pre-existing disease waiting period. Wherein, they shall be covered after the first 30 days from the Inception Date of first policy with Us. i. Asthma ii. Diabetes iii. Dyslipidemia iv. Obesity v. Hypertension **Note -** This optional cover is available only during the First Policy Year and not available during renewal. Once Opted cannot be opted out in the subsequent renewal.
	Room Rent Modification	The Insured Person shall be eligible to modify the room type category eligibility under the Policy as follows: **Option 1:** Any room; ICU Up to Sum Insured or **Option 2:** Twin Sharing AC room; ICU Up to Sum Insured
	Surplus Benefit	Additional 100% of Sum Insured, available from day 1 for 1st claim only, in each policy year.
	Anant	Unlimited Coverage for Hospitalization related to Cancer, Heart condition, Stroke or Major Organ/ Bone Marrow Transplant under In-patient Treatment, Day Care Procedure, or AYUSH Treatment. **Note:** i. This optional cover is available only for base Sum Insured ₹10Lac and above. ii. This optional cover is available only during the first policy year and cannot be availed during renewal. iii. Once opted for, this cover cannot be opted out of in subsequent renewal.
	Deductible Option	Insured has option to choose either **Option 1 -** Aggregate Deductible of ₹10K, ₹25K , ₹50K, ₹1L, ₹2 L, ₹3L, ₹4L , ₹5L, ₹10L or **Option 2 -** Per Day Deductible of ₹1K, ₹2K, ₹3K, ₹4K or ₹5K per day of Hospitalization on all admissible claims.
	Voluntary Co-Payment	Options of 10%, 20% or 30% will be applicable on each and every claim
	Coverage for Non-Medical Items and Durable Medical Equipment	**1. Non-Medical Items** Non-Medical items covered up to the Sum Insured opted under the base policy, in case of In-patient Hospitalization or Day Care Treatment or Domically hospitalization. **2. Durable Medical Equipment** Durable Medical Equipment up to ₹1 Lac in case, prescribed during hospitalization or within 30 days post-discharge. (CPAP Machine, BPAP Machine, Ventilator, Wheelchair, Prosthetic Device, Suction Machine, Commode Chairs, Infusion Pump, Continuous Passive Motion Devices In Case Of Knee Replacement, Oxygen Concentrator)
Add on cover (Rider) This section lists the Add on cover available under your plan	ManipalCigna Health 360 - OPD	Coverage available for OPD as per package opted.

Disclaimer:

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

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

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

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

Insurance is a subject matter of solicitation.

Annexure:

Illustration of Benefits

Rate Charts