

MANIPALCIGNA INFINIX – PROSPECTUS

SECTION – 1 PREFACE

A. Preamble

1. This is your health insurance policy from ManipalCigna Health Insurance Company Limited, issued to the policyholder and covering the insured member(s) mentioned in your Policy Schedule.
2. The Policy Wording, along with your Policy Schedule, the declarations / updates / endorsements made at the start of the policy or during the policy lifetime, together form your legal agreement with us.
3. This policy is based on the information you shared in the proposal form and during verification calls, and will be valid once we receive the required premium. As part of your welcome kit, you will also receive a copy of the Proposal Form, which includes the information and choices shared by You. We recommend that You review the welcome kit carefully and let Us know if You notice any errors.
4. For a complete understanding about your coverage, we recommend you read the Policy Wording in conjunction with your Policy schedule. If you would like a quick summary of the policy and its benefits, please refer to the Customer Information Sheet (CIS), which provides an easy-to-understand overview at a glance.
5. This Policy is governed by the applicable laws of India.
6. The examples in this document are meant to help explain the policy benefits and are for illustration purposes only.

B. Operative Clause

1. Your coverage may be on an individual basis or a family floater basis, as mentioned in your Policy Schedule.
2. Your coverage includes only the benefits shown as in force on your Policy Schedule.
3. You can choose to make a claim either through cashless, reimbursement, or both, as per eligibility and details in Table D.
4. Any claim payable under the policy will depend on the coverage terms, including deductibles, sub-limits, waiting periods, co-payments, conditions, definitions and availability of Base Sum Insured / benefit amount. Coverage under this Policy is also subject to the exclusions listed in Section 3, as well as any specific exclusions mentioned under the relevant benefit.
5. Your claims are covered as long as the treatment undertaken is medically necessary.
6. Claims are payable only when the covered event occurs and the related expenses are incurred during the policy period mentioned in your Policy Schedule, unless a benefit specifically provides otherwise.
7. We will cover medical expenses up to what is considered reasonable and customary for the treatment, based on standard charges in that location and for similar medical services.
8. We will pay only for medical expenses that are actually used and consumed during your treatment. Any items or services billed but not used will not be covered.
9. Unless explicitly called out in the terms of a benefit, the limits in your Policy Schedule reset and apply fresh for every policy year.

10. For certain service benefits offered through third-party service providers, we only help you access these services, discounts, or products. We are not responsible for any issues or liabilities arising from them, and such services cannot be used for medico-legal purposes.
11. In case of any increase in risk, for instance addition of a new Insured Member, enhancement of Base Sum Insured, or removal/reduction of deductible, all applicable waiting periods will apply afresh to the enhanced portion of such risk, unless expressly specified otherwise under the terms of the relevant benefit.

C. Definitions

For meaning of terms used in this document kindly refer to details in Annexure - 4. For ease of reference, all defined terms in these Policy Terms and Conditions are shown in bold.

SECTION – 2 BENEFITS COVERED UNDER THE POLICY

I. Base Benefits

- a. Base Benefits are inbuilt covers that come with this policy.
- b. Unless explicitly called out in the terms of a Base Benefit, any approved claim will be paid from the Base Sum Insured applicable for that policy year, and the balance available for the remainder of such Policy Year will reduce accordingly.
- c. Our maximum payout under all Base Benefits (unless explicitly specified otherwise in the terms of the benefit) of ManipalCigna Infinix health Insurance policy put together in a single policy year shall never exceed the Base Sum Insured as mentioned in your Policy Schedule
- d. The Base Sum Insured will reset at the start of every new policy year.

1. In-patient Hospitalization

Planned care or sudden emergencies, hospitalization expenses covered.

A. 2 hour hospitalization

Coverage for medically necessary hospitalization, even for shorter hospital stays.

What we cover

If you are hospitalized due to an illness or injury sustained during the Policy Period, we will cover the medical expenses listed under Table A for your **Medically Necessary Hospitalization**, as long as your hospital stay is for a continuous period of **2 hours or more**.

Let's understand 2-hour hospitalization with an example

Mr. Sharma had been experiencing severe abdominal pain since morning. Concerned, his family rushed him to the nearest hospital. After evaluation, the doctor advised immediate treatment as he was diagnosed with Acute appendicitis, and Mr. Sharma was admitted.

He stayed in the hospital for about **8 hours**, during which he received necessary treatment and monitoring. Once his condition stabilized, he was discharged the same day.

Since Mr. Sharma was **hospitalized for more than 2 hours and the admission was medically necessary**, his claim was accepted under the policy.

A few months later, Mr. Sharma had a minor issue and visited the hospital again. This time, he was discharged within **1.5 hours**, as the condition was mild. Since the hospitalization did not meet the **minimum 2-hour requirement**, this visit was **not covered** under the policy.

✓ Medically necessary hospitalization ≥ 2 Hours → **Covered** (Certain listed conditions may require 24 hrs hospitalization, please refer policy wordings)

✗ Medically necessary hospitalization < 2 Hours → **Not Covered**

TABLE A - List of Covered Medical Expenses	
Sr.No.	Particulars
1	Room Rent for accommodation in a Hospital room, up to the room category specified in the Policy Schedule
2	Intensive Care Unit (ICU) accommodation charges
3	Operation theatre charges
4	Fees of the Medical Practitioner (including specialist) and Surgeon
5	Anesthetist fees
6	Charges for services of Qualified nursing Staff
7	Cost of diagnostic tests
8	Cost of Medicines and drugs
9	Cost of applicable consumables, blood, oxygen, surgical appliances, and prosthetic devices, as recommended by the attending Medical Practitioner and used intra operatively during a Surgical Procedure

Key Service Terms

1. The date of admission to the hospital must fall within the Policy Period.
2. 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.
3. The proportionate deduction will apply to accommodation charges and associated medical expenses

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 (<i>not subject to proportionate deduction</i>) [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

What's not covered under 2 hour hospitalization

Any treatment which can be taken on an OPD (Outpatient) basis OR does not require medically necessary Hospitalization shall be excluded.

Given below are a few examples of medical treatments that shall remain excluded unless they genuinely require medically necessary Hospitalization

- Administration of intramuscular (IM) injections or intravenous (IV) fluids for nutritional or vitamin deficiencies
- Administration of antibiotics, analgesics and proton pump inhibitors (PPIs)
- Nebulization

B. Modern Treatments and Procedures

Access cutting-edge medical treatments with coverage for eligible, medically justified procedures.

What we cover

We will cover medical expenses for the Modern and Advanced Treatments listed below when they are received as part of a medically necessary hospitalization during the Policy Period.

The covered Modern Treatments and Procedures are:

1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2. Balloon Sinuplasty
3. Deep Brain stimulation
4. Oral chemotherapy
5. Immunotherapy - Monoclonal Antibody to be given as injection
6. Intra vitreal injections
7. Robotic surgeries
8. Stereotactic radio surgeries
9. Bronchial Thermoplasty
10. Vaporization of the prostate (Green laser treatment or holmium laser treatment)
11. IONM - (Intra Operative Neuro Monitoring)
12. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

Key Service Terms

1. Expenses incurred towards Modern Treatments and Procedures shall be covered up to the limit specified in the Policy Schedule.
2. Any Modern or Advanced Treatment that is **not specifically listed above** will not be covered under this benefit.
3. The modern treatment undertaken must be **certified in writing** by your **treating Medical Practitioner**, and coverage will be subject to applicable clinical protocols.
4. It is mandatory to provide prior intimation to Us for both cashless and reimbursement claims and to obtain prior approval from Us before commencement of the treatment. If a Modern Treatment is undertaken without obtaining prior approval from the Insurer, We will review the claim based on the medical information and circumstances of the case to assess the medical necessity and appropriateness of the treatment. Where our review indicates that a conventional treatment option could have provided a similar clinical outcome, the claim payable may be limited to the reasonable and customary costs that would have been incurred for the corresponding conventional treatment for the same condition.
5. Claims shall be adjudicated in accordance with the applicable guidance, directions, circulars, or clarifications issued from time to time by Regulatory Authorities including the General Insurance Council. You can check the details in the link below, which shares guidance from the General Insurance Council.

Link:

https://www.manipalcigna.com/documents/d/rewamp/modern_treatments_and_fever_guidelines

C. In-patient Care Hospitalization for HIV and AIDS

Inclusive hospitalization coverage for HIV/AIDS and related conditions.

What we cover

We will cover medical expenses specified in Table A above for **Medically Necessary Hospitalization** for treatment related to Human Immunodeficiency Virus - HIV - or HIV-related illnesses, including AIDS, AIDS related complex, any mutant derivative or variation of HIV/AIDS, and Sexually Transmitted Diseases.

This coverage will be provided in line with the **Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017**, as amended from time to time.

Key Service Terms

1. The treatment undertaken must be **certified in writing** by your **treating Medical Practitioner**, and coverage will be subject to applicable clinical protocols.
2. The treatments listed under this sub-benefit are covered only if the hospital stay is at least 24 consecutive hours
3. The key service terms applicable to '2 hour hospitalization' will also apply to this sub-benefit.

D. In-patient Care Hospitalization for Mental Illnesses

Because mental well-being is just as important as physical health.

What we cover

If hospitalization is required for the treatment of a mental illness or a condition affecting mental health, we will cover the eligible medical expenses listed in Table A above. Please refer to the table below for details of the covered mental health conditions.

TABLE B	
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

Key Service Terms

1. The modern treatment undertaken must be **certified in writing** by your **treating Medical Practitioner**, and coverage will be subject to applicable clinical protocols.
2. The treatments listed under this sub-benefit are covered only if the hospital stay is at least 24 consecutive hours
3. Coverage under **In-patient Care Hospitalization for Mental Illnesses** will be provided in line with the **Mental Healthcare Act, 2017**, as amended from time to time.
4. The key service terms applicable to '2 hour hospitalization' will also apply to this sub-benefit.

2. Day Care Treatment

Day care. Full protection.

