MANIPALCIGNA PROHEALTH PRIME

Plans: Active
Policy Contract

A. Policy Schedule

(To be captured here as per approved document)

B. Preamble

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

If any Claim arising as a result of a Disease/Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any). Claim shall be payable only if the requisite treatment taken is medically necessary. In case of a claim, we shall cover only upto the Reasonable and Customary charges applicable for the treatment taken. Furthermore, we shall provide coverage only for those medical expenses that have been utilized during treatment/procedures payable under this policy. Any medical expense incurred but not utilized shall not be payable under the Policy. All limits mentioned in the Policy Schedule are applicable for each Policy Year of coverage. The Sum Insured to be considered for payment of any hospitalization related benefit shall be of the Policy Year in which the date of admission occurred. Any Add-ons as launched from time to time may also be available subject to underwriting. For migration between ManipalCigna retail health products, eligibility will be assessed as per internal renewal guidelines.

C. Definitions

Please note that some terms used in this Policy have definitions that may differ from their everyday or commonly understood meaning. The meanings assigned to the below defined terms will apply wherever they appear in the Policy. If a term is not specifically defined, its dictionary meaning will prevail. Additionally, references to the singular include the plural, references to the masculine include the feminine, and references to any law also include any amendments made to it.

C.I.Standard Definitions

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any one Illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.

3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with the following criterion:
   i. having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

4. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner (s) comprising any of the following:
   a) Central or State Government AYUSH Hospital; or
   b) Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
   c) 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:
      i) Having at least five in-patient beds;
      ii) Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii) Having dedicated AYUSH therapy sections as required and/ or has equipped operation theatre where surgical procedures are to be carried out;
      iv) Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

5. **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6. **Break in policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

7. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider or common empanelled Hospital/healthcare providers by the insurer to the extent pre-authorization approved.

8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co payment does not reduce the Sum Insured.

9. **Condition Precedent** means a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.

10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly** – Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body.

11. **Critical Illness** means the following:

a) **Cancer of Specified Severity**

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

The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumor histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

b) Myocardial Infarction (First Heart Attack of Specific Severity)

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

i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. new characteristic electrocardiogram changes

iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris.

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

c) Open Chest CABG

I The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery (s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

d) Open Heart Replacement or Repair of Heart Valves

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

e) Coma of Specified Severity

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

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

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

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

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

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

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

   The following are excluded:

   i. Other stem-cell transplants

   ii. Where only islets of langerhans are transplanted

i) Permanent Paralysis of Limbs

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

j) Motor Neuron Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE is excluded.

12. **Cumulative Bonus** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

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

    a. has qualified nursing staff under its employment
    b. has qualified medical practitioner (s) in charge
    c. has a fully equipped operation theatre of its own where surgical procedures are carried out
    d. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

14. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

    i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii) Which would have otherwise required a Hospitalization of more than 24 hours.

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

15. **Deductible** means a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

16. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

17. **Disclosure to Information Norm** means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

18. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

    a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b) the patient takes treatment at home on account of non-availability of room in a hospital.

19. **Emergency Care** means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

20. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the coverage will be offered during the grace period, if the premium is paid in instalments during the policy period.

21. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56

(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 In-patient beds, in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

22. **Hospitalization or Hospitalized** means admission in a hospital for a minimum period of 24 consecutive in patient care hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

24. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

25. **In-patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

26. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner (s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

27. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

28. **Maternity expenses** means:

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

30. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

31. **Medically Necessary Treatment or Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

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

32. **Medical Practitioner** means a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by Government of India or a State Government and is and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

33. **Network Provider** means hospitals or health care provider enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

34. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.

35. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

36. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing disease and specific waiting periods from one health insurance policy to another with the same insurer.

37. **OPD Treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-patient.

38. **Pre-Existing Disease (PED)** means any condition ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

39. **Pre-hospitalization Medical Expenses**

Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:

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

40. **Post-hospitalization Medical Expenses**

Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

41. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing disease and specific waiting periods from one insurer to another insurer.

42. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

43. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

44. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

45. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

46. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner

47. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

C.II. Specific Definitions

1. **Age** or **Aged** means the completed years of the Insured Person as on his/her last birthday as on the first day of the relevant Policy Year.

2. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

3. **Annexure** means a document attached and marked as Annexure to this Policy.

4. **Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person which vary based on the room category occupied by the insured person whilst undergoing treatment in some of the hospitals. If Policy Holder chooses a higher room category above the eligibility defined in Policy Schedule, then proportionate deduction will apply on the Associated Medical Expenses and room rent. Such associated medical expenses do not include Cost of pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics. Proportionate deduction shall not be applicable to 'ICU charges'.

5. **Base Sum Insured [BSI]** means the coverage limit opted at the time of inception or modified at the time of renewal whichever is later. It forms a part of the Sum insured for a given Policy Year. It is also the coverage amount for which premium is computed and charged with respect to Base covers offered in this policy. The opted base sum insured applicable for a policy year shall be as specified in the Policy Schedule. In case of Individual Policies Base Sum Insured shall be on per Insured Person basis. In case of Family Floater policies, a common Base Sum Insured shall be available on a floating basis amongst all the Insured Persons. Claims made during the policy year shall reduce the Base Sum Insured and the balance shall be available for subsequent claims that may arise during the remainder of that policy year. The Base Sum Insured resets after the completion of each policy year.

6. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.

7. **Covered Relationships** shall include self (the policyholder himself) / legally married spouse, children, brother and sister of the Policyholder who are children of same parents, father, mother, grandparents, grandchildren, parent in laws, son in law, daughter in law, uncle, aunt, niece and nephew.

8. **Dependent Child** refers to a child (natural or legally adopted), who is:
   i. financially dependent on the Policyholder,
   ii. does not have his / her independent source of income,
   iii. is up to the age of 25 years.

9. **Emergency** means a serious illness or injury that happens suddenly and unexpectedly and requires the immediate medical attention of a medical practitioner. Treatment is usually required within 24 hours of symptoms starting in order to prevent loss of life or serious long-term damage to the insured person's health. Once the condition is stabilized and no longer needs urgent care, it is no longer considered an emergency.

10. **Inception Date** means the Inception date of this Policy as specified in the Schedule.

11. **Indian Resident** means an individual who was present in India for a total of 182 days or more in the immediately preceding financial year.

12. **Indemnify or indemnification** means the Insurer's obligation to pay for Medically Necessary proven admissible Medical Expenses incurred and also utilized by an Insured Person in respect of a covered claim, either through a Cashless Facility or by way of Reimbursement, strictly in accordance with the terms, conditions, exclusions, limits, sub-limits, deductibles, and co-payments specified under this Policy.

13. **In-patient** means an Insured Person who is admitted to hospital and stays for at least 24 consecutive hours for the sole purpose of receiving treatment.

14. **Insured Person** means the person(s) named in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

15. **Organ Donor** means a person whose organ(s) is/are harvested and successfully transplanted to the Insured Person. The donor herein voluntarily donates one or more of his or her organs to the Insured Person in accordance with applicable law for the purpose of organ transplantation to the Insured.

16. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit terms & conditions (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy Contract and shall be read together.

17. **Policy Period or Policy Tenure** means the period between the inception date and the earlier of
    a) the expiry date of the policy as specified in the Schedule to this Policy OR
    b) the date of cancellation of this policy.

18. **Policy Year** means a period of 12 consecutive months within the Policy Period commencing from the Policy Anniversary Date/Commencement Date.

19. **Policy Schedule** is a document attached to your policy that provides all key details about your policy such as who is covered, the premium details, the policy period, waiting periods, Base Sum Insured, Sum Insured benefits in force, and any special conditions. It may also include any updates or changes made later (like endorsements). If there is more than one schedule, the latest version will apply.

20. **Reasonable and Customary Charges** mean the amount we consider fair for a medical treatment or service. To decide this, we look at things like the type of illness, the doctor's experience, the category of hospital you choose, and what similar hospitals in the same area usually charge for the same treatment. We use this comparison to ensure that the charges are in line with normal rates for that location.

21. **Reimbursement or reimburse** means to compensate for the Medically Necessary medical expenses payable under the Policy which have already been paid for and also utilized by the Insured Person. Reimbursement shall be provided on basis submission of requisite proofs.

22. **Restored Base Sum Insured** means the amount restored in accordance with Section D.I.8 of this Policy.

23. **Single Private AC Room** refers to the most economical air-conditioned single room with any rating available in the Hospital at the time of Hospitalization. Such room accommodates only one patient, includes an attached toilet (lavatory and bath), and also provides space for an attendant. This definition excludes suites or any higher room category.

24. **Specific Conditions** refers to a set of conditions applicable that need to be fulfilled for a claim to be admissible under that particular benefit/policy.

25. **Specific Exclusions** refers to a set of conditions or situations wherein claim shall not be paid under the policy.

26. **Specific Waiting Period** means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

27. **Sum Insured [SI]** means, the aggregate limit of indemnity consisting of
    a. Base Sum Insured,
    b. Cumulative Bonus (if in force and earned),
    c. Restoration [if in force and as applicable]

    The Sum Insured thus represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy except any Add-ons/riders opted during a Policy Year. The Sum Insured applicable for a policy year shall be as specified in the Policy Schedule. In case of Individual Policies Sum Insured shall be on per Insured Person basis. In case of Family Floater policies, a common Sum Insured shall be available on a floating basis amongst all the Insured Persons. Claims made during the policy year shall reduce the Sum Insured and the balance shall be available for subsequent claims that may arise during the remainder of that policy year. The Sum Insured works on a per policy year basis. Add-ons / Riders may have separate and independent Sum Insured limits and the same shall be specified in the Policy Schedule if such covers are in force.

28. **Third Party Administrator (TPA)** means a company registered with the Authority, and engaged by Us, for a fee or, by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under TPA Regulations.

29. **Twin Sharing AC Room** means an air-conditioned Hospital room where two patients can be accommodated at same time. Such room shall be the most economical of all accommodations available as twin sharing room in that Hospital.

30. **We/Our/Us/Insurer** means ManipalCigna Health Insurance Company Limited.

31. **You/Your/Policy Holder** means the person named in the Schedule as the policyholder and who has concluded this Policy with Us.

B. Benefits covered under the policy

B.I. Basic covers or Base covers

B.I.1 In-patient Hospitalization:

We will indemnify the Medical Expenses of an Insured Person upto the Sum Insured in the event of Medically Necessary Hospitalization arising from a Disease/ Illness or Injury provided such Medically Necessary Hospitalization is for more than 24 consecutive hours and that the admission date of the Hospitalization due to Disease/ Illness or Injury is within the Policy Year. We will indemnify the Medical Expenses, up to the Sum Insured for:

a. Reasonable and Customary Charges for Room accommodation in hospital. Your room rent coverage / eligibility is as below

Opted Base Sum Insured	Room rent eligibility
₹ 3Lac	Upto 1% of opted base Sum Insured per day
₹ 5Lac and above	Upto Single Private AC room

b. Intensive Care Unit charges for accommodation in ICU shall be covered at actuals,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon,
e. Anaesthetist,
f. Qualified Nurses,
g. Specialists,
h. Cost of diagnostic tests,
i. Medicines,
j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

Proportionate Deduction Clause

If you choose a hospital room that is higher than your eligible room category, you will need to pay a proportionate share of the associated medical expenses. This will be calculated based on the difference between your eligible room rent and the actual room rent charged by the hospital.

