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

ManipalCigna Health Insurance

MANIPALCIGNA SUPER TOP UP
PROSPECTUS

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

I. What are the Key Highlights of the Policy?

Basic Covers
- Inpatient Hospitalisation
- Pre-hospitalisation
- Post-hospitalisation
- Inpatient hospitalisation for AYUSH Cover
- Day care Treatment
- Non – medical expenses Cover
- Ambulance Cover
- Donor Expenses

Value Added Covers
- Guaranteed Cumulative Bonus

Optional Covers
- Guaranteed Continuity on Deductible
- Reduction in Pre-existing disease waiting period

Discounts
- Family discount
- Long term discount
- Worksite marketing discount
- Online Renewal discount

II. What are the Basic covers?

i) Inpatient Hospitalisation

We will cover medical expenses in case of medically necessary hospitalisation of an Insured person incurred due to Disease, Illness or Injury when the Insured person is admitted as an in-patient for more than 24 consecutive hours provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year. The coverage will include Reasonable and Customary charges towards Room Rent for accommodation in a hospital, charges for accommodation in Intensive Care Unit, operation theatre charges, fees of medical practitioner, anaesthetist, qualified nurses, specialists, the cost of diagnostic tests, medicines, drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending medical practitioner that are used intra operatively during a surgical procedure.

Medical Expenses related to any admission (under In-patient Hospitalisation or Day Care Treatment) primarily for enteral feedings will be covered maximum up to 7 days in a Policy Year, provided it is Medically Necessary and is prescribed by a Medical Practitioner.

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

Medical expenses related to HIV/AIDS will be covered up to the Sum Insured with a maximum limit of Rs. 2 lacs per Policy year, after a waiting period of 2 years.

Under Hospitalisation expenses, we will cover the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Hospitalisation Expenses and the necessity being certified by an authorised Medical Practitioner. Benefit under this cover is payable, maximum up to the Sum Insured.

ii) Pre - hospitalisation

We will cover Medical Expenses of an Insured person due to a Disease or Injury or Illness that occurs during the Policy Year incurred immediately prior to hospitalisation, up to the limits specified under the Policy subject to a claim being admissible under Inpatient Hospitalisation and expenses are related to the same illness/condition.

iii) Post - hospitalisation

We will cover Medical Expenses of an Insured person incurred post hospitalisation due to a Disease or Injury or Illness that occurs during the Policy Year up to the limits specified under the Policy subject to a claim being admissible under In-patient Hospitalisation and expenses are related to the same illness/condition.

iv) Inpatient hospitalisation for AYUSH Cover

We will cover the Medical Expenses incurred during the Policy Year in case of Medically Necessary Treatment taken during Inpatient Hospitalisation for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

1. The Insured Person has undergone AYUSH Treatment in a AYUSH Hospital ; where an AYUSH hospital is a healthcare facility wherein medical/ surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospitals attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/ Central Council of Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      a. Having at least 5 in-patient beds;
      b. Having qualified AYUSH Medical Practitioner in charge round the clock;
      c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      d. Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

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

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

v) Day Care Treatment

We will cover payment of Medical Expenses of an Insured Person in case of Medically Necessary day care treatment or surgery that requires less than 24 hours hospitalisation due to advancement in technology and which is undertaken in a hospital / nursing home/day care centre on the recommendation of a medical practitioner. Any treatment in an outpatient department (OPD) is not covered. Coverage will also include pre-post hospitalisation expenses as available under the Plan opted.

vi) Non – medical expenses Cover

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

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

vii) Road Ambulance Cover

We will cover the Reasonable and Customary expenses incurred for transportation of an Insured person by road ambulance service provider to the hospital for treatment covered under the Policy following an emergency, requiring the Insured Person's admission to a Hospital. Necessity for road ambulance must be certified by the attending Medical Practitioner.

viii) Donor Expenses

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

However, Pre-Post hospitalisation expenses towards the donor, cost towards donor screening, cost directly or indirectly associated to the acquisition of the organ or any other medical treatment for the donor consequent on the harvesting will not be covered.

ix) Guaranteed Cumulative Bonus:

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

- Cumulative bonus will be calculated on sum insured excluding any bonus.
- No cumulative bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.
- The Cumulative Bonus will not be accumulated in excess of 50% of the Sum Insured under the current Policy with Us under any circumstances.
- Wherever the earned cumulative bonus is used for payment of a claim during a particular policy year, any earned Cumulative Bonus will not be reduced for claims made in the future.
- Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of that Policy Year if the policy is renewed with us within grace period and will be available for any claims made in the subsequent Policy Year.
- Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last policy year amongst all the expiring polices being merged.
- Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies then the Cumulative Bonus shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.
- Increase in Sum Insured: If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
- This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section VII.11

III. What are the Optional Covers?

The following optional covers are available under the product.

i) Guaranteed Continuity on Deductible

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

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

Conditions:

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

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

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

ii) Reduction in pre-existing disease waiting period

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

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

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

UIN: MCIHLIP21128V022021

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

IV. What are Features of the Policy?

i) Eligibility

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

Coverage for children:

a. Children from 91 days to 18 years will only be covered if one of the parents is the proposer.
b. Children up to 23 years can be covered under the floater.
c. Children beyond 23 years can be covered under an individual policy.