What we cover

Under this benefit we'll cover the medical expenses you incur during the Policy Period for all **Day Care Treatments** - These treatments or surgical procedures are done under **general or local anesthesia** and need medical supervision, but because of **technological / technical advancements**, they can be completed in less than 24 hours and do not require you to stay in the hospital overnight.

Key Service Terms

The Day Care treatment must be recommended by your treating **Medical Practitioner in writing** and carried out at a Registered **Hospital or Day Care Centre**.

What's not covered under Day Care Treatment

OPD (Out-Patient) treatments and diagnostic services are not covered under Day Care Treatment.

Let's understand a few key differences between 2 hour hospitalization, Day-Care and OPD treatments

1. 2 hour hospitalization: Refers to a medically necessary treatment where the insured person is formally admitted to the In-patient Department (IPD) of a hospital and stays for at least 2 consecutive hours or more. Your hospital records, such as the admission time, discharge time, discharge summary, allotment of hospital bed and hospital bill, help confirm your stay and treatment.
2. Day Care Treatment: Some medical procedures need hospital admission, but thanks to advances in medical technology, they can now be completed within a few hours and without an overnight stay. These are called day care treatments. The hospital/day-care centre records, including the admission time and discharge time along with discharge summary, help confirm the treatment. Day care procedures are usually performed under local or general anaesthesia.
3. OPD Treatments: OPD is when you *visit a doctor or clinic for consultation or minor treatment and go back home the same day*. There is no formal hospital admission involved.

3. Pre-Hospitalization Medical Expenses

Protecting you from the first step of treatment.

What we cover

Before a hospital admission, there are often important medical steps that help your doctor diagnose the condition and plan the right treatment. You may need to consult your doctor, purchase prescribed medicines or under-go prescribed medical tests before getting admitted to the hospital, we've got you covered! We'll reimburse those expenses incurred during the number of days mentioned in your policy schedule, right before your hospital admission.

Key Service Terms

1. This benefit applies only when your main claim for In-patient Hospitalization or Day Care Treatment has been paid under this policy. Pre-hospitalization expenses will be covered only if they are recommended in writing by your treating medical practitioner and are related to the same illness or injury.
2. Pre-hospitalization expenses will be settled only from the Base Sum Insured applicable to the policy year in which the date of hospital admission falls.
3. Unfortunately, we do not cover Pre-hospitalization Expenses incurred prior to first policy inception date with us

4. Post-Hospitalization Medical Expenses

Recovery doesn't stop at discharge, and neither does your coverage.

What we cover

Sometimes, your recovery continues even after you leave the hospital. You may need follow-up consultations, medicines, diagnostic tests, or other medical care linked to the same treatment. Under this benefit we'll reimburse the medical expenses you incur **after you're discharged from the hospital**, for the number of days mentioned in your Policy Schedule. These expenses may include doctor follow-up fees, physiotherapy, purchase of prescribed medicines, under-go prescribed medical tests or routine follow up treatment. Such expenses must be directly linked to the treatment you were hospitalized for.

Key Service Terms

1. This benefit applies only when your main claim for **In-patient Hospitalization or Day Care Treatment** has been paid. Post-hospitalization expenses will be covered only if they are recommended in writing by your treating medical practitioner and are related to the same illness or injury.
2. Post-hospitalization expenses will be settled only from the Base Sum Insured applicable to the policy year in which the date of hospital admission falls.
3. Post-hospitalization expenses incurred **even after your policy ends** will be covered, as long as all the conditions of this benefit are met.

5. Domiciliary Hospitalization

When hospitalization isn't possible, your coverage stays by your side.

What we cover

If you need medical treatment for an illness or injury that normally requires you to be admitted to a hospital—but you're instead treated at home—we'll reimburse the medical expenses, as long as it happens during the policy period.

Key Service Terms

1. **Your medical condition must be such that you are unable to move to a hospital, or** circumstances must be such that there's **no hospital bed available**.
2. The Domiciliary Hospitalization treatment must continue for **at least 3 consecutive days**.
3. Your treating **doctor has advised and certified in writing** the below that
 - a. you need this treatment and
 - b. your medical condition is such that you are unable to move to a hospital.
4. Under this benefit, we will also cover **pre-hospitalization medical expenses up to 30 days** and **post-hospitalization medical expenses up to 30 days**. Also, do note that, we do not cover Pre-hospitalization expenses incurred prior to first policy inception date with us.

What's Not Covered Under Domiciliary Hospitalization

1. Asthma, COPD, bronchitis, tonsillitis, and other upper/lower respiratory infections (including laryngitis, pharyngitis, flu, cough, cold)

2. Arthritis, gout, rheumatism (including joint/bone rheumatism and rheumatic heart disease)
3. Chronic nephritis and nephritic syndrome
4. All types of diarrhoea, dysentery, and gastroenteritis
5. Diabetes mellitus or diabetes insipidus
6. Epilepsy or seizure disorders
7. Hypertension
8. Pyrexia of unknown origin
9. Day-care treatments

6. **Road Ambulance**

During a medical emergency, reaching the hospital quickly and safely can be critical.

What we cover

If you happen to need an ambulance to get to the hospital, we've got you covered! We'll reimburse costs for a road ambulance incurred for an emergency during the Policy Period in the following situations:

1. To transport you from the incident site to the nearest hospital and/or
2. **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
3. **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

Key Service Terms

1. **Doctor's Advice:** The need for an ambulance must be confirmed in writing by your treating doctor.
2. **Registered Service:** The ambulance should be provided by a registered healthcare or ambulance service provider.
3. This benefit applies only when your main claim for **In-patient Hospitalization** or **Day Care Treatment** is paid and the ambulance ride is for the same illness or injury.

7. **Donor Expenses**

Sometimes, a transplant may be the only way forward, where the treatment journey may incur medical expenses, this benefit helps cover the medical costs related to the donor's organ harvesting, screening, and related donor care.

What is covered and Key Service Terms:

A. Organ Harvesting Expenses

We will indemnify the medical expenses related to harvesting an organ from a donor incurred during the Policy Period, as long as the Insured Person is the one receiving the organ. This is subject to the following:

1. The donor must be someone legally allowed to donate an organ under the **Transplantation of Human Organs Act, 1994** (and any updates to it). The organ must be donated specifically for the Insured Person who has been medically advised to undergo a transplant.
2. This benefit is available only if your main claim for **In-patient hospitalization** is paid under this policy

B. Organ Donor Medical Expenses

We will reimburse the below medical expenses in respect of the donor due to organ harvesting:

1. **Pre-hospitalization expenses:** up to 30 days before admission of the donor in a hospital.
2. **Post-hospitalization expenses:** up to 30 days after discharge of the donor from the hospital

C. Organ Donor Complication Support

If the donor faces any medical complications requiring hospitalization during the Policy Period because of the organ harvesting—either during his/her hospital stay or within 30 days after discharge—we'll cover the related medical expenses subject to the below:

1. Coverage for complications is available **up to ₹2 lakh per policy year**
2. This benefit is independent and **over and above the Base Sum Insured**
3. The ₹2 lakh limit **resets for every policy year**

D. Donor Screening Expenses

We will reimburse medical expenses incurred during the Policy Period for donor screening required before an organ transplant. This is payable only if:

1. The donor's organ is actually harvested, and the organ transplant surgery is **successful**
2. This benefit can be used for only **one donor and for only one incidence in a policy year**

What's not covered under Donor Expenses

1. We do *not* cover any cost related to purchasing an organ.

8. AYUSH Treatment

Supporting your preferred path to healing with AYUSH hospitalization coverage.

What Is Covered

For those who prefer AYUSH-based hospitalization, we will cover the medical expenses specified in Table A above that you incur during the policy period for **an AYUSH Hospitalization** (Ayurveda, Yoga & Naturopathy, Unani, Siddha, or Homeopathy) taken at a registered AYUSH Hospital.

Key Service Terms

1. The treatments listed under this benefit are covered only if the hospital stay is at least 24 consecutive hours
2. The key service terms mentioned in 2 hour hospitalization will also apply to this benefit.
3. The usual exclusion for non-allopathic treatment does **not** apply here, but **only** for the treatments covered under this AYUSH benefit.

What Is Not Covered

1. We will *not* cover expenses for AYUSH treatments taken for **pleasure, rejuvenation, or wellness purposes**, such as:
 - a. Beauty treatments
 - b. Detox or purification therapies
 - c. Panchakarma
 - d. Rejuvenation therapies
 - e. Any preventive or wellness-oriented services
 - f. Any other non-allopathic treatment not listed above.

9. Preferred Provider Network (PPN) [Smart Care Network]

Smart hospital choices, bigger savings.

What we cover

To make the most of your health plan, you must undertake **In-patient Hospitalization, Day Care Treatment, or AYUSH Treatment** at a hospital that is part of the **Preferred Provider Network (PPN)** package chosen by you. The details of your selected PPN package will be mentioned in your **Policy Schedule**.

Key Service Terms

1. You can view the list of PPN hospitals in each package: [Link: https://www.manipalcigna.com/locate-us](https://www.manipalcigna.com/locate-us)
This hospital list is **dynamic**, meaning hospitals may be amended from time to time. ManipalCigna reserves the right to update it strictly as needed. But there's generally no need to worry, most updates happen because we're continuously working to expand our network and add hospitals so that quality healthcare remains accessible and convenient for you. Only in a few rare cases might a hospital be removed from the network or moved to a different package tier based on various considerations.

So, before you go for treatment, we recommend checking the **latest updated list** to ensure your chosen hospital is part of the opted PPN package.