The proportionate deduction will apply to accommodation charges and associated medical expenses.

Associated Medical Expenses shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.

Understanding proportionate deduction with a simple example

Mr. Raj was hospitalized for **4 days** in a **Deluxe Room** at XYZ Hospital. However, as per his policy, he was eligible for the most economical **Single Private AC Room**.
Since he chose a higher room category than what his policy allowed, proportionate deduction will apply. This means the claim amount will be calculated based on the ratio between his eligible room rent and the actual room rent charged by the hospital.

Item	Details
Actual Room Rent Expense (Deluxe Room) [A]	₹ 10,000 per day * 4 days= ₹ 40,000
Eligible Room Rent expense (Single Private AC room) [B]	₹ 6,000 per day * 4 days = ₹ 24,000
Proportionate Ratio [B/A]	Eligible Room Rent ÷ Actual Room Rent = 6,000 ÷ 10,000 = **0.6**
Actual Associated Medical Expenses (AME) (includes Nursing charges, OT charges, consultation fees etc.) **[C]**	₹ 42,000
Eligible AME after Proportionate deduction [D]	₹ 25,200 (C*0.6)
Pharmacy & consumables, diagnostic tests, implants, medical devices ***(not subject to proportionate deduction)*** **[E]**	₹ 10,000
Total Bill Amount at actuals (F = A + C + E)	₹ 92,000
Amount Paid by Insurer after Proportionate deduction (G = B + D + E)	₹ 59,200
Amount Payable by Policyholder/Insured Person (F – G)	₹ 32,800

Sub-limits for Listed Treatment/Procedure

We will indemnify the Medical Expenses incurred by an Insured Person in respect of the ailments/procedures specified in the table below, up to the limit applicable to each ailment/procedure as per the opted Base Sum Insured. The specified limit shall be the maximum amount payable per Policy Year

Base Sum Insured (in ₹)	₹ 3 Lacs	₹ 5 Lacs	₹ 7.5 and ₹ 10 Lacs	>₹ 10 Lacs
Treatment for each ailment / procedure mentioned below: 1. Surgery for treatment of all types of Hernia 2. Hysterectomy 3. Surgeries for benign Prostate Hypertrophy 4. Surgical treatment of stones of renal system	₹ 50,000	₹ 65,000	₹ 80,000	NA
Treatment of Cataract (Per Eye)	₹ 20,000	₹ 30,000	₹ 30,000	NA
Treatment of Total Knee replacement (Per knee)	₹ 80,000	₹ 1,00,000	₹ 1,20,000	NA
Treatment for breakage of bones	₹ 2,00,000	₹ 2,50,000	₹ 3,00,000	NA

Wherever the above mentioned Sub-limits are applied, the Mandatory Co-payment under section F.II.6 shall not be applicable however co-payment for the treatment taken at higher zone as mentioned under section F.II.10 will continue to apply.

Coverage for Advanced/Modern Treatment procedures

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a hospital up to 50% of the Base Sum Insured as specified in the Policy Schedule, during the 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 prostate (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.

Coverage for HIV/AIDS

Indemnification of Medical Expenses upto the Sum Insured incurred for the Medically Necessary In-patient care Hospitalization 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) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, sexually transmitted diseases (STD), will be covered up to the Sum Insured as specified in the Policy Schedule during the Policy Year. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time. The necessity of the Hospitalization is to be certified by an authorized Medical Practitioner.

Coverage for Mental Illness

Indemnification of Medical Expenses upto the Sum Insured incurred for the Medically Necessary In-patient care Hospitalization 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 50% of the Sum Insured as specified in the Policy Schedule during the Policy Year. This coverage is provided in accordance with The Mental Health Care Act, 2017 as amended from time to time. For the below mentioned ICD Codes, the Insured Person should have been continuously covered under this Policy for at least 24 months before availing this benefit.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
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

All Claims under this benefit can be made as per the process defined under Section G.I.4 and G.I.5.

B.I.2 Pre-hospitalization

We will, reimburse Pre-Hospitalization Medical Expenses of an Insured Person which are incurred due to an Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalization up to the limits as specified in the Policy Schedule, provided that a Claim has been admitted under In-patient benefit under Section D.I.1 or Day Care Treatment Section D.I.4 and is related to the same illness/condition.

All Claims under this benefit can be made as per the process defined under Section G.I.5 & G.I.9.

B.I.3 Post-hospitalization

We will, reimburse Post-Hospitalization Medical Expenses of an Insured Person which are incurred due to an Illness or Injury that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital up to the limits as specified in the Policy Schedule, provided that a Claim has been admitted under In-patient benefit under Section D.I.1 or Day Care Treatment Section D.I.4 and is related to the same illness/ condition.

All Claims under this benefit can be made as per the process defined under Section G.I.5 & G.I.9.

B.I.4 Day Care Treatment

We will indemnify the Medical Expenses incurred for an Insured Person upto the sum Insured in the event of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in technology and which is undertaken in a Hospital/nursing home/Day Care Centre on the recommendation of a Medical Practitioner, up to the Sum Insured as specified in the Policy Schedule, provided that:

a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.
c. We will not cover any Out-Patient Treatment (OPD) Treatment and Diagnostic Services under this benefit.
d. Coverage under this benefit shall also include pre-post hospitalization expenses as per the limits applicable and specified in Policy Schedule.

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

B.I.5 Domiciliary Hospitalization

We will reimburse the Medical Expenses of an Insured Person, up to the limits specified in the Policy Schedule, for an Illness or Injury that would normally require Hospitalization, but it is instead treated at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a Hospital transfer; or
ii. A Hospital bed was unavailable;

Provided that, the treatment of the Insured Person continues for at least 3 days, in which case the reasonable cost of any Medically Necessary treatment for the entire period shall be payable.

a) We will pay for Pre-hospitalization, Post-hospitalization Medical Expenses up to 30 days each.

b) Restoration of Sum Insured shall not be available under this benefit

c) 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 & 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.

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

D.I.6. Road Ambulance

We will reimburse Reasonable and Customary expenses up to the Sum Insured as specified in the Policy Schedule that are incurred towards road transportation of an Insured Person by a registered Healthcare or Ambulance Service Provider to a nearest Hospital for treatment of an Illness or Injury covered under the Policy in case of an Emergency, necessitating the Insured Person's admission to the Hospital, provided that a Claim has been admitted under In-patient benefit under Section D.I.1 and is related to the same illness/condition.

The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

Reasonable and Customary expenses shall include:

a. To transport you from the incident site to the nearest hospital and/or

b. To transport you from one hospital to another nearest hospital if the current hospital doesn't have the required medical treatment facility you need and/or

c. To transport you from a hospital to a nearby diagnostic center and back, for diagnostic tests advised by your doctor, that aren't available at your current hospital

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

D.I.7. Donor Expenses

We will indemnify In-patient Hospitalization Medical Expenses towards the donor for harvesting the organ up to the Sum Insured as specified in the Policy Schedule, subject to the below mentioned conditions:

The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that the organ donated is for the use of the Insured Person who has been medically advised to undergo an organ transplant.

We have admitted a claim under Section D.I.1 – towards In-patient Hospitalization

We will not cover expenses towards the Donor in respect of:

Any Pre or Post-hospitalization Medical Expenses,

Cost towards donor screening,

Cost associated to the acquisition of the organ,

Any other medical treatment or complication in respect of the donor, consequent to harvesting.

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

D.I.8 Restoration:

Under restoration benefit, we will provide 100% restoration of the opted Base Sum Insured unlimited times in a Policy Year

Specific Conditions applicable to Restoration

a. The Base Sum Insured and earned Cumulative Bonus (if any) should be insufficient as a result of previous claims in that Policy Year.
b. The Restored amount shall not be available for claims towards an Illness/Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person.
c. The Restored amount will will not apply to the first admissible claim in the Policy Year. The Restored amount can only be used for future claims that may arise during the remainder of the Policy Year.
d. The restored amount can only be used to pay claims admissible under the below benefits:
    - Section D.I.1 'In-patient Hospitalization'
    - Section D.I.2 'Pre-Hospitalization'
    - Section D.I.3 'Post-Hospitalization'
    - Section D.I.4 'Day Care Treatment'
    - Section D.I.6 'Road Ambulance'
    - Section D.I.7 'Donor Expenses'
    - Section D.I.9 'AYUSH Treatment and
    - Section D.III.1'Non-Medical Items'
e. The Restored amount will not be considered while calculating the Cumulative Bonus.
f. The Restored amount will be available unlimited times, during a Policy Year to each insured in case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
g. Any Restored amount which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year.
h. For any single claim during a Policy Year the maximum claim amount payable shall be sum of:
    i. The Base Sum Insured
    ii. Cumulative Bonus (if opted or earned)
    iii. Restored amount

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

D.I.9 AYUSH Treatment

We will indemnify 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 In-patient care AYUSH Hospitalization for an Illness or Injury that occurs during the Policy Year, provided that:

The Insured Person has undergone treatment in an AYUSH Hospital.

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.

All claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.5.

D.I.10 Convalescence Benefit:

We will pay in lump sum the amount specified against this benefit in the Policy Schedule, if the Insured Person has been Hospitalized for at least 10 consecutive and continuous days for an illness or Accident, provided that:

i. The Hospitalization is only for In-patient care for the Insured Person; and
ii. The benefit payable under this cover is for each such Hospitalization
iii. The claims payable under Convalescence Benefit shall not reduce the Sum Insured and will be payable over and above the Sum Insured.
iv. We have accepted such claim under Section D.I.1 In-patient Hospitalization during the Policy Year

All claims under this benefit can be made as per the process defined under Section G.I.5.

D.I.11 Daily Cash for Shared Accommodation

We will pay a daily cash amount as specified in the Policy Scheule for each continuous and completed period of 24 hours that the Insured Person was hospitalized provided that,

a. We have accepted claim under Section D.I.1 In-patient Hospitalization during the Policy Year
b. The Insured Person has occupied a shared room accommodation during such Hospitalization
c. The Insured Person has been admitted in a Hospital for a minimum period of 48 continuous hours.
d. This benefit is available for Base Sum Insured of ₹ 5 Lacs and above.

What is not covered:

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

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

D.I.12 Home Treatment

Coverage for eligible treatments, even when care comes home.

<u>What we cover</u>

If you need treatment at home for the conditions listed below, we'll cover the medical expenses, provided the treatment is recommended in writing by your treating Medical Practitioner and approved by us in advance.

<u>Key Service Terms</u>

1. The treatment at home must be for a condition that would otherwise require hospitalization.
2. Your treating Medical Practitioner must continuously monitor your health throughout the treatment period.
3. A continuous and active line of treatment must be followed during the entire home treatment period.
4. The duration of medically necessary treatment must be certified in writing by your treating medical practitioner.
5. A day-wise treatment record must be maintained and signed by the treating Medical Practitioner.
6. Home Treatment will be covered for up to 60 days per policy year at the policy level. This may be extended only with our explicit prior approval.
7. Under this benefit, we only cover cost related to the medical treatment. Any other ancillary expenses such as expenses related to modification in residence, rental/purchase for medical equipment etc. shall not be covered.