Renewals will be available for lifetime.

ii) Individual and Family Floater

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

a. In case of an Individual policy, each Insured person under the policy will have a separate Sum Insured for them. Individual plan can be bought for self, lawfully wedded spouse, children, parents, siblings, parent in laws, grandparents and grandchildren, son in-law and daughter in-law, uncle, aunty, nephew & niece.

b. In case of a floater cover, one family will share a single Sum Insured as opted. A floater plan can cover self, lawfully wedded spouse, children up to the age of 23 years or parents. A floater cover can cover a maximum of 2 adults and 3 children under a single policy.

iii) Policy Period option

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

iv) Plan & Sum Insured Options

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

Plus		Select	
Deductible (INR in Lacs)	Sum Insured (INR in Lacs)	Deductible (INR in Lacs)	Sum Insured (INR in Lacs)
3, 3.5	3, 6	1	1, 2,4
4, 4.5	4, 8	2, 2.5	2, 4,5
5, 5.5	5, 10, 15, 20	3, 3.5	3, 6,10
7.5	10, 15, 20	4, 4.5	4, 8,15
10	10, 20, 30	5, 7.5	5, 10, 15, 20
-	-	10	10, 20, 30

v) Discounts under the Policy

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

a. Family Discount - Discount of 10% on the premium for covering 2 or more members under the same Policy under the individual policy option.

b. Long Term Policy Discount - Long term discount, on the premium, of 7.5% for selecting a 2 year policy term and 10% for selecting 3 year policy term. The discount is available only with 'Single' premium payment mode.

c. Worksite Marketing Discount – A discount of 10%, on the premium, will be available on polices which are sourced through worksite marketing channel.

d. Online Renewal Discount: Discount of 3% on the premium from next renewal, if the premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card).

Discount under v (a) is applicable only to individual policies. All discounts under v (b), (c) and (d) are available to both individual as well as floater policies. Maximum discount and rebate applicable on a single policy shall not exceed 30%.

Family Discount, Long Term Discount, Worksite Marketing Discount and Online Renewal discount is applied on the total Policy premium excluding statutory levis and taxes which is the sum total of individual premium for Family policies.

vi) Underwriting Loading & Special Conditions

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

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

We shall inform You about the applicable risk loading or special condition through a counter offer letter or through electronic mode, as the case may be and You would need to revert with consent and additional premium (if any), within the duration specified in the counter offer.

In case, You neither accept the counter offer nor revert to Us within the specified duration, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

vii) Premiums

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

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

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

viii) Premium payment mode

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

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

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

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

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

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

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

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

ix) Renewal Terms

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

- Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.
- 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.
- We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums 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.
- Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes of Sum Insured or addition/deletion of members, addition deletion of Medical Condition existing prior to policy inception, on renewal. The terms and conditions of the existing policy will not be altered.
- 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.
- Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 48/24 consecutive months as applicable to the relevant waiting periods of the Plan opted.
- 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 V will be applicable considering such Policy Year as the first year of Policy with the Company.
- Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the plan opted.
- In case of floater policies, children attaining 24 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits on the policy will remain intact. Guaranteed Cumulative Bonus earned on the Policy will stay with the Insured under the original Policy.

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

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

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

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

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

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.

x) 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 45 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.

For Detailed Guidelines on Portability, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020 and Schedule I of IRDAI (health insurance) Regulations 2016 for the Portability norms.

xi) 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).

xii) 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 at least fifteen 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) a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or;

b) where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or;

c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

xiii) Cancellation

The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

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

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

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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.

Policy Alignment:

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

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

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

Cancellation of the Super Top Up policy in order to align it with the base policy will be processed on request from the Policyholder and irrespective of claim. Premium shall be refunded on pro-rata basis for the balance Policy Period. The policy, with aligned date, will be issued subject to payment of premium applicable for Age of Insured Person as on alignment effective date. Continuity with respect to Cumulative bonus and Waiting periods shall be passed on to the policy issued, post alignment.

xiv) 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
- Change in the correspondence address of the Proposer
- 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)
- 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.

xv) Redressal of Grievance

In case of any grievance, the Insured Person may contact the Company through:

Our website: www.manipalcigna.com

Email: customercare@manipalcigna.com

Toll Free : 1800-102-4462

Contact No : + 91 22 61703600

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

Insured Person may also approach the grievance cell at any of company's branches with the details of 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, (formerly known as CignaTTK Health Insurance Company Limited), 401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai-400063, 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 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 the Ombudsman offices are provided on Our Website.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

xvi) Pre-Policy Medical Check-up

We will require You to undergo a medical check-up based on Your Age, Plan and the Sum Insured opted as provided in the grid below. Wherever any pre-existing disease or any other adverse medical history is declared, we may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age/ Sum Insured/Plan opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You.