2. If you choose a hospital that is **not** part of the opted PPN package, an **additional co-payment** will apply to each such admissible claim. This will be **added on top of any other co-payment** already applicable under the policy. However, this co-payment **will not apply in life threatening medical emergencies**.
3. Applicability of co-pay shall be mentioned in the below table

TABLE C		
Eligibility (opted package)	Hospital where-in actual treatment was undertaken	Co-pay percentage applicable
Classic	Classic	0%
Classic	Premier	10%
Classic	Premier +	25%
Premier	Premier OR Classic	0%
Premier	Premier +	25%
Premier +	Premier + OR Premier OR Classic	0%

Furthermore, please note that the co-payment applicable to your claim depends on where you receive treatment for In-patient Hospitalization, Day Care Treatment, or AYUSH Treatment. If this treatment is taken at a hospital that falls within your PPN eligibility, no co-payment will apply, even if other eligible medical expenses like pre-hospitalization expenses or post-hospitalization expenses or road ambulance expenses etc. were incurred at a hospital outside the PPN network.

However, if you receive treatment for In-patient Hospitalization, Day Care Treatment, or AYUSH Treatment at a hospital outside your PPN eligibility, the applicable co-payment will apply not only to such treatment expenses but also to all other eligible medical expenses like pre-hospitalization expenses or post-hospitalization expenses or road ambulance expenses etc. regardless of whether those expenses were incurred at a PPN hospital or not.

Kindly refer to the below table for additional clarity

Scenario	Treatment for In-patient Hospitalization, Day Care Treatment, or AYUSH Treatment	Other medical treatment like pre-hospitalization or post-hospitalization expenses	Co-pay
1	Treatment was taken within PPN eligibility	Treatment was taken within PPN eligibility	No co-pay shall be applicable
2	Treatment was taken within PPN eligibility	Treatment was taken outside PPN eligibility	No co-pay shall be applicable

3	Treatment was taken outside PPN eligibility	Treatment was taken outside PPN eligibility	Co-pay shall apply as per details in Table C
4	Treatment was taken outside PPN eligibility	Treatment was taken within PPN eligibility	Co-pay shall apply as per details in Table C

4. PPN clause shall not apply on expenses arising under the below listed benefits. It shall apply on expenses incurred on all other benefits (base and optional) under this policy
 - a. Domiciliary Hospitalization
 - b. Home Treatment
 - c. Tele-Consultation
 - d. Discounts and Health Services from Network Providers
 - e. Emotional quotient
 - f. NutriBoost
 - g. Personal Accident Plus
 - h. Health Check-Up
 - i. High-End Diagnostic Tests
 - j. Air Ambulance
 - k. New beginnings
 - l. Wellness Program
 - m. Durable Medical Equipment
5. Also, kindly note that we won't be able to cover treatment taken at Unrecognised hospitals, unless it is a life-threatening medical emergency. Only in such cases where-in treatment is undertaken in an unrecognised hospital, we will cover expenses only until your condition is stable enough for transfer. During such period, no additional co-payment will apply for using an unrecognised hospital. You can check the list of unrecognised hospitals here. [Link: https://www.manipalcigna.com/locate-us](https://www.manipalcigna.com/locate-us)
6. You can change your PPN package only when your Policy comes up for renewal. You may choose to upgrade or downgrade it at that time. Any change will be subject to our underwriting review.

Let's understand working and applicability of Preferred Provider Network with an example

Mr. Sharma had opted for utilising the Classic **Preferred Partner Network (PPN)** while **purchasing the policy**, which meant he could get treatment at listed hospitals under the Classic package without additional co-payment.

One day, he planned a minor surgery and chose a hospital that was **outside his opted PPN network**. The surgery went on smoothly, and his claim was approved. However, since he chose a

hospital from the Premier **PPN network**, an **additional co-payment of 10%** was applied to his claim.

A few months later, Mr. Sharma met with a life-threatening **road traffic accident** while commuting. Bystanders rushed him to the **nearest hospital**, which was not part of his selected PPN network.

Given the **urgent and life-threatening situation**, the hospital immediately admitted and treated him. As this was a **genuine medical emergency**, and supported by hospital records and accident reports, **no additional co-payment was applied**, despite the hospital being outside his PPN network.

- ✓ Non-PPN hospital (planned treatment) → **Extra co-pay applies**
- ✓ Non-PPN hospital (emergency) → **No extra co-pay (with proof)**

Let's understand working and applicability of Preferred Provider Network with one more example

Mr. Ram had opted for the Premier PPN Package, which gives him access to **Hospitals** listed within the **Premier Package**.

He undergoes a surgery at a hospital listed within the **Premier Package Network**. His total admissible medical expenses were:

- **In-patient Hospitalization Expenses:** ₹2,00,000
- **Pre-hospitalization Expenses:** ₹15,000
- **Post-hospitalization Expenses:** ₹7,500
- **Road Ambulance expenses:** ₹2,500

Total Claim Amount: ₹2,25,000

Even though some of the pre-hospitalization and post-hospitalization expenses were incurred with providers outside the Premier Package Network (PPN), no co-payment will apply because the main hospitalization was undertaken at an eligible network hospital. As a result, the full eligible claim amount of **₹2,25,000** will be payable.

Simply put, since the main hospitalization was undertaken at a hospital covered under his Premier PPN Package, Mr. Ram can enjoy the PPN co-payment waiver on all related medical expenses covered under the Policy for that claim.

His friend Mr. Shyam had also opted for the Premier PPN Package, which gives him access to **Hospitals** listed within the **Premier Package**.

Mr. Shyam undergoes treatment at a hospital outside of the **Premier Package**. **It was established that he had undertaken treatment in a Hospital that falls under Premier Plus package.**

His total admissible medical expenses were:

- **In-patient Hospitalization Expenses:** ₹2,00,000

- **Pre-hospitalization Expenses:** ₹15,000
- **Post-hospitalization Expenses:** ₹7,500
- **Road Ambulance expenses:** ₹2,500

Total Claim Amount: ₹2,25,000

Although Mr. Shyam avails his post-hospitalization consultations at a hospital within the **Premier Package**, as the **main In-patient hospitalization** was undertaken at a hospital outside the PPN package a **co-payment of 25%** will apply to the entire eligible claim amount of **₹2,25,000**.

- **Total Eligible Claim Amount:** ₹2,25,000
- **25% Co-payment Payable by Mr. Shyam:** ₹56,250
- **Claim Amount Payable under the Policy:** ₹1,68,750

10. Wellness Program (Not available in Infinix Active)

What we cover

We believe good health starts with healthy habits. We want to encourage you to stay active and take care of your health. Under our **Healthy Life Management Program**, you can earn **reward points** based on the number of steps you complete per day and during a policy year. These reward points can be redeemed for a **discount on your next renewal premium**.

The more consistently you stay active, the higher your reward percentage can be, as explained below:

Healthy Life Management Program - Rewards Structure				
No. of days in a policy Year	No. of steps achieved per day			
	10,000 steps or more	8,000 - 9,999	6,000 - 7,999	Less than 6,000
240 days and above	20%	15%	10%	0%
180 - 239 days	15%	10%	5%	0%
120 - 179 days	10%	5%	0%	0%
Less than 120 days	0%	0%	0%	0%

Key Service Terms

- Activities done during the **last 3 months of a Policy Year** will not be considered for reward point calculation. So, the required number of active days must fall within the **first 9 months** of a given Policy Year.
- This Wellness Program is available only to Insured Persons who are **18 years or above** at the start of the Policy Year.

- In a **Family Floater Policy**, reward points will be calculated at the policy level. All eligible adult Insured Persons together can earn reward points up to a maximum of **20% of the expiring Base Premium**.
- In a Family Floater Policy, the reward percentage earned by each eligible adult will be divided equally among the eligible adults covered under the policy as illustrated below.
- Discount shall be provided only if policy is renewed within the grace period
- The reward percentage will be applied on your **expiring policy premium**, and the resulting amount will be deducted from your renewal premium.

Example for Family Floater Policy

Suppose you have a **2 Adult + 2 Children** Family Floater Policy. The Wellness Program will apply only to the **2 adults**.

If:

- Adult 1 completes **10,000 steps per day for 240 days**, they earn **20%** reward.
- Adult 2 completes **6,000 steps per day for 240 days**, they earn **10%** reward.

Since there are 2 eligible adults, the reward will be calculated as:

Insured Person	Reward earned	Calculation	Eligible reward
Adult 1	20%	$20\% \div 2$	10%
Adult 2	10%	$10\% \div 2$	5%
Total reward discount			15%

Maximum reward you can earn

The maximum reward points you can earn in a single Policy Year will be limited to **20% of the premium paid under the existing Policy**.

Using your reward points

- Each reward point is equal to **₹1**.
- Reward points can be used only as a discount against the **immediate upcoming renewal premium**.
- Reward points cannot be carried forward to future policy years post renewal. If they are not used, they will lapse.

- For policies with a Policy Period of **2 or 3 years**, the maximum reward points that can be earned will not exceed **20% of the net premium paid for the respective expiring policy**, as applicable.