8. Claims under this benefit will be payable only for the duration that is medically necessary.

9. Kindly note that you must pre-inform us before starting the treatment. The request will be valid only after we approve it. If the treatment is taken without our prior approval, the claim will not be payable. Also, home treatment may not be accessible in every location. This benefit will therefore be available subject to service availability in your area.

Treatments covered under Home Treatment

This benefit is available only for the treatments specifically listed below. Any treatment not listed here will not be covered.

1. **Infectious Diseases**
   Treatment for infectious diseases

2. **Injectable Chemotherapy at Home**
   Injectable chemotherapy at home will be covered only under strict protocols.

3. **Dialysis**
   Peritoneal dialysis and home haemodialysis are covered.

4. **Post-operative Care and Wound Management**
   We'll cover post-operative care of the operated site and wound management for a severe wound at the operated site. This does not include laparoscopic surgery.

5. **Brain and Spinal Injury Care After Discharge**
   We'll cover an active line of treatment for brain injury and spinal injury cases after discharge from the hospital.

6. **Palliative Care**
   Palliative care may be covered for the following conditions:

   a. End-stage oncology conditions
   - i. Advanced or metastatic cancers, such as Stage IV or refractory cancers, where the treating oncologist has confirmed that the treatment is not intended to cure the condition.
   - ii. ECOG (Eastern Cooperative Oncology Group) performance status 3–4.

   b. End-stage organ failure
   - i. End-stage renal disease - CKD Stage 5, where dialysis is not being pursued or has been discontinued.
   - iii. End-stage liver failure or cirrhosis with refractory complications.
   - iv. Advanced heart failure - NYHA Class III or IV.
   - v. End-stage COPD or respiratory failure requiring long-term oxygen support with no curative option.

   c. Progressive infections or systemic conditions
   - i. Refractory septic shock or multi-organ failure where further escalation of care is considered futile.
   - ii. End-stage HIV/AIDS with failing ART and recurrent opportunistic infection.

What is included under Home Treatment

1. Doctor-prescribed treatment with written medical advice and supervision.
2. Medicines, drugs, and IV therapies related to the covered condition.
3. Medical consumables such as syringes, dressings, and IV sets.
4. Diagnostic tests required to monitor the home treatment.

What's not covered under Home Treatment

1. Non-medical expenses mentioned in List I of Annexure 2
2. Non-medical care, such as caretakers or attendants.
3. Rental or purchase of equipment such as hospital beds or oxygen concentrators.
4. Any kind of AYUSH Treatment under this benefit.
5. Oral Chemotherapy
6. Any ancillary expenses - such as home modifications, rental or purchase of medical equipment, or similar ancillary costs.

B.II. Value added covers

B.II.1 Domestic Second Opinion:

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

You understand and agree that You can exercise the option to secure an expert opinion, provided:

a We have received a request from You to exercise this option.

b That the expert opinion will be based only on the information and documentation provided by You that will be shared with the Medical Practitioner.

c This benefit can be availed by each Insured Person only once during a Policy Year for one Critical Illness and multiple times for different Critical Illness/es with the same limitation of one opinion per critical illness.

d This benefit is only a value-added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

e The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

f We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

g The expert opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medico legal purposes.

h We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

For the purpose of this benefit, covered Critical Illnesses shall include as below:

1. Cancer of Specified Severity

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

The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of Specified Severity)

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

i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. new characteristic electrocardiogram changes

iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris.
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra - arterial cardiac procedure.

3. Open Chest CABG

I The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery (s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

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

5. Coma of Specified Severity

1. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

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

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

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

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

8. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

   The following are excluded:

   i. Other stem-cell transplants

   ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

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

11 Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis;

   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

II. Other causes of neurological damage such as SLE is excluded.

12. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery Pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with, lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

13. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen.

For the purpose of this benefit, Aorta means the thoracic and abdominal aorta but not its branches.

You understand and agree that We will not cover:

a. Surgery performed using only minimally invasive or intra-arterial techniques.

b. Angioplasty and all other intra-arterial, catheter based techniques, “keyhole” or laser procedures.

c. Congenital narrowing of the aorta and traumatic injury of the aorta are specifically excluded.

14. Deafness

Total and irreversible Loss of hearing in both ears as a result of Illness or accident.

This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing” in both ears.

15. Blindness

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

16. Aplastic Anemia

Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a. Blood product transfusion;

b. Marrow stimulating agents;

c. Immunosuppressive agents; or

d. Bone marrow transplantation.

The diagnosis must be confirmed by a hematologist Medical Practitioner using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

a. Absolute neutrophil count of less than 500/mm^3 or less;
b. Platelets count less than 20,000/mm^3 or less;
c. Reticulocyte count of less than 20,000/mm^3 or less.

We will not cover temporary or reversible Aplastic Anemia under this Section.

17. Coronary Artery Disease

The first evidence of narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, regardless of whether or not any form of coronary artery Surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery and not its branches which is evidenced by the following:

a. evidence of ischemia on Stress ECG (NYHA Class III symptoms)
b. coronary arteriography (Hearth Cath)

18. End Stage Lung Failure

End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 liter measured on 3 occasions 3 months apart; and
ii. Requiring continuous and permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHgor less (PaO2 < 55 mm Hg); and
iv. Dyspnea at rest.

19. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

a. Permanent jaundice;
b. Ascites; and
c. Hepatic Encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

20. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

21. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
c. Rapid deterioration of liver function tests;
d. Deepening jaundice; and
e. Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

22. Alzheimer's Disease

Alzheimer's disease is a progressive degenerative Illness of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist Medical Practitioner and supported by Our appointed Medical Practitioner.

The following conditions are however not covered:

a. non-organic diseases;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

23. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and Permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist Medical Practitioner.

24. Benign Brain Tumor

a. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull.

   The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

b. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

   The following conditions are however not covered by Us:

   a. cysts;
   b. granulomas;
   c. malformations in the arteries or veins of the brain;
   d. hematoma;
   e. Abscesses
   f. Pituitary Tumors
   g. tumors of skull bones and
   h. tumors of the spinal cord

25. Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist Medical Practitioner acceptable to Us and the condition must be documented by such Medical Practitioner for at least one month.

26. Parkinson's Disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist Medical Practitioner acceptable to Us.

The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and, adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

We will not cover Parkinson's disease secondary to drug and/or alcohol abuse under this Section.

27. Medullary Cystic Disease

A progressive hereditary disease of the kidneys characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

28. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterized by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist Medical Practitioner acceptable to Us, with confirmation of at least 3 of the following 4 conditions

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram;
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available;

vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

29. Loss of Speech

a. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

30. Systemic Lupus Erythematous

A multi-system, multifactorial, autoimmune disorder characterized by the development of auto-antibodies directed against various self - antigens. Only those forms of systemic lupus erythematous which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification) will be covered by Us under this Section. The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us. Other forms of systemic lupus erythematous, discoid lupus and those forms with only hematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

- Class I: Minimal change – Negative, normal urine.
- Class II: Mesangial – Moderate proteinuria, active sediment.
- Class III: Focal Segmental – Proteinuria, active sediment.
- Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
- Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. Loss of Limbs

a. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease.

The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

32. Major Head Trauma

a. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident.

This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

b. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

c. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

d. The following are excluded:

a) Spinal cord injury

33. Brain Surgery

The actual undergoing of surgery to the brain, under general anesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

34. Cardiomyopathy

The unequivocal diagnosis by a consultant cardiologist of Cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least Class IV of the New York Association (NYHA) Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment (Source: "Current Medical Diagnosis and Treatment- 39th Edition"):

a. Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or angina pain.

b. Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

c. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

d. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

We will not cover Cardiomyopathy related to alcohol abuse under this Section.

35. Creutzfeldt-Jacob Disease (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

Mental functioning would mean functions/processes which we can do with our minds.

36. Terminal Illness

An Insured Person shall be regarded as terminally ill only if he/she is diagnosed as suffering from a condition which, in the opinion of two appropriate independent Medical Practitioners, is highly likely to lead to death within 12 months from the date of the diagnosis and the Insured Person is not receiving any active treatment for the terminal illness, other than that of the pain relief. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with the Indian Medical Association and approved by Us.

All claims under this benefit can be made as per the process defined under Section G.I.12.

B.II.2 Tele Consultation

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

All claims under this benefit can be made as per the process defined under Section G.I.13.

D.II.3. Cumulative Bonus

On completion of each Policy Year with Us, Insured Persons shall be granted Cumulative Bonus irrespective of any claims made during the expiring Policy Year

Special Conditions for Cumulative Bonus

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period.

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

c) Bonus shall be provided irrespective of claims made in the expiring policy year

d) Any accumulated Cumulative bonus shall be carried forward to subsequent policy years.

e) Claims made during a policy year under Cumulative bonus shall reduce the balance bonus amount available for the remainder of such Policy Year.

f) Cumulative Bonus can be accumulated upto a maximum of 100% of your Base Sum Insured under the current Policy.

g) Reduction in Base Sum Insured: If the Base Sum Insured is reduced at Renewal, the applicable Cumulative Bonus will also be reduced in the same proportion .

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

i) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, 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 among all the Insured Persons.

j) 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 opted Base Sum Insured in to two or more Family Floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

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

D.II.4 Wellness Program

Who can avail these wellness programs:

If You have been suffering from one or more of the following conditions such as Asthma, Diabetes, Hypertension, Dyslipidaemia, Obesity and the same has been declared/identified at the time of buying the policy or subsequently in any policy year, You can be a part of Wellness Program based on the covered conditions as per the applicability of the opted plan and earn rewards based on adherence to program metrics.

The details of the Wellness Programs are as below:

Plan Type	**Active Plan**
Wellness Program	Condition Management Program
Conducted By	ManipalCigna along with its Network Partners
Program Components	- Health Risk Assessment - Baseline assessment (Medical test) - Coaching - Improvement assessment (Medical test)
Medical Tests	
Diabetes	HbA1c + Lipid profile + Serum creatinine + Microalbuminuria + MER + Ophthalmologist Consultation + ECG
Hypertension	Lipid profile + Serum creatinine + Microalbuminuria + Uric acid + MER + ECG

Obesity	Lipid profile + Serum creatinine + Thyroid Profile + HbA1c + MER
Dyslipidaemia	Lipid profile + Serum creatinine + HbA1c + MER
Asthma	MER + Spirometry
More than 1 disease	Combination of tests pertaining to each condition (No repetition of tests)
Program Metric	- Health Risk Assessment completion - Medical tests undertaken at the beginning of the program in the policy year - Coaching completion - Improvements achieved at the end of the program in the policy year
Reward Accrual- 1 year Policy Tenure (Refer Annexure A for illustration, provided as part of the benefit)	Maximum reward points which could be accrued is upto 15% of the existing base premium (excluding Premium for optional cover(s), Rider(s) and taxes) applicable for the respective insured

In order to be eligible for the rewards, You shall adhere to all the components of the programs as specified under program metric, as per the applicability of opted plan.