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

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

Plan Name	Sum Insured (Lacs)	Age Group (years)	Medical Tests
Plus & Select	1 L to 30 L	Up to 55	No Test
		56 - 65	Tele UW
		>65	Medical Test (Set 14 - MER, CBC-ESR, FBS, Lipid Profile, Sr. Creatinine, ECG)

The above grid is indicative and we may in our sole discretion add, modify or amend this on approval from the Head of Underwriting.

xvii) 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.

For Detailed Guidelines on Migration, kindly refer IRDAI Guidelines Ref No: IRDAI/HLT/REG/CIR/003/01/2020.

xviii) Moratorium Period:

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

V. What are the Waiting Period and Exclusions?

We shall not be liable to make any payment for any claim directly or indirectly 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 waiting Period Code – Excl-01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months (24 months, if Reduction in Pre-existing disease waiting period, if opted) of continuous coverage after the date of inception of the first policy with us.

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

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

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

ii. 30 day waiting period Code – Excl 03

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

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

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

iii. Two Year waiting period (Specified disease/procedure waiting period) Code- Excl-02

1. 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.
2. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
3. 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.
4. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
5. 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.
6. List of specific diseases/procedures provided under 'Specified disease/procedure Waiting period'
   a. Cataract,
   b. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
   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 Inter-vertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylitis, Spondylolisthesis, Congenital Internal,
   d. Varicose Veins and Varicose Ulcers,
   e. Stones in the urinary uro-genital and biliary systems including calculus diseases,
   f. Benign Prostate Hypertrophy, all types of Hydrocele,
   g. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids 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 tumour s/skin tumour s, 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 then they will have to be covered after the pre-existing disease waiting period of 48 months or as opted.

iv. Personal Waiting period:

A special waiting period not exceeding 48 months, may be applied to individual Insured persons for the list of acceptable Medical Ailments listed under Section IV.6.,Underwriting Loading & Special Conditions, depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule and will be applied only after receiving Your specific consent.

v. Permanent Exclusions

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

1. Investigation & Evaluation- Code- Excl 04
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
2. Rest Cure, rehabilitation and respite care- Code- Excl 05
   a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.
      This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
3. Obesity/ Weight Control: Code- Excl 06

   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1. Surgery to be conducted is upon the advice of the Doctor
   2. The surgery/Procedure conducted should be supported by clinical protocols

3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea
   iv. Uncontrolled Type2 Diabetes

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

   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery: Code- Excl 08

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

6. Hazardous or Adventure sports: Code- Excl 09

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

7. Breach of law: Code- Excl 10

   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. (e.g. Intentional self-Injury, suicide or attempted suicide (whether sane or insane).

8. Excluded Providers: Code- Excl 11

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

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl 12
10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13
11. Dietary supplements and 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 hospitalisation 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 hospitalisation) 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, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalisation or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
17. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

    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.

18. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
19. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
20. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.
21. Any form of Non-Allopathic treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine except Inpatient hospitalisation under AYUSH covered specifically under Section II.4.
22. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
23. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
24. Any deductible amount or percentage of admissible claim under co-pay if applicable and as specified in the Schedule to this Policy.
25. External Congenital Anomaly or defects, inherited disorders or any complications or conditions arising therefrom including any developmental conditions of the Insured Person.
26. For complete list of non-medical items, please refer to the Annexure III, list I of "Non Payable Items" and also on Our website.
27. Existing diseases disclosed by the Insured Person (Limited to the extent of the ICD Codes mentioned in line with Chapter IV, Guidelines on Standardization of Exclusions in Health Insurance Contracts, 2019), provided the same is applied at the underwriting and consented by You/ Insured Person.

VI. How can I buy the Policy?

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

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

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

Step 4: If You are required to undergo medicals tests as per the chosen Sum Insured and Age band, we would arrange the medical check-up's 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 with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to You within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by Us.

Where a proposal deposit is refundable to a prospect under any circumstances, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

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 and refund any premium collected.

VII. What is the Claim Process?

a) Duties of the claimant

- You must Intimate and submit a claim in accordance with the Claim Process defined in the Policy
- You must follow the advice provided by a Medical Practitioner.
- You must upon Our request, submit Yourself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
- Provide Us with complete documentation and information that We have requested to establish admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

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
- Estimate length of stay
- Estimate hospital bill
- Any other information as requested by Us

For a Cashless Claim -

In case of Planned Hospitalisation - at least 3 days prior to the planned date of admission.