Illustration of Healthy Life Management Program Reward point discount calculation

	Policy Term - 3 years (Premium indicated here is just for illustration purposes in case of 1 Adult policy and may not be the actual premium.) Each earned reward point will be valued at 1 Rupee						
	Year	Premium (Excluding optional covers/ Rider and taxes)	Activity	No. of Days	Reward %	Reward Points Earned	
	Year 1	10000	10,000 and above steps/day	240 days and above	20%	2000	
	Year 2	11000	8,000 - 9,999 steps/day	240 days and above	15%	1650	
	Year 3	12000	6,000 - 7,999 steps/day	240 days and above	10%	1200	
	Total	33000				4850	
	The earned reward points can be redeemed as discount as per the below process to pay a portion of the renewal premium						
	Renewal of Policy as per below table						
	If Renewed Policy Term is	Renewal Premium (Excluding optional covers, Rider and taxes as applicable)	Reward discount utilized		Renewal Premium Payable after adjusting Reward discount		
	1 Year Policy	13000	1617 (4850*1/3 as Insured is renewing 3 Year policy to 1 Year Policy)		11383		
	2 Years Policy	27000	3233 (4850*2/3 as Insured renewing 3 Year policy to 2 Year Policy)		23767		
	3 Years Policy	42000	4850 (Insured renewing to the same policy tenure of 3 years)		37150		
	Increase of Renewal Policy Year	Policy Term - 1 year (Premium indicated here is just for illustration purposes and may not be the actual premium.) Each earned reward point will be valued at 1 Rupee					
		Year	Premium paid (Excluding optional cover, Rider and taxes as applicable)	Activity	No. of Days	Rewards %	Points Earned

Year 1	10000	6,000 - 7,999 steps / day	180 - 239 days	5%	500
Total	10000				500
The earned reward points could be redeemed as discount as per the below process to pay a portion of the renewal premium					
Renewal of Policy as per below table					
If Renewed Policy Term is	Renewal Premium (Excluding optional cover, Rider and taxes as applicable)	Rewards discount utilized		Renewal Premium Payable after adjusting Rewards discount	
1 Year Policy	11000	500 (as Insured is renewing the 1 Year policy to 1 Year Policy)		10500	
2 Year Policy	21000	500 (as Insured is renewing the 1 Year policy to 2 Year Policy)		20500	
3 Year Policy	33000	500 (as Insured is renewing the 1 Year policy to 3 Year Policy)		32500	

How we'll keep you updated

We may communicate updates related to the Wellness Program through **SMS, email and/or the program-specific mobile application**. Details of your accrued reward points may also be available through the Mobile App, SMS, email, and/or your Renewal Notice.

11. Tele-Consultation

Unlimited doctor consultations, anytime and anywhere.

What is covered:

If you are unwell or have suffered an injury, you can consult a **General Physician**, virtually, through our empanelled service provider and get medical advice without visiting a clinic in person.

Key Service Terms

- You can avail this benefit unlimited **times** during the Policy Period.
- Tele-consultations are available only on a **cashless basis**.
- Reimbursement of tele-consultation expenses is **not available** under this benefit.

What's not covered under Tele-consultations

- In-clinic / In-person consultations.
- Expenses for diagnostic tests or investigations
- Medicines & pharmacy
- Medical procedures

12. Discounts and Health Services from Network Providers

More than insurance. Enjoy savings on healthcare and wellness services.

What is covered:

Because your well-being matters, we help make quality healthcare more accessible with exclusive partner offers and special rates.

As an Insured Person, you can enjoy a range of **health services and discounts** offered by our Network Providers OR hospitals/service partners. These may include savings or special offer rates on:

- i. Outpatient consultations and treatments
- ii. Diagnostic tests
- iii. Medicines
- iv. Health supplements
- v. Fitness and wellness activities
- vi. Other related health services

Key Service Terms

- a. **Usage Disclaimer:** We only help you access these services, discounts, or products. You may choose to use them based on your own decision and responsibility. We will not be responsible for any issues, losses, or liabilities that may arise from their use. These services also cannot be used for medico-legal purposes. If you choose to use any paid service under this Section, the cost of that service will have to be paid by you.

13. Home Treatment

Coverage for eligible treatments, even when care comes home.

What we cover

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.

Key Service Terms

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. This benefit is available if you have opted for Unlimited Base Sum Insured
9. Claims under this benefit will be payable only for the duration that is medically necessary.
10. 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.
11. Kindly reach out to us on the below for availing Home treatment services

Home Treatment Service for	Contact Details
Infectious Diseases	Call on – 8796906222 OR Email - homecare@getvisitapp.com
Other than infectious diseases	Call on - 1800-102-4461 Email - Reimbursementclaim@manipalcigna.com

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.
- ii. End-stage liver failure or cirrhosis with refractory complications.
- iii. Advanced heart failure - NYHA Class III or IV.
- iv. 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.

14. Emotional Quotient (Not available in Infinix Active)

Your companion for a healthier, happier mind.

What is covered:

Taking care of your mental and emotional well-being is just as important as taking care of your physical health. As awareness, support solutions, and approaches to mental wellness continue to develop, We may from time to time make available certain services, resources, or features that are intended to support overall mental and emotional well-being. These offerings may be updated during the Policy Period and may help individuals better understand, manage, and improve their mental health. Some indicative examples of such offerings are described below.

a. Mental Health Assessment

You can take a digital mental health assessment that helps evaluate key aspects such as stress, anxiety, sleep patterns, and addictive behaviours. Based on your responses, a personalized health report may be generated with helpful insights and recommendations to support your mental wellness and reduce potential health risks.

b. Pre-recorded Fitness & Yoga Sessions

You get access to demand fitness, yoga, meditation, and wellness e-sessions. These e-sessions are designed to support different fitness levels, personal preferences, and wellness goals, so you can choose what works best for you.

c. Webinars with Mental Wellness Experts

You can attend expert-led digital webinars on topics such as stress management, anxiety, depression awareness, emotional resilience, work-life balance, mindfulness, and sleep health. These webinars may also include interactive Q&A sessions, practical coping techniques, and educational content on preventive mental healthcare.

d. Guided Meditations & Mental Health Podcasts

You get access to a curated e-library of 250+ guided meditation sessions and mental wellness podcasts focused on mindfulness, stress management, emotional resilience, relaxation, and overall psychological well-being. Personalized content recommendations may also be provided based on your wellness needs.

e. Mood Tracker

You can use an in-app mood tracker to record and monitor your emotions over time. This e-tool provides graphical insights and trend analysis to help you become more aware of your emotional patterns and take proactive steps towards better mental well-being.

f. Psychologist Consultations

You can avail unlimited tele and video consultations with qualified psychologists through our network, available 24x7. This service provides timely, confidential, and professional support to help you manage mental health concerns and emotional well-being.

Key service terms

1. **Access through Service Provider:** The services listed above shall be made available through our empanelled service provider or through the requisite mobile application.
2. **Usage Disclaimer:** We only help you access these services, discounts, or products. You may choose to use them based on your own decision and responsibility. We will not be responsible for any issues, losses, or liabilities that may arise from their use. These services also cannot be used for medico-legal purposes. If you choose to use any paid service under this Section, the cost of that service will have to be paid by you.

15. NutriBoost (Not available in Infinix Active)

Expert nutrition guidance for a healthier you.

What is covered:

Good nutrition plays an important role in maintaining overall health, managing lifestyle-related risks, and supporting long-term well-being. Recognising that nutritional science, wellness practices, and related support solutions continue to evolve, we may make available certain nutrition and wellness-related services, resources, tools, or features during the Policy Period that We believe may help individuals make informed dietary and lifestyle choices aligned with their personal health goals. Such offerings may vary from time to time and may be updated in line with emerging trends, advancements, and evolving customer needs. Illustrative examples of the types of offerings that may be made available are set out below.

You can avail the following services during the Policy Period:

a. Teleconsultations with Nutritionists and Health Coaches

Access e-consultations with qualified Nutritionists and Health Coaches through our empanelled service provider for personalized dietary guidance, expert inputs on nutrition plans, healthy eating habits, weight management, and overall well-being.

Key service terms

1. **Access through Service Provider:** The services listed above shall be made available through our empanelled wellness / mental health service provider or through the requisite mobile application.
2. **Usage Disclaimer:** We only help you access these services, discounts, or products. You may choose to use them based on your own decision and responsibility. We will

not be responsible for any issues, losses, or liabilities that may arise from their use. These services also cannot be used for medico-legal purposes. If you choose to use any paid service under this Section, the cost of that service will have to be paid by you.

II. Optional Benefits

- a. Optional benefits mean extra protection or customisation that you can add to your policy to customize it as per your needs. The policy holder opts for them at the time of inception or renewal (wherever applicable) by providing declarations (if required) and payment of additional premium (if required). Some optional covers may be included in your plan as inbuilt benefits to provide you with enhanced and comprehensive protection. For details of such optional covers kindly refer to the plan chart provided in the product prospectus available on our website.
- b. The optional benefits that are in force and applicable for you shall be mentioned in your Policy Schedule
- c. Claims under some optional covers will be paid from and shall reduce the Base Sum Insured. Claims under other optional covers will be paid over and above the Base Sum Insured. The applicable approach is clearly mentioned in the terms of each optional cover.

1. Personal Accident Plus (PA+) (Not available in Infinix Active)

Your safety net against life's uncertainties.

What we cover under Personal Accident Plus (PA+)

Accidents can be sudden and life changing. If you opt for this cover, you have the flexibility to decide which insured person it will apply to. You will also be needed to choose one of the below options at policy level.

Option 1: Accidental Death Cover only

Option 2: Permanent Disablement (PD) Cover only, which includes:

- Permanent Total Disablement (PTD); and
- Permanent Partial Disablement (PPD)

Both PTD & PPD will be covered under a common Sum Insured.

Option 3: Accidental Death Cover + Permanent Disablement Cover, where Accidental Death, Permanent Total Disablement and Permanent Partial Disablement will be covered under a common Sum Insured.

The details of the selected option and benefit amount will be mentioned in your Policy Schedule.

Key Service Terms for Personal Accident Plus (PA+) Cover (includes AD, PTD and PPD)

1. The minimum entry age for this benefit is 18 years.
2. The maximum entry age for this benefit is 65 years. Renewals are offered lifelong.
3. You can opt for this benefit at policy inception, at renewal or mid-term at member level.

4. All eligible Insured Persons opting for PA+ must have the same benefit amount and the same coverage option.
5. The benefit amount opted for PA+ shall be separate, independent and over and above the Base Sum Insured.
6. The benefit amount shall be on individual Sum Insured basis
7. Our maximum liability in respect of an Insured Person under PA+ will not exceed 100% of the PA+ Benefit Amount applicable to that Insured Person in the lifetime of this policy.
8. The entire PA+ benefit will end for the Insured Person in respect of whom we pay 100% of the Benefit Amount during the lifetime of this policy.
9. If we pay less than 100% of the Benefit Amount, only the remaining Benefit Amount will be available from the next policy year, if this benefit is continued. For future claims, the applicable benefit percentage will be calculated on the original Benefit Amount and deducted from the remaining Benefit Amount.
10. You can opt out of this benefit or change the coverage option only at renewal. If you want to opt in again after opting out, it will be subject to underwriting.
11. The geographical scope of coverage provided under this benefit is restricted to India only. Claims for accidental Injuries sustained outside of India shall not be payable.
12. If there is any change in the occupation of an Insured Person after this benefit starts, you must inform us in writing at the immediate upcoming renewal.
13. If any Insured Person is 76 years or above at renewal, the maximum payout under PA+ specifically for that Insured Person in all future policy years will be limited to ₹10 lakh or the applicable Benefit Amount, whichever is lower. Premium will be charged in line with such applicable Benefit Amount.