At the end of the policy year, 'Health Scores' shall be calculated based on the final test values and improvement in health parameters (wherever applicable). Thereafter, 'Weighted Health Score' shall be calculated provided there was no hospitalization during the Policy Period for the covered conditions and/or its complications

Reward Accrual Methodology under Active Plan:

Disease-wise Health Score for Active Plan:

Final Test Values and Improvement will be considered for health score allocation.

Diabetes:

Diabetes (HbA1c Final Test Value)	< or = 6.5 %	Final value	< or = 6.5		
		Health Score	100		
	>6.5 %	Final Value Reduced by (improvement by)	0.50%	0.51% to 1%	>1 %
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in HbA1C values only.
2. No rewards will be allocated for increase in HbA1c value or reduction <0.5% (for HbA1c >6.5).
3. Eligible for rewards provided there is no hospitalization for diabetes or its complications.

Hypertension:

Hypertension (SBP/DBP Final Test Value)	SBP < or = 140 mm Hg and DBP < or= 90 mm Hg (AND)	Final value	SBP < or = 140 and DBP < or= 90		
		Health Score	100		
	SBP > 140 mm Hg and /or DBP > 90 mm Hg (AND / OR)	Final Value Reduced by (improvement by)	5 mm Hg	6 to 10 mm Hg	>10 mm Hg
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in BP values only.
2. Increase in any one marker (SBP/DBP) will disqualify the rewards.
3. No rewards will be allocated for improvement in BP values <5 mm Hg (for SBP >140 mm Hg and/ or DBP > 90 mm Hg).
4. Eligible for rewards provided there is no hospitalization for hypertension or its complications.

Obesity:

Obesity (BMI)	Final BMI upto 29	Final value	BMI upto 29		
		Health Score	100		
	Final BMI above 29	Final Value Reduced by (improvement by)	1	>1 to 2	>2
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in BMI values only.
2. No rewards will be allocated for increase in BMI value and reduction in BMI <1 (for Final BMI above 29).
3. Eligible for rewards provided there is no hospitalization for obesity or its complications.

Dyslipidaemia:

Dyslipidaemia Total Cholesterol (TC) and Triglycerides (TG)	TC upto 200 and TG upto 150	Final value	TC upto 200 and TG upto 150		
		Health Score	100		
	TC > 200 and/or TG > 150	Final Value Reduced by (improvement by)	20	21 to 40	>40
		Health Score	25	50	75

Reward Principle:

1. Reward points will be allocated for improvement in both TC and TG value only.
2. Increase in any one marker (TC/TG) will disqualify the rewards.
3. No rewards will be allocated for increase in TC and TG and reduction in TC and /or TG values < 20 mg/dl (for TC > 200 and/or TG > 150)
4. Eligible for rewards provided there is no hospitalization for Dyslipidaemia or its complications.

Asthma:

Asthma	Treatment type	Final Value	On oral medications except steroids/ immunodilators	On Inhalers	Not on treatment
		Health Score	50	75	100

Reward Principle:

1. Reward points will be allocated for improvement or status quo in type of treatment only.
2. No rewards will be allocated for change in line of treatment to a higher category.
3. Hierarchy for type of treatment: Category 1: Not on treatment; Category 2: On Inhalers; Category 3: On oral medications; Category 4: On steroids/immunomodilators.
4. Eligible for rewards provided there is no hospitalization for asthma or its complications.

Health Score and Reward Allocation:

a. Health Score will be allocated against the final value of each ailment.
b. In case of more than one ailment, a weighted average of all health scores will be calculated. The weights will be assigned for ailments in decreasing order as follows: Diabetes, Hypertension, Obesity, Dyslipidaemia, Asthma.

Reward Allocation Grid:

Weighted Health Score	<25	>25 to 50	>50 to 75	>75
Rewards - % of premium paid (Excluding Optional Covers/Rider and taxes) in the existing Policy	0%	5%	10%	15%

Conditions under this benefit:

i. The reward points earned will be at eligible member level.
ii. Maximum reward points that can be earned in a single Policy Year will be limited to 15% of premium paid (excluding Optional covers, Riders and taxes) in the existing Policy.
iii. 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 1st Renewal of the Policy.
iv. The earned reward points can be utilized as Discount in the renewal premium falling due immediately after the accrual. Carry forward of earned reward points shall not be allowed.
v. 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 Reward Points

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 (Excluding Optional Cover, Rider and taxes)**	**Weighted Health Score**	**Rewards %**	**Points Earned**
Year 1	10000	40	5%	500
Total	10000			500

The notifications related to wellness programs 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.

D.II.5 Discount from Network Providers

The Insured Person can avail discount on Diagnostic, Pharmacy and Health Supplements offered through Our Network Providers. You may avail the requisite discount by calling our call centre or through our mobile application.

D.II.6 Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers Death due to an injury caused by an Accident within 365 days from the date of the of such event or he/she is diagnosed with a Critical Illness that listed under this benefit, We will pay the full Policy premium of the immediate next renewal [including Optional covers, Riders and Taxes (as applicable)] of the Policy. The premium shall be paid towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.

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

The cover is available subject to below conditions:

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

  For the purpose of this benefit, Critical Illnesses shall include as below-

  1. Cancer of Specified Severity
  2. Myocardial Infarction (First Heart Attack of Specific Severity)
  3. Open Chest CABG
  4. Open Heart Replacement or Repair of Heart Valves
  5. Coma of Specified Severity
  6. Kidney Failure Requiring Regular Dialysis
  7. Stroke Resulting in Permanent Symptoms
  8. Major Organ/Bone Marrow Transplant
  9. Permanent Paralysis of Limbs
  10. Motor Neuron Disease with Permanent Symptoms
  11. Multiple Sclerosis with Persisting Symptoms

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

B.III. Optional covers

The following Optional Covers shall be available under this Policy only if specifically opted for and indicated as active in the Policy Schedule. Once selected, the Optional Cover shall apply uniformly to all Insured Persons covered under the Policy and cannot be chosen on an individual basis.

B.III.1 Non-Medical Items

We will indemnify the cost associated with Non-Medical items, listed under Annexure III List 1 of the Policy, incurred towards Medically Necessary Hospitalization of the insured person, arising out of Disease/Illness or Injury.

The cover is available subject to the claim being admissible under Section D.I.1 In-patient Hospitalization and/or Section D.I.4 Day Care Treatment cover under this policy and the expenses on Non-medical items are related to the same Illness/Injury.

Exclusion E.II.13 shall not be applicable for this benefit.

Any claim made under this optional benefit will reduce the Sum Insured.

All claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.5.

D.III.2. Waiver of Mandatory Co-pay

The Policyholder shall have an option to remove the Mandatory Co-payment which is applicable for all insured persons as specified under section F.II.6 and available on payment of additional premium.

D.III.3 Worldwide Accidental Emergency Hospitalization Cover:

We will indemnify all eligible Medical Expenses incurred during the Policy Year for Emergency In-patient Hospitalization Treatments of the Insured Person, due to an Injury arising out of an Accident, incurred outside India, covered up to the amount and as specified in the Policy Schedule, provided that:

(a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India and is payable under Section D.I.1 In-patient Hospitalization of the Policy. Our maximum liability under this benefit, in a single Policy Year shall not exceed the amount available under this benefit as specified in the Policy Schedule.

(b) The Medical Expenses payable shall be limited to In-patient Hospitalization only.

(c) Any payment under this benefit will only be made in India, in Indian rupees on a reimbursement basis and subject to availability of limits under this coverage. Insured Person can contact Us at the numbers provided on the Health Card for any claim assistance.

(d) The payment of any claim under this benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

(e) You have given Us, intimation of such hospitalization within 48 hours of admission.

(f) Any claim made under this benefit will be as per the claims procedure provided under Clause G.I.5 & G.I.14 of this Policy.

(g) Any claim payable under this benefit is over and above the Sum Insured.

(h) This benefit is available once in a Policy Year for each Insured Person.

(i) Restoration shall not be available under this benefit.

(j) This cover is available to all Insured Persons provided they are Indian resident at inception of the Policy and at subsequent renewals of this Policy.

D.III.4 Health Check Up

(a) Health Check Up benefit can be availed only in case where the Wellness Benefit is not chosen by the Insured person.

(b) If the Insured Person is 18 years or above at the start of Policy Year, the Insured Person may avail a comprehensive health check-up with Our Network Provider as per the eligibility details mentioned in the table below. Health Check Ups will be arranged by Us and conducted at Our Network Providers.

(c) This benefit is available once every third policy year. And all the tests must have been done on the same date

(d) Copies of all reports will be provided to You.

Health Check-Up				
Sr no.	**Base Sum Insured**	**Age**	**Package Name**	**Tests**
1	**For All Base Sum Insureds**	**Up to 40**	Health Screening Package	CBC-ESR, FBS, BUN, Lipid Profile, TSH, Liver Function Test, Kidney Function Test
2		**Above 40 for males**	Health Screening Package - Males	CBC-ESR, FBS, BUN, Lipid Profile, TSH, HbA1c, Liver Function Test, Kidney Function Test, PSA
		Above 40 for females	Health Screening Package 1 - Females	CBC-ESR, FBS, BUN, Lipid Profile, TSH, HbA1c, Liver Function Test, Kidney Function Test, Serum Calcium

Full explanation of Tests is provided here: FBS - Fasting Blood Sugar, CBC- ESR - Complete Blood Count- Erythrocyte Sedimentation Rate, HbA1c - Glycosylated Hemoglobin, PSA - Prostate Specific Antigen, TSH - Thyroid Stimulating Hormone, CBC - Complete Blood Count, BUN- Blood Urea Nitrogen

(e) This benefit shall be over and above the sum insured.

(f) Opting this cover shall mean that the coverage under section D.II.4 Wellness Program shall not be applicable for the Insured members for the lifetime of the Policy. The Insured members shall not be able to participate in any of the wellness programs and shall not be able to earn any rewards under the coverage section D.II.4 Wellness Program.

(g) We shall cover Health Check Up only on cashless basis within MCHI Network.

(h) This benefit shall only be opted at the time of renewal of the Policy or at inception and once opted, cannot be removed.

(i) Restoration shall not be available under this benefit.

(j) All Claims under this benefit can be made as per the process defined under Section G.I.13.

D.III.5 Waiver of Disease Specific Sublimit

The Policyholder shall have an option to remove the Disease Specific Sublimit which is applicable for listed ailments / procedures as specified under section D.I.1 and available on payment of additional premium.

D.III.6 Cumulative Bonus

The Policyholder can select from any one of the options below, and the applicable bonus benefit will be adjusted accordingly:

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

b) A bonus of 25% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

c) A bonus of 50% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 200% of Base Sum Insured.