In case of Emergency Hospitalisation - within 48 hours of such admission.

Cashless facility is available only at Our Network Hospital. 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
- Original pre-authorisation request
- Copy of pre-authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Hospital attested Discharge/Death Summary
- Operation Theatre Notes(if any)
- Hospital attested, hospital main bill and break up bill
- Hospital attested Investigation Reports, X Ray, MRI, CT Films, HPE
- Doctors Reference Slips for Investigations/Pharmacy
- Hospital attested Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if any)
- KYC documents (Photo ID proof, address proof, recent passport size photograph)
- Doctors Reference Slips for Investigations/Pharmacy
- Original Settlement letter from the primary Insurer
- In case of base claim with some other insurer, we would require, Insurer or TPA attested copies of documents.
- Cancelled cheque for NEFT payment

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

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

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

Cashless and Reimbursement Claim processing and access to network hospitals is through our service partner/TPA, details of the same will be available on our website as also provided to you along with the Policy documents. The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on Our website. Wherever a TPA is used, the TPA will only work to facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

VIII. What are the Plans Benefit Details?

The policy is available under 2 Plans as detailed below:

ManipalCigna Super Top Up (Plan Benefit Structure)

Title	Description				
Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief					
Your Coverage Details:	**Identify your Plan**	**Plus**		**Select**	
Basic Cover (This section lists the Basic benefits available on your plan)	Identify your Opted Sum Insured	Deductible (INR in Lacs)	Sum Insured (INR in Lacs)	Deductible (INR in Lacs)	Sum Insured (INR in Lacs)
		3, 3.5	3, 6	1	1, 2, 4
		4, 4.5	4, 8	2, 2.5	2, 4, 5
		5, 5.5	5, 10, 15, 20	3, 3.5	3, 6, 10
		7.5	10, 15, 20	4, 4.5	4, 8, 15
		10	10, 20, 30	5, 7.5	5, 10, 15, 20
		-	-	10	10, 20, 30
	Inpatient Hospitalisation(When you are hospitalised)	Covered up to any Room Category. Covers Hospital expenses for admission longer than 24 hours.			
	Pre - hospitalisation	Medical Expenses Covered up to 60 days before date of hospitalisation			
	Post - hospitalisation	Medical Expenses Covered up to 90 days post discharge from hospital			
	Day Care Treatment	Covered up to the limit of Sum Insured opted			
	Non – medical expenses Cover	Actual expense incurred towards non – medical items listed under policy wordings under Annexure III			
	Road Ambulance Cover	Actual incurred expenses paid per hospitalisation event			
	Donor Expenses (Hospitalisation Expenses of the donor providing the organ)	Covered up to full Sum Insured			
	Inpatient hospitalisation of AYUSH Cover	Covered up to full Sum Insured			
	Guaranteed Cumulative Bonus	A guaranteed 5% Increase in Sum Insured per policy year, maximum up to 50% of Sum Insured.			
Optional Covers (This section lists the available optional covers under your plan and the limits under each of these options	Guaranteed continuity on Deductible	From 5th Policy Year onwards, the Insured Person will have an option to opt for a base policy*, with guaranteed continuity on waiting periods# applicable under the base Policy. No fresh risk assessment shall be done for Sum Insured up to the deductible amount opted under this Policy (ManipalCigna Super Top Up). Cover under existing policy, ManipalCigna Super Top Up, will continue to be available for the Insured person, subject to Renewal and policy terms and conditions. #Waiting Periods here will mean initial waiting period, specific illness waiting period and pre-existing disease waiting period of base policy. * ManipalCigna ProHealth Insurance – Protect Plan (UIN CTTHLIP18045V031819 or any subsequent versions approved by the IRDAI) or equivalent product offered by Us. This optional cover is available at the purchase of this Policy and the same shall apply to Insured person/s for which the cover is opted.			
	Reduction in Pre-existing disease waiting period	Option to reduce pre-existing waiting period under this Policy to 24 months. This optional cover shall apply to all insured persons covered under the policy.			
Add on cover(Rider) This section lists the Add on cover available under your plan	Critical Illness UIN: MCIHLIP21128V022021	Lump sum payment of an additional 100% of Sum Insured Opted			
Premium	Premium Payment Options	Single, Yearly, Half yearly, Quarterly and Monthly mode of payment available.			

Disclaimer:

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

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

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

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of 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 prospectus or tables of the insurers.
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

Your Health Relationship Manager Has The Answer

Be it claims assistance or guidance, contact your Health RM anytime.:

1800-102-4462 customercare@manipalcigna.com www.manipalcigna.com

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