A. Accidental Death Cover

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and this results in death or disappearance within **365 days** from the date of the Accident, we will pay **100% of the Benefit Amount** as a lump sum to the Nominee.

Disappearance clause

If the Insured Person's body cannot be found within **365 days** after any of the following events, it will be treated as disappearance:

- a. Forced landing, stranding, sinking, or wrecking of a common carrier in which the Insured Person was travelling as a fare-paying passenger; or
- b. A catastrophic event in which the Insured Person was a victim.

For a disappearance claim, we will need a missing-person police report and/or any other documents reasonably required to support the claim.

If it is later found that the Insured Person is alive, the claim amount paid must be returned to us in full.

B. Permanent Disablement Cover

Permanent Total Disablement

If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period, and this results in a listed **Permanent Total Disablement** within **365 days** from the date of the Accident, we will pay **100% of the Benefit Amount** as a lump sum.

Listed Permanent Total Disablement (PTD) covered
1. Total and irrecoverable loss of sight of both eyes
2. Loss by physical separation or total and permanent loss of use of both hands or both feet
3. Loss by physical separation or total and permanent loss of use of one hand and one foot
4. Total and irrecoverable loss of sight of one eye and loss of a Limb
5. Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
6. Total and irrecoverable loss of hearing of both ears and loss of speech
7. Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye

Key Service Terms for Permanent Total Disablement

1. The claim will be considered only if Permanent Total Disablement is confirmed while the Insured Person is alive.
2. The disablement must be supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
3. The disablement must continue for at least **180 continuous days** from the date it started. Also, at the end of such period, the treating Medical Practitioner must certify in writing that there is no reasonable medical chance of improvement.

Permanent Partial Disablement

If the Insured Person suffers an Injury solely and directly due to an Accident during the Policy Period, and this results in a listed **Permanent Partial Disablement** within **365 days** from the date of the Accident, we will pay the applicable percentage of the Benefit Amount as a lump sum.

Listed Permanent Partial Disablement (PPD) covered	% of Benefit Amount payable
i. Total and irrecoverable loss of sight of one eye	50%
ii. Loss of one hand or one foot	50%
iii. Loss of all toes - any one foot	10%
iv. Loss of great toe - any one foot	5%

Listed Permanent Partial Disablement (PPD) covered	% of Benefit Amount payable
v. Loss of toes other than great, if more than one toe lost, each	2%
vi. Total and irrecoverable loss of hearing in both ears	50%
vii. Total and irrecoverable loss of hearing in one ear	15%
viii. Total and irrecoverable loss of speech	50%
ix. Loss of four fingers and thumb of one hand	40%
x. Loss of four fingers	35%
xi. Loss of thumb-both phalanges	25%
xii. Loss of thumb - one phalanx	10%
xiii. Loss of index finger - three phalanges - two phalanges - one phalanx	10%, 8%, 4%
xiv. Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	6%, 4%, 2%

Key Service Terms for Permanent Partial Disablement

1. The claim will be considered only if Permanent Partial Disablement is confirmed while the Insured Person is alive.
2. The disablement must be supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
3. The disablement must continue for at least **180 continuous days** from the date it started. At the end of this period, the treating Medical Practitioner must certify in writing that there is no reasonable medical chance of improvement.

4. If more than one listed disablement results from the same Injury, the payable percentages will be added together. However, the total payout will not exceed **100% of the Benefit Amount**.
5. If we pay 100% of the Benefit Amount under Permanent Partial Disablement for an Insured Person, the entire **Personal Accident Plus** cover will end for that Insured Person.
6. If we pay less than 100% of the Benefit Amount, only the remaining Benefit Amount will be available from the next policy year or renewed policy, if this cover is continued. For future claims, the applicable percentage will be calculated on the original Benefit Amount and deducted from the remaining Benefit Amount.

What's not covered under Personal Accident Plus

1. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including 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, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority
2. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof
3. Involvement of Insured person in any unlawful/Criminal activity.
4. Intentional self-injury or attempted suicide.
5. Any Injury sustained while working, storing or transporting explosives.
6. Injury caused due to
 - i. Insect bites or
 - ii. Animal bites or
 - iii. Animal attacks or
 - iv. Serpent (snake) bites or attacks
7. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.
8. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand
9. Claims arising out of Non-accidental Injuries
10. Injuries arising from participation in Adventure Sports or similar high-risk activities — whether called hazardous sports, action sports, extreme sports, aggressive sports, or by any other name — will not be covered. This exclusion applies regardless of whether the Insured Person is trained or untrained, participates professionally or non-professionally, or undertakes the activity for leisure. Such activities will be treated as hazardous even if safety precautions are taken while participating in them. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighting / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving, gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, lugging, risky manual labour, marathon running, martial arts, micro

– lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all-terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkelling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weightlifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

2. Health Check-up (Not Applicable for Infinix Active)

Taking care of your health starts with regular check-ups.

What we cover

Under this benefit, every Insured Person who is **18 years or above** at the start of a Policy Year can avail a **Health Check-up once during every Policy Year**, including the first Policy Year.

You can use this benefit even irrespective of whether you made a claim under the policy or not.

Classification	Name of Test
Blood Test	CBC - Complete Blood Count
Diabetes / Sugar Monitoring	Glucose Fasting; HbA1C - Glycated Haemoglobin
Kidney Function	BUN - Blood Urea Nitrogen; Creatinine; RUA - Routine Urine Analysis
Uric Acid / Gout Risk	Uric Acid
Liver Function	LFT - Liver Function Test
Heart Risk / Cholesterol	Lipid Profile
Thyroid Function	Free T3 - Free Triiodothyronine; Free T4 - Free Thyroxine; TSH - Thyroid Stimulating Hormone
Inflammation / Autoimmune Screening	ESR - Erythrocyte Sedimentation Rate; RA Factor - Rheumatoid Arthritis Factor
Bone, Vitamin & Mineral Health	Sr. Vitamin D; Sr. Vitamin B12; Sr. Calcium; Electrolytes
Pancreas Function	Serum Amylase; Serum Lipase
Cancer Marker	Serum PSA - Prostate-Specific Antigen, for Male; CA-125 - Cancer Antigen 125, for Female
Iron Deficiency	Iron Studies

Key Service Terms

1. All tests under the selected Health Check-up package must be done on the **same date**.
2. This benefit is available only on a **cashless basis** and must be taken only through our Network available for this benefit.

3. This benefit cannot be availed during the **Free Look Period** of the policy.
4. If you do not use this benefit during a Policy Year, it will lapse and will not be carried forward to the next or any future Policy Year.
5. This benefit can be opted at the policy level, on an **all-or-none basis**, only at policy inception or renewal.
6. This benefit can be opted out only at renewal. If you want to opt in again after opting out, it will be subject to underwriting.

3. High-End Diagnostic Tests (Not Applicable for Infinix Active)

Sometimes, your doctor may need advanced diagnostic tests to understand your medical condition better.

What we cover

If you have opted for this benefit, we will reimburse the **Reasonable and Customary expenses** incurred during the **Policy Period** only for the below listed high-end diagnostic tests.

Tests covered under this benefit

1. Brain Perfusion Imaging
2. CT-guided Biopsy
3. CT Urography
4. Digital Subtraction Angiography - DSA
5. MR Cholangiography
6. PET-CT
7. PET MRI
8. Diffusion MRI - DTI
9. Cardiac MRI
10. Endoscopic Ultrasound – EUS
11. Coronary Angiography
12. Carotid Doppler

Key Service Terms

1. The test must be prescribed in writing by the treating Medical Practitioner.
2. The prescribed test can be done **only at a hospital**. Such hospital could be from within our network or outside our network.

3. The prescribed test won't be covered if undertaken at any diagnostic centre.
4. Claims under this benefit will be paid on a **reimbursement basis only**.
5. This benefit cannot be availed during the **Free Look Period** of the policy.
6. This benefit can be opted at the policy level, on an **all-or-none basis**, only at policy inception or renewal.
7. Once you opt out of this benefit, you cannot opt in again at later renewals
8. This benefit is available ONLY if you have opted for Unlimited Base Sum Insured

Benefit Limit

High-end diagnostic tests has a separate independent benefit limit of **₹50,000 per policy year**. This is the maximum amount that can be used by all Insured members under this policy combined. This limit will reset at the start of every new policy year.

4. Air Ambulance

Airlifted to care when it matters most.

What we cover

In a serious medical emergency, if the Insured Person is in a **life threatening medical emergency** and needs immediate rapid transportation to the nearest hospital by air ambulance, we will reimburse the **Reasonable and Customary expenses** incurred during the Policy Period. This benefit applies only when ground transport cannot provide the required immediate and rapid transportation.

Under this benefit, we will only reimburse Air Ambulance expenses for:

- a. Transferring the Insured Person from the place of incident to the nearest hospital; and/or
- b. Transferring the Insured Person from one hospital to another nearest hospital within India, if the required treatment is not available at the existing hospital.

Key Service Terms

1. This cover under this benefit is applicable only within India.
2. The need for air ambulance transportation must be certified in writing by the treating Medical Practitioner.
3. The air ambulance service must be provided by a lawfully registered healthcare or ambulance service provider.
4. This benefit will apply only if a claim has been admitted under **In-patient Hospitalization**, and the air ambulance expense is related to the same illness or injury for which hospitalization was needed.
5. This benefit can be opted at the policy level, on an **all-or-none basis**, only at policy inception or renewal. If you opt out and later want to opt in again, it will be subject to underwriting.