Special conditions applicable to Cumulative Bonus Booster

a) When the Policyholder chooses the Cumulative Bonus Booster at renewal, any Cumulative Bonus already earned under this Policy will be carried forward. From that renewal onwards, the regular Cumulative Bonus under Section D.II.3 will stop applying, and any future bonus accumulation will happen as per the terms of the Cumulative Bonus Booster benefit.
b) All clause applicable under Cumulative Bonus section D.II.3 shall apply to this benefit as well

D.III.7 Modification of Pre & Post Hospitalization Days

The Policyholder may opt to modify the Pre-Hospitalization and Post-Hospitalization days by selecting any one of the options specified below. We shall reimburse the reasonable and customary Pre-Hospitalization and Post-Hospitalization Medical Expenses incurred by an Insured Person for an Illness or Injury for which a claim has been admitted under the In-patient Hospitalization Benefit (Section D.I.1) OR Day Care Treatment (Section D.I.4), provided such expenses are directly related to the same Illness / Injury for which the Hospitalization occurred.

The available options are:

Option	Pre-Hospitalization	Post-Hospitalization
Option A	60 days	90 days
Option B	60 days	180 days

For the selected option:

- **Pre-Hospitalization Medical Expenses** shall mean expenses incurred during the specified period immediately preceding the admission date of Hospitalization.
- **Post-Hospitalization Medical Expenses** shall mean expenses incurred during the specified period immediately following discharge from the Hospitalization.

The limits applicable under this Optional Cover shall be as specified in the Policy Schedule.

All Claims under this benefit can be made as per the process defined under Section G.I.5 & G.I.9.

D.IV Add on Cover

D.IV.1 **ManipalCigna Prime Plus**

Along with this Product You can also avail the ManipalCigna Prime Plus Add On Cover . Please ask for the Terms & Conditions and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of the applicable rider including medical check-up requirement will apply.

1. **Room Rent Modification:** The Insured Person shall be eligible to modify the room type category eligibility under the Policy as follows:
   a. Option 1: Any room; ICU Up to Sum Insured
   b. Option 2: Twin Sharing AC room; ICU Up to Sum Insured

2. **Deductible:** Option to opt from ₹10,000, ₹25,000, ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 and ₹5,00,000 on aggregate basis.

C. Exclusions

a) We will not pay for any claim caused by or related to the conditions listed below, unless it is specifically covered under a benefit in your policy.

b) Waiting periods will apply separately to each insured person, and claims will be assessed accordingly.

c) The waiting periods and exclusions listed below will apply to all benefits (base and optional) under the policy, except for:

i. Domestic Second Opinion
ii. Tele Consultation
iii. Wellness Program
iv. Discount from Network Provider
v. Health Check-up

C.I. Standard Exclusions

E.I.1. Pre-existing Disease - Code-Excl. 01

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with Us.

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

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

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

Any condition or illness, complication or ailment as specified in the Policy Schedule out of any of the below mentioned conditions, shall not be considered as part of this waiting period. Wherein, they shall be covered after the first 90 days from the Inception Date of first policy with Us.

a. Asthma
b. Diabetes
c. Dyslipidaemia
d. Obesity
e. Hypertension

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

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

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

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

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

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

f. List of specific diseases/procedures:

i. Cataract,

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

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

Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

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

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

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

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing the highest between the Specified disease/procedure Waiting Period or Pre-existing Diseases waiting period as mentioned in the Policy Schedule shall apply.

E.I.3. 30 days Waiting Period - Code-E.I.3

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.

E.I.4. 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.

E.I.5. 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.

E.I.6. Obesity/ Weight Control Code-Excl 06

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

1. Surgery to be conducted is upon the advice of the Doctor,
2. The surgery/Procedure conducted should be supported by clinical protocols,
3. The member has to be 18 years of age or older, and
4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

E.I.7. 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.

E.I.8. 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.

E.I.9. 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.

E.I.10. 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.I.11. 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.

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

E.I.13. 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**

E.I.14. 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**

E.I.15. Refractive Error Code-Excl 15

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

E.I.16. 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.

E.I.17Sterility 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

E.I.18 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.

C.II. Specific Exclusions

E.II.1. 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.

E.II.2. 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.

E.II.3. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

E.II.4. 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.

E.II.5. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

E.II.6. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the illness/injury for which the Insured Person was Hospitalized.

E.II.7. 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.

E.II.8 Treatment received outside the geographical limits of India other than for coverage under Worldwide Accidental Emergency Hospitalization Cover (if opted).

E.II.9. 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 D.I.7 ‘Organ Donor’.

E.II.10. Any form of Non-Allopathic treatment (except AYUSH Treatment), Hydrotherapy, Acupuncture, Reflexology or Chiropractic treatment.

E.II.11. 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 nuclear, chemical or biological attack or in any other sequence to the loss.

E.II.12. 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.

E.II.13. 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"

E.II.14. Any percentage of admissible claim under co-payment if applicable and as specified in the Policy Schedule.

E.II.15. Pre-existing condition disclosed by the Insured Person will be reviewed according to the company's underwriting policy.

E.II.16. Expenses related to cataract treatment involving all types of Multi-focal Lenses (including intraocular lenses), Multi-focal Toric Lenses, and Femto Laser-assisted surgeries are not covered.

E.II.17. Expenses related to any Modern & Advanced Treatments other than those covered under this Policy shall not be payable.

E.II.18. Any kind of Out-Patient Treatment expenses including fractures (not requiring any kind of hospitalization).

E.II.19. Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

E.II.20. Stem cell harvesting.

E.II.21. Vaccination including inoculation and immunisations (except post animal bite treatment).

E.II.22. Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.

E.II.23. Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.

E.II.24. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.

E.II.25. Drugs or treatments which are not supported by a prescription.

E.II.26. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

E.II.27. Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre or AYUSH Hospital.

E.II.28. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

E.II.29. Expenses incurred towards artificial life maintenance, including life support, after the patient has been certified to be in a vegetative state by the treating medical practitioner shall not be payable.

E.II.30.

C.III. Exclusion which can be opted for cover by payment of additional premium

E.III.1. 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"

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.1 of the Policy and limits as specified in the Policy Schedule)

E.III.2. Treatment received outside India other than for coverage under Worldwide Accidental Emergency Hospitalization Cover (if opted).

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.3 of the Policy and limits as specified in the Policy Schedule).

D. General Terms and Clauses

D.I. Standard General Terms and Clauses

F.I.1. Disclosure of Information

a. The Policy shall be null and void, and all premium paid thereon shall be forfeited to the Company in the event of any misrepresentation or mis-description of any material fact by the policyholder.

b. The Policy shall be null and void, and all premium paid thereon shall be forfeited to the Company in the event of non-disclosure of any material fact by the policyholder

("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

F.I.2. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim (s) arising under the policy.

F.I.3. Claim Settlement (provision for Penal Interest)

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

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

F.I.4. Complete Discharge

Any payment to the policyholder, insured person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

F.I.5. Multiple Policies

Where an Insured Person has policies from more than one Insurer to cover the same risk on an indemnity basis, the Insured Person shall only be indemnified for the treatment costs in accordance with the terms and conditions of the chosen policy.

In case of multiple indemnity policies taken by an Insured Person during a period from one or more Insurers, the Insured Person shall have the right to require settlement of his/her claim under any of his/ her policies,

subject to proper disclosure of information about their multiple indemnity policies to chosen Insurer, either at policy inception, at renewal, or at the time of claim intimation.

Upon a claim, the Insurer chosen by the Insured for claim settlement shall be treated as the Primary Insurer and shall be obligated to settle the claim within the limits and terms of the chosen policy. If the available coverage under the chosen policy is less than the admissible claim amount, the Primary Insurer shall co-ordinate with other Insurer to ensure settlement of the balance amount as per the policy contract.

F.16. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent.

The company shall not repudiate the claim and/or forfeit the policy benefits on the ground of Fraud, if the insured person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

F.17. Cancellation

i. The policyholder may cancel this policy by giving 7 days written notice at any time during the term and in such an event, the Company shall refund premium for the unexpired policy period as detailed 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 (in Year)	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 (in Year)	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.

The Company may cancel the policy at any time on grounds of misrepresentation, non- disclosure of material facts, fraud by the insured person subject to moratorium clause, 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.

F.I.8. 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, to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc.as per IRDAI guidelines on migration.

F.I.9. 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 to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, moratorium period etc. as per IRDAI guidelines on portability.

F.I.10. Renewal of Policy

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

i. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days, to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
iv. No loading shall apply on renewals based on individual claims experience.

F.I.11. Withdrawal of Policy

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

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

F.I.12. 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.

F.I.13. Premium Payment in Instalments (Wherever applicable)

If the insured person has opted for Payment of Premium on an Instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.
ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
iii. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged if the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

F.I.14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the policy including the premium rates. The insured person shall be notified atleast 45 days before the changes are effected.

F.I.15. Free Look period

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

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

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

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

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

F.I.16. 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.: **022 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 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,

401/402, 4th Floor, Raheja Titanium, Western Express Highway,

Goregaon (East),

Mumbai - 400063, Maharashtra, 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.

F.I.17. Nomination

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

D.II. Specific Terms and Clauses

F.II.1. Material Change

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

F.II.2. Alterations in the Policy

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

F.II.3. Change of Policyholder

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

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

F.II.4. No Constructive Notice

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

F.II.5. Geography

The geographical scope of this policy applies to events within India other than for D.III.3 Worldwide Accidental Emergency Hospitalization Cover (if opted) and which are specifically covered in the Policy Schedule. However all admitted or payable claims shall be settled in India in Indian rupees.

F.II.6. Mandatory Co-payment

A compulsory Co-payment of 10% is applicable on all claims irrespective of Age of entry in to the Policy under Active Plan. Co-payment will be applied on the admissible claim amount. In case the claim amount is processed as per the sub-limits for the named ailments/procedures as mentioned under section D.I.1 In-patient Hospitalization, the Mandatory Co-payment shall not be applicable.

F.II.7. Records to be maintained

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

F.II.8. Grace Period

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

F.II.9. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. The Policy with Optional cover Worldwide Accidental Emergency Hospitalization Cover shall be renewed subject to the Insured Person being an Indian resident at the time of renewal.
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 45 days prior to date of such revision or modification.

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

h. Any enhanced Base 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 Base Sum Insured is reduced on any Policy Renewals, the waiting periods shall be waived only up to the lowest Base Sum Insured of the last 24 consecutive months as applicable to the relevant waiting periods of the Plan opted.

j. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section E.I.1 to E.I.3 and E.II.1 will be applicable considering such Policy Year as the first year of Policy with the Company.

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

III. 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 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.

F.II.10. Premium calculation

Premium will be calculated based on the Sum Insured, Policy Tenure, Age, Policy Type, Optional covers, Add-on covers, Zone of cover opted and risk classification. Default zone of cover will be based on Proposer's city-location pin code as mentioned in KYC document.

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

Zone Classification

Identification of Zone will be based on Proposer's city-location pin code as mentioned in KYC documents. The residential address provided by You should be true, correct and complete. Any discrepancy or mismatch identified during claim adjudication may lead to delays, disputes or denial of claim settlement. The policyholder is required to promptly inform the company of any changes to the residential address to ensure uninterrupted communication and smooth claim processing.

Zone	Region / District / State
Zone I	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 II	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: Chennai, Bangalore, Wayanad, Chandigarh, Panchkula, Bokaro, Dhanbad.
Zone III	Rest of India excluding the locations mentioned under Zone I & Zone II

(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)

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

(b) Persons paying Zone II premium

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

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

(c) Person paying Zone III premium

i) Can avail treatment in Zone III, without any Co-pay.

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

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

***Option to select Zone 1 if the actual Zone is Zone 2 or Zone 3 and would be available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals.

Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalization due to Accident. The aforesaid Co-payments applicable are in addition to the Mandatory Co-payment under section F.II.6 and will be applied in conjunction to section F.II.6.

F.II.11. Discounts under the Policy

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

i. <u>Lifetime Discounts:</u>

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

b. No Claim Discount – The insured shall be eligible for 1% discount on the renewal premium if no claim has been made during the expiring policy tenure, subject to the following conditions:

(i) For the purpose of determining eligibility for No Claim Discount, the utilization of following benefits shall not be considered as a claim:

a. D.II.1 - Domestic Second Opinion,
b. D.II.2 – Tele Consultation,
c. D.II.4 - Wellness Program,
d. D.II.5 - Discount from Network Providers, and
e. D.III.4 - Health Check-up

(ii) The No Claim Discount shall be applicable on the renewal premium, including premium of all optional covers/riders and any applicable loading.

(iii) No Claim Discount shall be applied individually at insured person level.

ii. Short term Discounts:

a. **Worksite Marketing Discount** - A discount of 10% will be available on polices which are sourced through worksite marketing channel. This discount is applicable once, only at inception of the Policy.

<u>Maximum discount applicable as per this section on a single policy shall not exceed 40%</u>.

F.II.12. Loadings & Special Conditions

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

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations or additional waiting periods (a maximum of 36 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 an electronic mode, as the case may be and You would need to revert with consent and premium, within the duration specified in the counter offer letter.

F.II.13. Communications & Notices

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

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

F.II.14. Electronic Transactions

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

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

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

F.II.15. Limitation of Liability

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

F.II.16. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

F.II.17. Dispute Resolution

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law without reference to any principle which would result in the application of the law of any other jurisdiction.

F.II.18. Revival of policy

If your Policy has passed the stipulated grace period due to non-payment of premium, you may be allowed for revival of your policy, subject to certain specific terms and conditions.

<u>Specific conditions applicable to revival of policy</u>

a. The policy could be revived maximum within 180 days from lapse of the first payment due date
b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):

1. Special conditions,
2. Assessment of current health status or Good health declaration
3. Undergoing medical examinations
4. Payment of all the premium (inclusive of applicable taxes) that was due and unpaid

c. Any claim/medical expense incurred during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.
d. If a ‘Good Health Declaration’ is sought by us and is later proven to be fraudulent, the entire policy shall be

cancelled, and no claims shall be payable.

e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

F.II.19. Coverage Standards & Protocols

Medicine is an evidence-based science. Clinical diagnosis supported by positive investigation test findings are its founding principles. Treatment in Medicine are given as per well-defined protocols.

Our goal is to deliver care that is appropriate, effective, and safe. Equally important is avoiding treatments that are not medically necessary, as this helps safeguard patient well-being. Insurance, by design, is to support healthcare needs and not to change treatment choices. Furthermore, a key principle in insurance suggests that having coverage should not influence healthcare decisions. Patients naturally consider the benefits of treatment along with its cost and choose care that offers the best value and medical results. This approach supports responsible, value-based care that focuses on what is truly needed for recovery and long-term health.

A. Medical Protocols

We are committed towards supporting safe, effective, and evidence-based medical care. To help bring clarity and consistency, we will be referring to trusted and widely accepted sources such as leading medical textbooks, All India Institutes of Medical Sciences

(AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence **(**NICE).

These guidelines are designed to help explain:

a. When hospitalization is needed, including guidance on the appropriate level of care (for example: admission in an ICU or non-ICU room)

b. What treatments and procedures are considered appropriate, based on the medical condition and its severity, including recommended medicines and procedures

To ensure patient safety and quality of care, coverage under this policy shall be aligned with treatments and medicines that are approved by recognized regulatory authorities such as the Central Drugs Standard Control Organisation (CDSCO), Food and Drug administration (FDA), and other relevant bodies in India. Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India shall not be covered under the policy.

We also follow official guidance provided by manufacturers and regulatory authorities regarding how medicines and procedures should be used, including their approved indications and precautions. Treatments or medications used outside their approved purpose (often called "off-label" or extra usage) shall not be covered under the policy, as these fall outside established approval and safety guidelines.

Our approach is focused on transparency, safety, and supporting care that is medically appropriate and widely accepted, helping customers make informed healthcare decisions with confidence.

B. Position statements

Medicine is constantly evolving, wherein, new technologies and treatment approaches are emerging regularly. While many innovations offer promise, not all deliver outcomes that are meaningfully better when considered alongside their costs and established alternatives.

As a responsible insurer, we believe in being transparent and clear with our customers. Therefore, our decision on the coverage of illnesses or injury shall be basis texts and medical protocols published/recognised by globally trusted establishments like All India Institutes of Medical Sciences (AIIMS), Indian Council of Medical Research (ICMR), the Clinical Establishments Act 2010, Pradhan Mantri Jan Arogya Yojana (PMJAY), various health schemes like Mukh Mantri Sehat Yojana (MMSY Punjab), the Department of Health Research (Ministry of Health), and internationally respected institutions like Mayo Clinic, Cleveland Clinic, and National Institute for Health and Care Excellence **(**NICE). Our evaluations will be based on comprehensive Health Technology Assessments, health economic evaluations, cost-benefit and cost-efficiency analyses, along with other well-regarded global research published in reputable medical journals. Any research found to have conflicts of interest will be excluded from consideration.

Medical protocols published by these establishments will outline how we assess different medicines, treatments, procedures, investigations, and therapies. Depending on the clinical and scientific evaluation, we may either cover the Reasonable and Customary charge incurred on a treatment wholly or partially or may recommend suitable alternatives or may seek additional review or in some cases may be unable to provide coverage under this product.

Importantly, if our medically-informed assessment results in no coverage or partial coverage for a particular treatment, we will still ensure payment at least up to the cost of the most widely accepted and commonly used alternative treatment currently available for that condition.

C. Prolonged Hospitalization extending beyond 10 days

a. It is important that you inform us in a timely manner. If we do not receive intimation within 10 days from the date of admission, we may apply an additional cumulative co-payment of 10% on the final admissible claim amount.
b. We may request for indoor case papers, treatment sheets, and daily monitoring records to help us understand and support the medical need for the extended stay.
c. If the medical records indicates that the insured's health parameters have stabilized and yet the hospitalization continues, expenses related to the extended period of stay may not be payable under this policy.

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.
b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.
c. For all Kidney, liver and pancreas transplants, a biopsy of the recipient's organ may be required as part of the medical evaluation process.
d. If treatment is taken at a non-network hospital and we do not receive the required intimation or the biopsy report as outlined above, an additional 20% co-payment may be applicable on the admissible claim amount.

F.II.20. Utilization of Sum Insured

Sequence of utilization of Sum Insured will be as follows:

a. Base Sum Insured (if remaining for that claim)
b. Cumulative Bonus – if opted (earned and remaining for that claim)
c. Restoration (applicable for that claim)

F.II.21. Personal Data and Privacy

Personal and health data will be processed only for policy issuance, servicing and claims, and may include ABDM/ABHA-enabled services where consented; you can withdraw such consent at any time (see Policy T&C).

F.II.22. Pre-Policy medical check up

Where a pre-policy medical check-up has been undertaken by the proposed Insured Person(s) and the insurance policy is not issued or the proposal is not taken forward, the entire expenses incurred towards the pre-policy medical check-up shall be payable by the Proposer.

F.II.23. Indemnity principle clause

The total amount paid for the same admissible claim, whether under one or more indemnity covers or policies, with us or any other insurer, will not be more than the actual expenses incurred by the Insured Person.

E. Other terms and conditions

E.I. Claim process & management

G.I.1. Condition Preceding

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

Completed claim forms and processing documents must be furnished to Us within the stipulated timelines for all reimbursement claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim. The due intimation, submission of documents and compliance with requirements as provided under the Claims Process under this Section, by You shall be essential failing which We shall not be bound to accept a claim.

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

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

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

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

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

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

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

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

G.I.3. Claim Intimation

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

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

- Planned Hospitalization, You/the Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization, You/the Insured Person will intimate such admission within 24 hours of such admission.

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

G.I.4. Cashless Facility

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

(a) For Planned Hospitalization:

i. The Insured Person should at least 48 hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

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

iii. The Network Provider or shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty four) hour authorization/ cashless department along with contact details of the treating Medical Practitioner and the Insured Person.

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

v. Wherever the information provided in the request is sufficient to ascertain the authorization We shall issue the authorization Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorization will be issued. All authorizations will be issued within a period of 1 hour from the receipt of request.

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

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

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

i. The Network Provider shall request Us for an enhancement of authorization limit as described under Section G.I.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit.

ii. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

iii. We shall accept or decline such additional expenses within 1 (one) hour of receiving the request for enhancement from You.

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

At the time of discharge:

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

ii. We shall accept or decline such additional expenses within 3 (Three) hours of receipt of request for final discharge from Network provider.

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

(b) In case of Emergency Hospitalization

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

ii. The Network Provider shall forward the request for authorization within 24 hours of admission to the Hospital as per the process under Section G.I.4 (a).

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

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

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

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital as specified by Insurance Council for Illness or Injury which are covered under the Policy and shall not be available to the Insured Person for coverages under Worldwide Accidental Emergency Hospitalization Cover (Section D.III.3), Convalescence Benefit (Section D.I.10) and Daily Cash for Shared Accommodation (Section D.I.11). For all Cashless authorizations, You will, in any event, be required to settle all non-admissible expenses, Co-payment and/or Deductibles (if applicable), directly with the Hospital.

The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us.

The following claim documents should be submitted to Us within 15 days from the date of discharge from Hospital -

- Claim Form Duly Filled and Signed
- Original pre-authorization request
- Copy of pre-authorization approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes(if any)
- Original Hospital Main Bill and break up Bill
- Original Investigation Reports, X Ray, MRI, CT Films, HPE
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted) We may call for any additional documents as required based on the circumstances of the claim

There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to Us which will be considered subject to the Policy Terms & Conditions. We in our sole discretion, 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/latest list of Network Hospital on the Company's website or by calling our call centre.

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents

i. Wherever You have opted for a reimbursement of expenses, You may submit the following documents for reimbursement of the claim to Our branch or head office at your own expense not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of our Branch Offices or download a copy from our website https://www.manipalcigna.com/downloads/claims

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

a. Common claim documents required for all claims:

- Claim form duly signed
- Copy of photo ID of patient
- KYC documents (Photo ID proof, address proof, recent passport size photograph)
- Cancelled cheque for NEFT payment
- Payment receipt

b. Additional Claim documents required for below benefits:

S. No.	Name of Benefit	Name of Document
1	In-patient Hospitalization	• Hospital Discharge summary • Operation Theatre notes/ ICP papers • Hospital Main Bill • Hospital Break up bill • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices • Copy of FIR/ Panchnama / Police Inquest Report (if conducted) duly attested by the concerned Police Station in case of Accident
2	Day Care Treatment	
3	Donor Expenses	
4	AYUSH Treatment	
5	Worldwide Accidental Emergency Hospitalization Cover	
6	Pre – hospitalization	• Pharmacy Bills • Diagnostic tests reports in relation to admitted hospitalization expenses • Prescription in support of Pharmacy, Investigations
7	Post – hospitalization	
8	Domiciliary Hospitalization	• Certificate from treating Medical Practitioner that condition of the Insured Person does not allow a Hospital transfer; or • Evidence that hospital bed was unavailable in nearest hospitals. • Final Bill and invoice • Nursing chart/TPR chart • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation Pharmacy bills, prescription and invoices

9	Road Ambulance	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance

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

iii. Our branch offices shall give due acknowledgement of collected documents to You.