Benefit Limit

Air Ambulance has a separate independent benefit limit of **₹10 lakh per policy year**. This is the maximum amount that can be used by all Insured members under this Policy combined. This limit will reset at the start of every new policy year.

What's not covered under Air Ambulance

We will not cover expenses for return transportation of the Insured Person to their residence by air ambulance.

5. Annual Aggregate Deductible

A yearly threshold - cross it once, and your policy starts paying.

What we cover

An Annual Aggregate Deductible is the amount you agree to pay on your own, once, each policy year before your policy starts paying for covered claims.

The deductible amount that you choose will be mentioned in your Policy Schedule. Once your total admissible medical expenses in a policy year exceed this amount, we start paying for admissible claims as per policy terms for that policy year. Discount applicable shall be basis the grid below. The applicable discount for the entire Policy will be calculated based on the age of the eldest member covered under the Policy.

Deductible - ₹ 1L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	45.0%	45.0%	35.0%	32.5%	30.0%	25.0%
Above 55	40.0%	40.0%	25.0%	22.5%	20.0%	15.0%

Deductible - ₹ 2L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	55.0%	55.0%	45.0%	42.5%	40.0%	35.0%
Above 55	50.0%	50.0%	35.0%	32.5%	30.0%	25.0%

Deductible - ₹ 3L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	62.5%	62.5%	52.5%	50.0%	47.5%	42.5%
Above 55	57.5%	57.5%	42.5%	40.0%	37.5%	32.5%

Deductible - ₹ 4L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	67.5%	67.5%	57.5%	55.0%	52.5%	47.5%
Above 55	62.5%	62.5%	47.5%	45.0%	42.5%	37.5%

Deductible - ₹ 1L						
Deductible - ₹ 5L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	70.0%	70.0%	60.0%	57.5%	55.0%	50.0%
Above 55	65.0%	65.0%	50.0%	47.5%	45.0%	40.0%

Deductible - ₹ 10L						
Plan Variant	Other than active		Active			
Eldest member age / BSI (₹)	10L	Unlimited	<7.5L	7.5L to 10L	15L to 25L	>25L
Upto 55	75.0%	75.0%	65.0%	62.5%	60.0%	55.0%
Above 55	70.0%	70.0%	55.0%	52.5%	50.0%	45.0%

Key Service Terms

- When you can choose it:** The deductible can be selected at the time of buying the policy or at renewal, and it applies to the entire policy on all or none basis.
- Deductible discount:** The deductible discount offered for each policy year will be basis the age of the eldest insured member in the Policy.
- Changes at renewal:** You can increase, reduce, or remove the deductible only at renewal and subject to underwriting approval.
 - Whenever you reduce or remove the deductible, waiting periods will apply again on the reduced portion.
 - If you remove the deductible, you cannot choose this benefit again in future renewals
- Mutually exclusive option:** You can choose only any one from the below
 - One-time Aggregate Deductible or
 - Annual Aggregate Deductible or
 - ManipalCigna GMC discount
- Benefits where deductible does NOT apply:** You can claim the below benefits without exhausting the deductible:
 - Personal Accident Plus
 - Air Ambulance
 - New Beginnings
 - Health Check-Up
 - High-End Diagnostic Tests
 - Tele-Consultation

- g. Wellness Program
- h. Discounts and Health Services from Network Providers
- i. Emotional quotient
- j. NutriBoost

6. **Policy Terms Apply:** All other policy terms, conditions, waiting periods, and exclusions will continue to apply.
7. **Meeting the deductible & Claim Consideration:** This deductible will be calculated on an **annual aggregate basis**, considering only the claims made during the Policy Year, that are admissible under the policy terms and conditions and fall under the coverages listed below
- i. In-Patient Hospitalization
 - ii. Day Care Treatment
 - iii. Pre-Hospitalization Medical Expenses
 - iv. Post-Hospitalization Medical Expenses
 - v. Domiciliary Hospitalization
 - vi. Home Treatment
 - vii. Road Ambulance
 - viii. Donor Expenses
 - ix. AYUSH Treatment
 - x. Coverage for Non-Medical Expenses & Durable Medical Equipment (if opted and in force)
 - xi. QuickAccess (if opted and in force)

Claims will be paid only after you submit documents proving that the deductible has been exhausted. Expenses that are not admissible under the policy terms and conditions shall not be considered for meeting the deductible.

7. **Splitting of a policy having annual aggregate deductible:** If your Policy with an Annual Aggregate Deductible is split into two or more separate Policies, the same deductible amount will continue to apply to each split Policy.
8. **Merging of policies / Member addition:** If a new member is added OR a certain policy is merged with another Policy having an Annual Aggregate Deductible, then, the highest amount of deductible amongst the two policies will be applicable to all Insured persons in the merged policy.

6. One-time Aggregate Deductible (Not Applicable for Infinix Active)

One-time commitment, long-term savings on premium.

What we cover

A One-time Aggregate Deductible is the amount you agree to pay **only once in every block of ten policy years** from the time this benefit is in force before your insurance coverage starts paying for claims.

The one-time deductible amount that you choose will be mentioned in your Policy Schedule. All admissible claims made under this policy over one or more policy years are added together to calculate this deductible.

Once you opt for this benefit, you can enjoy an attractive premium discount every year for 10 policy years. The applicable discount will continue to be available throughout this period, regardless of whether the deductible has been exhausted or not. Discount applicable shall be basis the grid below. The applicable discount for the entire Policy will be calculated based on the age of the eldest member covered under the Policy.

Deductible - ₹ 25,000				
Plan Variant	Now		Other than Now	
Eldest member age / BSI (₹)	10L	Unlimited	10L	Unlimited
91 days to 30 years	17.5%	17.5%	20.0%	20.0%
31-35	12.5%	12.5%	15.0%	15.0%
36-40	10.0%	10.0%	12.5%	12.5%
41-45	7.5%	7.5%	10.0%	10.0%
46-50	5.0%	5.0%	7.5%	7.5%
51-55	2.5%	2.5%	5.0%	5.0%
Above 55	2.5%	2.5%	2.5%	2.5%

Deductible - ₹ 50,000				
Plan Variant	Now		Other than Now	
Eldest member age / BSI (₹)	10L	Unlimited	10L	Unlimited
91 days to 30 years	30.0%	30.0%	35.0%	35.0%
31-35	25.0%	25.0%	30.0%	30.0%
36-40	20.0%	20.0%	25.0%	25.0%
41-45	15.0%	15.0%	20.0%	20.0%
46-50	10.0%	10.0%	15.0%	15.0%
51-55	5.0%	5.0%	10.0%	10.0%
Above 55	5.0%	5.0%	5.0%	5.0%

Deductible - ₹ 1L				
Plan Variant	Now		Other than Now	
Eldest member age / BSI (₹)	10L	Unlimited	10L	Unlimited
91 days to 30 years	35.0%	35.0%	40.0%	40.0%
31-35	30.0%	30.0%	35.0%	35.0%
36-40	25.0%	25.0%	30.0%	30.0%
41-45	20.0%	20.0%	25.0%	25.0%

46-50	15.0%	15.0%	20.0%	20.0%
51-55	10.0%	10.0%	15.0%	15.0%
Above 55	7.5%	7.5%	10.0%	10.0%

Key Service Terms

1. **When you can choose it:** This option can be selected only at the time of entering into this policy or at renewal on all or none basis. Once selected, the Policyholder will not have the option to opt out of this benefit.
2. **Deductible amount:** The deductible amount selected at the time of opting for this optional cover shall remain fixed and cannot be modified in any subsequent Renewal.
3. **Deductible discount:** The deductible discount offered for each policy year will be basis the age of the eldest insured member in the Policy.
4. **Automatic Waiver rule:** Once 10 policy years have been completed from the date you opt for this benefit, the deductible will automatically be waived. Also, the premium discount associated with this benefit will stop thereafter. In such cases of automatic waiver NO waiting period shall apply afresh on the waived deductible portion.
5. **Mutually exclusive option:** You can choose only any one from the below
 - a. One-time Aggregate Deductible or
 - b. Annual Aggregate Deductible or
 - c. ManipalCigna GMC discount
6. **How deductible is applied:**
 - a. The deductible is calculated on an aggregate basis across one or more policy years
 - b. Once fully exhausted, no deductible will apply further
7. **Benefits where deductible does NOT apply:** You can claim the below benefits without exhausting the deductible:
 - a. Personal Accident Plus
 - b. Air Ambulance
 - c. New Beginnings
 - d. Health Check-Up
 - e. High-End Diagnostic Tests
 - f. Wellness Program
 - g. Discounts and Health Services from Network Providers
 - h. Tele-Consultation
 - i. Emotional Quotient
 - j. NutriBoost

8. **Policy Terms Apply:** All other policy terms, conditions, waiting periods, and exclusions will continue to apply
9. **Meeting the deductible & Claim Consideration:** This deductible will be calculated, considering only the claims that are admissible (need not be paid) under the policy terms and conditions and that fall under the coverages listed below
 - i. In-Patient Hospitalization
 - ii. Day Care Treatment
 - iii. Pre-Hospitalization Medical Expenses
 - iv. Post-Hospitalization Medical Expenses
 - v. Domiciliary Hospitalization
 - vi. Home Treatment
 - vii. Road Ambulance
 - viii. Donor Expenses
 - ix. AYUSH Treatment
 - x. Coverage for Non-Medical Expenses & Durable Medical Equipment (if opted and in force)
 - xi. QuickAccess (if opted and in force)

Claims will be paid only after you submit documents proving that the deductible has been exhausted. Expenses that are not admissible under the policy terms and conditions shall not be considered for meeting the deductible.

10. **Splitting of a policy having one-time aggregate deductible:** If a Policy with a one-time deductible is split into two or more separate Policies, the remaining deductible amount from the original Policy will continue to apply to both new Policies. Any deductible amount already used before the split will be considered. Only the unused balance, if any, will apply under each of the split Policies. All other terms shall continue as is.
11. **Merging of policies:** When one Policy is merged into another Policy, only the highest remaining deductible amongst the 2 policies, if any, will apply to all members under the merged Policy. All other terms shall continue as is.

Let's understand One-time Aggregate Deductible with an example

Mr. Sharma had opted for **One-time aggregate deductible of ₹50,000**, enjoying a lucrative discount from the start.

In the first year, he was hospitalized for **dengue** (a claim admissible as per terms of this policy), with a bill of **₹30,000**. Since he had to meet his one-time deductible, he paid this amount himself.

In the 4th policy year, Mr. Sharma needed treatment again, and the admissible hospital bill came to **₹1,75,000**. At this point, he had already paid ₹30,000 earlier and submitted the requisite proofs to the Insurer, so he only needed to pay the **remaining ₹20,000** to complete his **₹50,000 deductible**.

Once this was met, the insurer covered the **remaining ₹1,55,000** of the bill.

From this point onward, **Mr. Sharma's deductible was fully exhausted**, and he continued to enjoy **policy coverage for all future admissible claims**, along with the **lucrative premium discount until this benefit completed 10 years (calculated from inception of this benefit)**.

In short:

- ✓ First ₹50,000 paid once by Mr. Sharma (across claims and across policy years)
- ✓ After that → **full coverage + continued premium savings until this benefit completes 10 years**

7. Room Rent Modification

Choose your hospital room your way — upgrade or save based on your comfort.

What we cover

You can modify the type of hospital room you're eligible for under your policy, based on your preference and plan.

Your selected room category will be clearly mentioned in your Policy Schedule.

By default you are covered upto Single AC private room. However, through this optional cover you can choose to upgrade or save from the following options:

Choice	Room rent eligibility	Applicability
Upgrade	Any hospital room	Can be opted only with Unlimited Base Sum Insured
Upgrade	Upto Any hospital room (except a suite category room or above)	Can be opted only with Unlimited Base Sum Insured
Save	Upto Twin Sharing AC room	Can be opted with any Base plan variant

Key Service Terms

- ICU Coverage:** If you are admitted in an ICU or ICCU, room charges will be covered at actuals, irrespective of your chosen room category.
- Higher Room Selection:** If you choose a room category higher than what you are eligible for, you will need to bear a proportionate share of all associated medical expenses. This proportion is calculated based on the difference between your eligible room rent and the actual room rent charged. You may refer to example on proportionate deduction under '2 hour hospitalization' sub-benefit
- Change at Inception or Renewal:** You can optimise your premium or upgrade your room category only at the time of buying the policy or at renewal, subject to underwriting approval
- Policy-level selection:** The room category choice applies to all insured members under the policy (all or none basis).

8. Coverage for Non-Medical Expenses & Durable Medical Equipment

From consumables to medical equipment — we've got the extras covered.

What we cover

If you choose this optional benefit, you get coverage for both:

- Listed **Non-medical expenses** typically not covered under standard health insurance, and
- Durable medical equipment** needed for your treatment or recovery

This benefit can be selected for the entire policy at the time of policy inception or renewal, and your choice will apply to all insured members. If you opt out and later want to opt in again, it will be subject to underwriting.

A. Non-Medical Expenses

Reducing your out-of-pocket hospitalization expenses.

What we cover

We will indemnify expenses for non-medical items, such as consumables, incurred during hospitalization in the Policy Period. These items are usually not covered under the policy and are listed in List I of Annexure 2.

Key Service Terms – Non-Medical Expenses

- Linked to Hospitalization:** This benefit applies only if a claim is admissible (need not be paid) under the below listed benefits and the expenses relate to the same illness or injury
 - In-patient hospitalization
 - Day Care Treatment
 - Domiciliary Hospitalization
 - Maternity Expenses
- No Separate Limit:** There is no separate sum insured for this benefit. Any claim paid will be paid from and reduce your available Base Sum Insured.
- Override of Exclusion:** The usual exclusion on non-medical items will not apply, but only to the extent covered under this benefit.

B. Durable Medical Equipment

Essential medical devices, protected.

What we cover

We will reimburse reasonable costs for purchasing or renting only the below listed medically necessary equipment during the Policy Period:

Sr. No	List of Durable Medical Equipment
1	CPAP machine
2	BPAP machine
3	Ventilator

4	Wheelchair
5	Prosthetic device (a Prosthetic device means an externally applied device used to replace wholly or partly an absent or deficient body part limited to arm or leg or auditory system).
6	Suction Machine
7	Commode Chairs
8	Infusion pump
9	Continuous Passive motion devices in case of Knee Replacement
10	Oxygen concentrator

Key Service Terms – Durable Medical Equipment

- Doctor's Prescription & Link to Treatment:** The equipment must be prescribed by your treating doctor and should be related to an admissible claim for the same illness or injury under any of the below benefits.
 - In-patient hospitalization
 - Day Care Treatment
 - Domiciliary Hospitalization
- Purchase Timeline:** The equipment must be purchased or rented within 30 days from the date of prescription.
- Override of Exclusion:** The standard exclusion on claim payment for such equipment will not apply, but only to the extent covered under this benefit.

Benefit Limit

Durable Medical Equipment has a separate benefit limit of ₹1 lakh per policy year. This is the maximum amount that can be used by all Insured members under this Policy combined. This limit will reset at the start of every new policy year.

9. New Beginnings (Not Applicable for Infinix Active)

Complete care for motherhood — from pregnancy to your baby's first year.

What we cover under New Beginnings

- If you choose this optional benefit, you get coverage for reasonable and customary medical expenses for all three benefits mentioned below (they cannot be opted separately):
 - Maternity Expenses
 - New-Born Baby Expenses
 - First Year Vaccinations
- Common Benefit Limit:** A single benefit limit applies across maternity, new-born baby, and vaccination benefits. Thus, claims under the 3 sub-benefits will be paid from a common benefit limit applicable to New Beginnings.

Eligibility for New Beginnings

1. Who can opt for this benefit (Eligible members): Any Male or Female Insured Person aged 18 years or above
2. For family floater policies: This optional benefit can be selected at the **member level**, which means it can be selected separately for eligible members covered under the policy. However, the benefit amount selected for all opting members must be same.
3. A male Insured Person can opt for this benefit if he is **18 years or above**. However, the coverage will be available and claim shall be payable only in respect of his spouse irrespective whether she is covered under this policy or not. At the time of claim, the male Insured Person will be required to submit a document confirming that the beneficiary is their spouse. Any one of the following government-issued documents can be considered as proof, provided it clearly shows that the person availing the benefit is your spouse.
 - a. Marriage Certificate
 - b. Passport
 - c. Aadhaar Card
 - d. Voter ID Card

Also, the waiting period served by the male Insured Person under this benefit will be considered for his spouse's coverage.
4. For policies where-in both the spouses have opted for new-beginnings: In such cases the claim payout for a particular delivery/termination event will be paid by using only one benefit amount of either the husband or wife but not both. The highest available benefit amount will be used for the claim.

Benefit Limit applicability for New Beginnings

- a. New Beginnings comes with a separate, independent benefit limit. This benefit is available on an individual Sum Insured basis and will apply separately to each Insured Person covered under this benefit.
- b. At the time you initially enroll for the New Beginnings benefit, you can choose a base benefit limit of ₹5,000, ₹10,000, or ₹20,000, based on your preference. Such benefit limit chosen must be same for all Insured Persons opting for this benefit. Once selected, this limit cannot be changed during the lifetime of the policy. The benefit limit chosen by you will be mentioned in your Policy Schedule. Once you have completed two policy years with this benefit, your chosen base benefit limit will increase by 100% each year. Thus, Your coverage will keep growing over time, up to a maximum of 1000% of the original base benefit limit you selected when you first opted for this benefit.
- c. The maximum benefit limit that will be available to you across policy years (irrespective of claims under New Beginnings) is as shown below and will be effective from the policy year when you first opted for the New Beginnings benefit.

Start of Policy Year*	Maximum Benefit amount (₹) applicable for first-time maternity	Maximum Benefit amount (₹) applicable for Customers with
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	cover buyers (Fresh/Migration/Port policies)	Previous Maternity Cover (Port/Migration policies)
1	10,000 Waiting Period of 12 months is applicable, hence no claim payout will be available	10,000 Waiting Period of 12 months is NOT applicable, hence claim payout will be available
2	10,000	10,000
3	20,000	20,000
4	30,000	30,000
5	40,000	40,000
6	50,000	50,000
7	60,000	60,000
8	70,000	70,000
9	80,000	80,000
10	90,000	90,000
11	100,000	100,000
12	100,000	100,000
13	100,000	100,000
Please note: The table above uses a base benefit limit of ₹10,000 for Illustrative purposes. The way the benefit limit grows and applies will be similar for base benefit limits of ₹5,000 and ₹ 20,000		

Let's understand with an example

Mr. Sharma and his wife opted for the '**New Beginnings**' (coverage for maternity, new-born and first year vaccinations) benefit with a base benefit amount of **₹20,000**.

In the first year, Mrs. Sharma had a maternity cover of **₹20,000**. Post completion of 2 policy years, a **100% bonus** was added, increasing the total cover to **₹40,000 for the third year**.

With each passing year after that, the benefit continued to grow—
₹40,000 → ₹60,000 → ₹80,000 → ₹1,00,000...

By the time Mrs. Sharma planned her delivery a few years later, her total maternity cover had grown significantly, reaching close to the **maximum limit of ₹2,00,000**.

This ensured that when she was admitted for delivery, the couple had strong financial support for their expenses.

Key Service Terms applicable to New Beginnings

1. **Waiting Period:** A waiting period of 12 months applies from the date of commencement of this optional benefit. If you're joining through portability or migration and your previous policy already included maternity coverage, this waiting period will not apply. Claims are payable only if delivery/termination happens after completion of this period. For claims arising from maternity-related complications, the hospital admission must take place after the completion of the applicable waiting period for the claim to be eligible for coverage. If the date of delivery or termination falls after the waiting period is completed, eligible pre-natal expenses will be covered, even if they were incurred during the waiting period.