In case You/ Insured Person delay submission of claim documents as specified in G.I.5 (a) above, then in addition to the documents mentioned in G.I. 5. (a) above, You are also required to provide Us the reason for such delay in writing. 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 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.

G.I.6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.

b. We shall settle the claim payable amount arrived post scrutinizing the claim documents.

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

G.I.7. Claim Assessment

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

a)

i) Where a room accommodation is opted for higher than the eligible room category under the plan, the room rent for the applicable accommodation will be apportioned on pro rata basis.
Such apportioned amount will apply to all “Associated Medical Expenses”. [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]

ii) Any Sub-limits, Mandatory or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7 (i)

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

i) Mandatory Co-payment

ii) Zonal Co-Payment (if applicable)

iii) Sum Insured

iv) Cumulative Bonus

v) Restored Sum Insured

Note: Wherever the disease specific Sub-limits as mentioned under In-patient Hospitalization (section D.I.1) are applied, the Mandatory Co-payment shall not be applicable and they are mutually exclusive.

Claim Assessment for Benefit Plans:

We will pay fixed benefit amounts as specified in the Policy Schedule in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not specified in the Policy.

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

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

G.I.8. Claims Investigation

We may, at Our discretion, depending upon the facts of the case, investigate and determine the validity of claims. Such investigation shall be conducted on case to case basis and will be concluded accordingly. Any verification or investigation will be carried out by individuals or entities authorized by Us, and the cost of such verification/investigation will be borne by Us.

G.I.9. Pre and Post-hospitalization claims

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

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

G.I.10. Representation against Rejection:

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

G.I.11 Payment Terms

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

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

We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured, Cumulative Bonus under section D.II.3 and Restoration of Sum Insured under section D.I.8 for that Insured Person is exhausted.

All claims will be payable in India and in Indian rupees.

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

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

Claim process Applicable to the following Sections:

G.I.12 Domestic Second Opinion

(a) Receive Request for Expert Opinion on Critical Illness

You can submit Your request for an expert opinion by calling Our call centre or register request through email.

(b) Facilitating the Process

We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner. The expert opinion is available only in the event of the Insured Person being diagnosed with Covered Critical Illness.

G.I.13 Health Check up and Tele-Consultation

(a) You or The Insured Person shall seek appointment by calling Our call centre.

(b) We will facilitate Your appointment and We will guide You to the nearest Network Provider for conducting the medical examination. Reports of the Medical Tests can be collected directly from the centre.

G.I.14 Worldwide Accidental Emergency Hospitalization Cover

a) In an unlikely event of You or the Insured Person requires Emergency medical treatment outside India arising due to an accident, You or Insured Person, must notify Us either at Our call centre or in writing within 48 hours of such admission.

b) You shall file a claim for reimbursement in accordance with Section G.I.5 of the Policy.

G.I.15 Application of Multiple policies clause

In case this clause is invoked in accordance to the terms and conditions as provided under this Policy, the Claim will be adjudicated as under:

a) Retail policy of the Company & any other Policy from other insurers:

i. **Cashless hospitalization:** If the Insured Person avails cashless facility for hospitalization, the Insured, Network Provider will intimate us of the admission through a preauthorization request with all details and estimated amount for the hospitalization. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

ii. **Reimbursement claim:** If the Insured Person is admitted and pays the entire bill, then files for a reimbursement claim, he/she may submit the documents for reimbursement of the claim through our mobile App or on our website or at our designated claims office (details as mentioned in Section G.I.3) at his/her own expense not later than 15 days from the date of discharge from the Hospital. All the documents shall be required in original, except in case of deductible we require attested photocopy of documents mentioned under section G.I.5 and settlement letter of previous insurer (partial payment cases).

b) Retail policy & group policy from the Company:

i. **Cashless process:** If the insured needs to utilize the cashless facility for hospitalization, the insured/ hospital will intimate the Company about the hospitalization through pre-authorization process. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. Subsequently, the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen. Post discharge, hospital will send as many separate claims as no. of policies with the Company, each with attached authorization letters & original documents for settlement to the Company. The Company will settle all the claims as per policy terms & conditions & authorization letter issued.

ii. **Reimbursement Claim process:** In case the Insured gets admitted & pays the entire bill, & then files for reimbursement claim, he/she may submit the documents for reimbursement of the claim through our mobile App or on our website or at our designated claims office(details as mentioned in Section G.I.3) at his/her own expense not later than 15 days from the date of discharge from the Hospital. All the documents shall be required in original, except in case of deductible we require attested photocopy of documents mentioned under section G.I.5 and settlement letter of previous insurer (partial payment cases).

G.I.16 Policy Servicing and Claims Servicing details

Particulars	Details
Official Website	www.manipalcigna.com
Official Mobile Application	myManipalCigna
Designated Claims Office Address	Techweb center 2nd Floor New Link Rd, Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India
Claims page	https://claim.manipalcigna.com/claims/
Claims form (download)	https://www.manipalcigna.com/downloads/claims
Customer Care	customercare@manipalcigna.com
Head Customer Care	headcustomercare@manipalcigna.com
Toll free customer care contact number	1800-102-4462 (available between 9:00 AM to 9:00 PM)
Senior Citizens Support	seniorcitizensupport@manipalcigna.com
For policy servicing	https://eservicing.manipalcigna.com/login
List of network hospitals	https://www.manipalcigna.com/locate-us
List of Unrecognised hospitals	https://www.manipalcigna.com/locate-us
For complaints	complaints@manipalcigna.com
Chief Grievance Redressal Officer	Compliance@manipalcigna.com
Grievance Redressal contact number	022-61703600 (available Monday to Friday between 10 AM to 6 PM)

G.II Annexure – I:

Ombudsman

The contact details of the Insurance Ombudsman offices are as below:

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD **Office of the Insurance Ombudsman,** **Jeevan Prakash Building, 6th floor,** **Tilak Marg, Relief Road,** **Ahmedabad – 380 001.** **Tel.: 079 - 25501201/02** **Email:- oio.ahmedabad@cioins.co.in**	Gujarat, Dadra and Nagar Haveli, Daman and Diu.
BENGALURU **Office of the Insurance Ombudsman,** **Jeevan Soudha Building,PID No. 57-27-N-19** **Ground Floor, 19/19, 24th Main Road,** **JP Nagar, Ist Phase,** **Bengaluru – 560 078.** **Tel.: 080 - 26652048 / 26652049** **Email: oio.bengaluru@cioins.co.in**	Karnataka
BHOPAL **Office of the Insurance Ombudsman,** **1st floor,"Jeevan Shikha",** **60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills** **Bhopal – 462001.** **Tel.: 0755 - 2769201 / 2769202/2769203**	Madhya Pradesh and Chhattisgarh

Email:- oio.bhopal@cioins.co.in	
BHUBANESWAR **Office of the Insurance Ombudsman,** **62, Forest park,** **Bhubaneshwar – 751 009.** **Tel.:- 0674-2596461/2596455/2596429/ 2596003** **Email:- oio.bhubaneswar@cioins.co.in**	Odisha.
CHANDIGARH **Office of the Insurance Ombudsman,** **Jeevan Deep Building SCO 20-27,** **Ground Floor Sector- 17 A,** **Chandigarh – 160 017** **Tel.:- 0172 - 2706468** **Email:- oio.chandigarh@cioins.co.in**	Punjab, Haryana, (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh
CHENNAI **Office of the Insurance Ombudsman,** **Fatima Akhtar Court,** **4th Floor, 453 (old 312), Anna Salai, Teynampet,** **CHENNAI – 600 018.** **Tel.:- 044 - 24333668 / 24333678** **Email:- oio.chennai@cioins.co.in**	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI **Office of the Insurance Ombudsman,** **2/2 A, Universal Insurance Building,** **Asaf Ali Road,** **New Delhi – 110 002.** **Tel.:- 011 - 46013992/ 23213504/ 23232481** **Email:- oio.delhi@cioins.co.in**	Delhi and following Districts of Haryana - Gurugram, Faridabad, Sonepat and Bahadurgarh
GUWAHATI **Office of the Insurance Ombudsman,** **'Jeevan Nivesh', 5th Floor,** **Nr. Panbazar over bridge, S.S. Road,** **Guwahati – 781001(ASSAM).** **Tel.:- 0361-2632204/2602205/2631307** **Email:- oio.guwahati@cioins.co.in**	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD **Office of the Insurance Ombudsman,** **6-2-46, 1st floor, "Moin Court"** **Lane Opp. Hyundai Showroom A. C. Guards, Lakdi-Ka-Pool,** **Hyderabad - 500 004.** **Tel.:- 040 - 23376991 / 23376599 / 23328709 / 23325325/23312122** **Email:- oio.hyderabad@cioins.co.in**	Andhra Pradesh, Telangana, Yanam and part of Territory of Puducherry.

JAIPUR **Office of the Insurance Ombudsman,** **Jeevan Nidhi – II Bldg., Gr. Floor,** **Bhawani Singh Marg,** **Jaipur - 302 005.** **Tel.: 0141- 2740363** **Email:- oio.jaipur@cioins.co.in**	Rajasthan
KOCHI **Office of the Insurance Ombudsman,** **10th Floor, Jeevan Prakash, LIC Building,** **Opp to Maharaja's College Ground,** **M.G.Road,** **Kochi - 682 011.** **Tel.: 0484 - 2358759** **Email:- oio.ernakulam@cioins.co.in**	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA **Office of the Insurance Ombudsman,** **Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue,** **KOLKATA - 700 072.** **TEL : 033 - 22124339 / 22124341** **Email:- oio.kolkata@cioins.co.in**	West Bengal, Sikkim, Andaman and Nicobar Islands
LUCKNOW **Office of the Insurance Ombudsman,** **6th Floor, Jeevan Bhawan,** **Phase-II, Nawal Kishore Road, Hazratganj,** **Lucknow-226 001.** **Tel.:- 0522 - 4002082 / 3500613** **Email:- oio.lucknow@cioins.co.in**	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.
MUMBAI **Office of the Insurance Ombudsman,** **3rd Floor, Jeevan Seva Annexe,** **S. V. Road, Santacruz (W),** **Mumbai - 400 054.** **Tel.:- 022 - 69038800/27/29/31/32/33** **Email:- oio.mumbai@cioins.co.in**	List of wards under Mumbai Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai
NOIDA **Office of the Insurance Ombudsman,** **Bhagwan Sahai Palace** **4th Floor, Main Road,** **Naya Bans, Sector 15,** **Distt: Gautam Buddh Nagar,** **U.P-201301.** **Tel.: 0120-2514252 / 2514253** **Email: oio.noida@cioins.co.in**	State of Uttarakhand and the following districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA **Office of the Insurance Ombudsman,** **2nd Floor, Lalit Bhawan,** **Bailey Road,** **Patna 800 001.** **Tel.: 0612-2547068 Email: oio.patna@cioins.co.in**	Bihar and Jharkhand.

PUNE **Office of the Insurance Ombudsman,** **Jeevan Darshan Bldg., 3rd Floor,** **C.T.S. No.s. 195 to 198,** **N.C. Kelkar Road, Narayan Peth,** **Pune – 411 030.** **Tel.: 020-24471175** **Email: oio.pune@cioins.co.in**	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE **Office of the Insurance Ombudsman,** **2nd Floor, Jeevan Chintamani Building,** **Vasantrao Naik Mahamarg,** **Thane (West)- 400604** **Tel.: 022-20812868/69** **Email: oio.thane@cioins.co.in**	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

Note: For Updated list of Insurance Ombudsman details including Address and Jurisdiction, kindly visit : https://irdai.gov.in/ombudsman

G.III Annexure – II:

<table>
<tr><td>Title</td><td colspan="6">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>Your Coverage Details:</td><td>Identify your Plan</td><td colspan="5">Active</td></tr>
<tr><td rowspan="8">Basic Cover

This section lists the Basic benefits available on your plan Basic Cover</td><td>Identify your Opted Base Sum Insured (BSI) (in₹)</td><td colspan="5">₹ 3 Lacs, ₹ 5 Lacs, ₹ 7.5 Lacs, ₹ 10 Lacs, ₹ 12.5 Lacs, ₹ 15 Lacs, ₹ 20 Lacs, ₹ 25 Lacs, ₹ 30 Lacs, ₹ 40 Lacs, ₹ 50 Lacs & ₹ 1 Cr</td></tr>
<tr><td rowspan="7">In-patient Hospitalization (When you are hospitalized) (₹)</td><td colspan="5">Room Rent :
For Base Sum Insured 3 lacs: 1% of Base Sum Insured
For Base Sum Insured 5 lacs and above: Single Private A/C
Room For ICU - At Actuals</td></tr>
<tr><td>Base Sum Insured</td><td>₹ 3 Lacs</td><td>₹ 5 Lacs</td><td>₹ 7.5 and ₹ 10 Lacs</td><td>> ₹ 10 Lacs</td></tr>
<tr><td>Treatment for each ailment / procedure mentioned below:
1. Surgery for treatment of all types of Hernia
2. Hysterectomy
3. Surgeries for benign Prostate Hypertrophy
4. Surgical treatment of stones of renal system</td><td>₹ 50,000</td><td>₹ 65,000</td><td>₹ 80,000</td><td>NA</td></tr>
<tr><td>Treatment of Cataract (Per Eye)</td><td>₹ 20,000</td><td>₹ 30,000</td><td>₹ 30,000</td><td>NA</td></tr>
<tr><td>Treatment of Total Knee replacement (Per knee)</td><td>₹ 80,000</td><td>₹ 1,00,000</td><td>₹ 1,20,000</td><td>NA</td></tr>
<tr><td>Treatment for breakage of bones</td><td>₹ 2,00,000</td><td>₹ 2,50,000</td><td>₹ 3,00,000</td><td>NA</td></tr>
<tr><td colspan="5"></td></tr>
</table>

<table>
<tr><td></td><td></td><td>Wherever the above mentioned Sub-limits are applied, the Mandatory Co-payment under section F.II.6 shall not be applicable however co-payment for the treatment taken at higher zone as mentioned under section F.II.10 will continue to apply.
This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments: up to 50% of Sum Insured
b. HIV/AIDS & STD: up to Sum Insured
c. Mental Illness: up to 50% of Sum Insured
For below mentioned ICD Codes: Waiting Period of 24 months shall apply:
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>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></td><td>Pre – hospitalization</td><td>Medical Expenses incurred during policy period covered up to 30 days before the date of hospitalization;
Covered upto the Sum Insured</td></tr>
<tr><td></td><td>Post – hospitalization</td><td>Medical Expenses Covered up to 60 days post discharge from the hospital;
Covered upto the Sum Insured</td></tr>
<tr><td></td><td>Day Care Treatment</td><td>All Day Care Treatments Covered up to the Sum Insured</td></tr>
<tr><td></td><td>Domiciliary Hospitalization (Treatment at Home)</td><td>Covered up to 10% of the Sum Insured.
Pre and Post Hospitalization Expenses: 30 days each</td></tr>
<tr><td></td><td>Road Ambulance (Reimbursement of Ambulance Expenses)</td><td>Covered up to the Sum Insured</td></tr>
</table>

	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to the Sum Insured
	Restoration (When opted Base Sum Insured is insufficient due to claims)	Multiple Restoration is available in a Policy Year for unrelated illnesses, in addition to the Base Sum Insured
	AYUSH Treatment	Covered up to the Sum Insured
	Convalescence Benefit (For Hospitalization >=10 days)	Applicable for Base Sum Insured of ₹ 5 lacs and above: Lumpsum benefit amounting to ₹ 30,000 per hospitalization upon completion of at least 10 consecutive days of hospitalization.
	Daily Cash for Shared Accommodation (in ₹)	Daily Cash benefit for occupying shared accommodation while hospitalized shall be covered as below:- a. For Base Sum Insured from ₹ 5 lacs up to ₹ 10 Lacs: ₹ 800 per day up to maximum of ₹ 5600 b. For Base Sum Insured above ₹ 10 Lacs: ₹ 1,000 per day up to maximum of ₹ 7000 Payable for each continuous and completed 24 Hours of Hospitalization during the Policy Year. This benefit gets triggered post 48 hours of In-patient hospitalization and shall be payable from 1st day onwards.
Value Added Covers This section lists the additional value added benefits that are available along with your plan	Domestic Second Opinion	Available for 36 listed Critical Illness/es
	Tele consultation	Unlimited Tele-consultation in a Policy Year
	Cumulative Bonus	Bonus of 10% per Policy Year, subject to a maximum: upto 100% of Base sum insured.
	Wellness Program (For Lives suffering from one or more of the following conditions: Asthma, Diabetes, Hypertension, Dyslipidaemia, Obesity)	Rewards can be earned by adhering to Condition Management Program and improving the Health Parameters. These earned Reward Points can be used against payable Renewal premium (excluding premium for optional covers, Rider and taxes)as discount from 1st Renewal of the Policy. Reward Accrual - Max upto 15% of the expiring base Premium (excluding premium for premium for optional covers, Rider and taxes), applicable for the respective insured. Reward Redemption: The earned reward points could be redeemed as discount to pay a portion of the renewal premium (excluding optional covers, Rider and taxes). The earned rewards shall lapse, in case the same is not used at the time of subsequent renewal (renewal falling due immediately after the accrual).
	Discount from Network Provider	Discount on Pharmacy, Diagnostics and Health Supplement offered by Our Network Providers

	Premium Waiver Benefit	Waives off one year Policy Premium (including premium for optional covers, rider and taxes) upon occurrence of any of the listed contingencies (Accidental death/ listed Critical Illnesses) to the Policyholder who is also an Insured Person in the Policy
Optional Covers	Non-Medical Items	Non-Medical items covered up to Sum Insured opted in case of In-patient Hospitalization and/or Day Care Treatment a policy year
	Waiver of Mandatory Co-payment	Waiver of Mandatory Co-payment of 10% per claim subject to underwriting
	Worldwide Accidental Emergency Hospitalization Cover (Applicable to Indian Residents only)	Covered up to Sum Insured opted for Emergency In-patient Hospitalization outside India. This benefit is available once in a Policy Year for each Insured Person.
	Health Check Up (in ₹)	Available once every third policy year, to all Adult insured persons who are 18 years or above at the start of the Policy Yearin lieu of 'Wellness Program'. This benefit shall be offered on cashless basis only.
	Waiver of Disease Specific Sublimit	Disease Specific Sublimit which is applicable for listed ailments / procedures as specified under section D.I.1 In-patient hospitalization shall be waived subject to underwriting.
	Cumulative Bonus	Option to choose any one of the following: Option a): 10% of Base Sum Insured, Max upto 200% of Base Sum Insured. OR Option b): 25% of Base Sum Insured, Max upto 200% of Base Sum Insured. OR Option c): 50% of Base Sum Insured, Max upto 200% of Base Sum Insured.
	Modification of Pre & Post Hospitalization Days	Option to Modify Pre-Hospitalization & Post-Hospitalization days: Option A) 60/90 days respectively Option B) 60/180 days respectively

	Add-on Cover	
	ManipalCigna Prime Plus	
1	Room rent modification (Available for Base Sum Insured of ₹ 5Lacs and above)	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 Option 2: Twin Sharing AC room; ICU Up to Sum Insured
2	Deductible	Option to opt from ₹ 10,000, ₹ 25,000, ₹ 50,000, ₹ 1,00,000, ₹ 2,00,000, ₹ 3,00,000, ₹ 4,00,000 and ₹ 5,00,000 on annual aggregate basis.

You are advised to refer to the attached Customer Information Sheet (CIS) for summary of benefits available in the Policy Wordings.

G.IV. Annexure - III

List I - Items for which Coverage is not available in the Policy

Sl. No.	Item
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS/BRACES
5.	BUDS
6.	COLD PACK/HOT PACK
7.	CARRY BAGS
8.	EMAIL I INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER
42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG / SHORT / HINGED)
46.	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53.	SUGAR FREE Tablets
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

List II - Items that are to be subsumed into Room Charges

Sl. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES

6.	COMB
7.	EAU-DE-COLOGNE I ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET / WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES I ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS I VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES I MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND I NAME TAG
37.	PULSEOXYMETER CHARGES
List III - Items that are to be subsumed into Procedure Charges	
1.	HAIR REMOVAL CREAM
2.	DISPOSABLES RAZORS CHARGES (for site preparations)
3.	EYE PAD
4.	EYE SHEILD
5.	CAMERA COVER
6.	DVD, CD CHARGES
7.	GAUSE SOFT
8.	GAUZE
9.	WARD AND THEATRE BOOKING CHARGES
10.	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11.	MICROSCOPE COVER
12.	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13.	SURGICAL DRILL
14.	EYE KIT
15.	EYE DRAPE
16.	X-RAY FILM
17.	BOYLES APPARATUS CHARGES
18.	COTTON
19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment	
Sl. No.	**Item**
1.	ADMISSION / REGISTRATION CHARGES
2.	HOSPITALIZATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3.	URINE CONTAINER
4.	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5.	BIPAP MACHINE
6.	CPAP / CAPO EQUIPMENTS
7.	INFUSION PUMP - COST
8.	HYDROGEN PEROXIDE \SPIRIT \ DISINFECTANTS ETC
9.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10.	HIV KIT
11.	ANTISEPTIC MOUTHWASH
12.	LOZENGES
13.	MOUTH PAINT
14.	VACCINATION CHARGES
15.	ALCOHOL SWABES
16.	SCRUB SOLUTIONISTERILLIUM
17.	GLUCOMETER & STRIPS
18.	URINE BAG