2. **Benefit Limit Usage Rule:** All admissible expenses under New beginnings will be paid from the benefit limit available in the Policy Year in which the delivery takes place.
3. **Multiple Births:** Twins or multiple births in a single delivery will be treated as one delivery event
4. **Opt-in/Opt-out:** Can be opted at inception or renewal, Can be opted out only at renewal
5. **Rejoining** is subject to underwriting and fresh waiting period
6. **PPN clause, Deductible & Co-pay Applicability:** The PPN clause, any Deductible (if opted) and Co-pay will NOT apply to this benefit
7. **Override of exclusions:** Standard exclusions related to maternity and vaccinations will not apply, but only to the extent covered under this benefit
8. **Merging of policies:** Insured A had chosen a New Beginnings base benefit limit of ₹20,000. Over the years, this amount increased to ₹80,000. Insured B now wants to join the same Policy. Insured B already had an accumulated maternity benefit of ₹35,000 under his own policy (not necessarily Infinix). After the policies are merged, the 'same benefit amount' rule will apply. So, as Insured B wishes to join Insured A's policy he will have to settle for a New Beginnings benefit of ₹20,000 under the merged policy. As continuity on waiting period will be provided, the 12 months waiting period will be waived for Insured B. Insured A will continue to keep his own accumulated benefit amount under the Policy
9. **Event Limit:** Claims for a Maximum of 2 delivery events OR 2 Lawful termination events OR 1 delivery & 1 Lawful termination event, is covered in the lifetime of this policy, per Insured Person who has opted for New Beginnings

Let's understand with an example:

Consider a policy covering six adult members (all aged 18 years or above) – three males (Azeem, Raja, and Tom) and three females (Geeta, Priyanka, and Anne).

Out of these six members, Tom, Geeta, and Anne have opted for the New Beginnings benefit. Each of them has a base benefit amount of ₹20,000. Tom and Anne are husband and wife. Since both Tom and Anne have opted for the benefit, they are each eligible to make claims for two events each under the new beginnings benefit.

At the beginning of the 5th policy year, both had accumulated a total benefit amount of ₹80,000 each.

During the policy year, Tom and Anne were blessed with a baby boy and incurred delivery expenses of ₹50,000.

Please note: Even though both spouses under the same policy have opted for the New Beginnings benefit, the maximum benefit available for a single delivery event is ₹80,000, not ₹1,60,000. This is because, for any one claim event, only the total benefit amount accrued by either the husband or the wife can be utilized, and the benefits of both spouses cannot be combined for the same claim.

The remaining ₹30,000 can be used to cover expenses related to the newborn baby as well as any pre-natal expenses (if applicable). Also, vaccination expenses for the baby will also be

covered from this remaining balance, even if those expenses are incurred in the next policy year.

A. Maternity Expenses

Before birth. Beyond birth. Maternity Expenses Covered.

What we cover under Maternity Expenses

We will indemnify reasonable and customary medical expenses incurred for:

- a. Delivery of a child during the Policy Period and while New Beginnings benefit is active
- b. Medically necessary and lawful termination of pregnancy during the Policy Period and while New Beginnings benefit is active
- c. Pre-natal expenses up to 270 days before delivery / termination. Pre-natal expenses shall be covered only if the same are incurred during the Policy Period and while New Beginnings benefit is active. Also, pre-natal expenses shall be paid only if the claim with regard to delivery/termination is admissible under New beginnings regardless of whether such claim was paid under New Beginnings or not.
- d. Post-natal expenses up to 90 days after delivery / termination. Post-natal expenses shall be paid only if the claim with regard to delivery/termination is admissible under New Beginnings regardless of whether such claim was paid under New Beginnings or not. Post natal expenses shall be payable regardless of whether New beginnings benefit is renewed or not.

B. New-Born Baby Expenses

Your baby's first cover

What we cover under New-Born Baby Expenses

We will indemnify In-patient Care hospitalization (24 hours or more) OR day care treatment expenses of the newborn baby for up to 90 days from birth, within the new beginnings benefit limit

Key Service Terms for New-Born Baby Expenses

1. New-Born Baby expenses shall be paid only if the claim with regard to delivery/termination is admissible under New Beginnings regardless of whether such claim was paid under New Beginnings or not. New-Born Baby expenses shall be payable regardless of whether New beginnings benefit is renewed or not.
2. The New-Born Baby can be added to the policy (subject to underwriting) as an Insured Person after 90 days of birth by paying the requisite additional premium

C. First Year Vaccinations

Growing up protected.

What we cover under First Year Vaccinations

We will reimburse vaccination expenses incurred within the first year of birth for the newborn as per the below listed National Immunization Program (India):

Time Interval from birth	Vaccinations to be done (Age)	Frequency
0 – 3months	BCG (Birth to 2 weeks)	1
	OPV (0,6,10 weeks) OR OPV + IPV1 (6,10 weeks)	3 OR 4
	DPT (6 & 10 week)	2
	Hepatitis-B (0 & 6 week)	2
	Hib (6 & 10 week)	2
3 – 6 months	OPV (14 week) OR OPV + IPV2	1 or 2
	DPT (14 week)	1
	Hepatitis-B (14 week)	1
	Hib (14 week)	1
9 months	Measles (+9 months)	1
12 months	Chicken Pox (12 months)	1

Key Conditions applicable to First Year Vaccinations

1. Only the vaccines listed in the table above are covered
2. Expenses must be incurred within 1 year from birth
3. First Year Vaccination expenses shall be paid only if the claim with regard to delivery/termination is admissible under New Beginnings regardless of whether such claim was paid under New Beginnings or not. First Year Vaccination expenses shall be payable regardless of whether New beginnings benefit is renewed or not.

What is not covered under New Beginnings

1. Stem cell harvesting and storage expenses
2. Ectopic pregnancy expenses (as this is covered separately under In-patient hospitalization / day-care benefit)
3. Newborn expenses beyond 90 days if baby is not added to the policy
4. Abortions (except if lawful) undertaken by choice of the Insured Person are not covered under this policy.
5. Infertility treatments

10. Reduction of Waiting Period (Not Available with Infinix Now & Infinix Active)

Because waiting less means peace of mind sooner.

What we cover

This benefit reduces both the below waiting periods from 36 months wherever applicable to 24 months so that you can access coverage for these conditions sooner under your policy.

- **Pre-Existing disease waiting period (Code – Excl. 01)** and
- **Specified diseases/procedure waiting period (Code – Excl. 02)**

Key Service Terms

1. **Eligibility:** This benefit can be opted only at the inception of the Policy on all or none basis. It cannot be opted at renewal.
2. **No selection later:** This benefit is **not available at renewal, portability, or migration**
3. **No changes after opting:** Once selected, this benefit **cannot be removed or discontinued** at future renewals
4. **Premium:** The applicable premium/loading for this optional benefit will continue to be charged at each renewal for as long as the Policy remains active with Us.
5. **Policy-level Selection:** If opted, the reduction of Waiting Period shall be applicable to all insured members under the policy (all or none basis)
6. **Mutually exclusive option:** You can choose only any one benefit from the below, not both
 - a. QuickAccess or
 - b. Reduction of Waiting Period

11. QuickAccess (Not Available with Infinix Now & Infinix Active)

Fast-track your health coverage.

What we cover

We understand that some common health conditions may already exist before you buy a health insurance policy. With **QuickAccess**, if you have declared certain pre-existing diseases and we have accepted them, you can get faster coverage specifically for the below listed conditions.

- 1) Diabetes mellitus
- 2) Hypertensive diseases
- 3) Obesity
- 4) Dyslipidaemia
- 5) Asthma
- 6) Hypothyroidism
- 7) Migraine
- 8) Leucoderma

Key Service Terms

1. **Commencement of coverage:** Coverage for any illness, complication or ailment arising from the above listed conditions declared by you and accepted by us will start from the 31st day of this benefit being in force. Therefore, the standard Pre-existing waiting period shall not apply specifically for such conditions.
2. **Other PEDs:** Any other Pre-existing Disease, condition, illness, complication, or ailment that is not listed above and Pre-existing Diseases not declared by you or accepted by Us will continue to be subject to the applicable Pre-existing Disease Waiting Period
3. **Eligibility:** This benefit can be opted only at the inception of the Policy on all or none basis. It cannot be opted at renewal.
4. **No changes after opting:** Once selected, this benefit **cannot be removed or discontinued** during future renewals.
5. **Premium:** The applicable premium/loading for this optional benefit will continue to be charged at each renewal for as long as the Policy remains active with Us.
6. **Extra benefit:** If the Specified Disease/Procedure Waiting Period under Your selected plan variant is 36 months by default, the same will automatically reduce to 24 months when You opt for this benefit.
7. **Mutually exclusive option:** You can choose only any one benefit from the below, not both
 - a. QuickAccess or
 - b. Reduction of Waiting Period
8. All other terms and conditions of this policy shall remain unaltered

SECTION – 3 WAITING PERIOD AND 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 force) in your policy
- b. Waiting periods will apply separately to each insured person, and claims will be assessed accordingly.
- c. The applicable waiting period will depend on the plan variant and/or optional benefits selected by You. For easy reference, the applicable waiting period will also be mentioned in Your Policy Schedule.
- d. The waiting periods and exclusions listed below will apply to all benefits (base and optional) under the policy, except for:
 - i. Personal Accident Plus
 - ii. Tele-Consultation
 - iii. Discounts and Health Services from Network Providers
 - iv. Wellness Program
 - v. Health Check-Up
 - vi. Emotional quotient
 - vii. NutriBoost

A. Standard Exclusions

1. **Pre-existing Disease Waiting Period – Code - Excl. 01 (Not Applicable for Infinix Now)**
 - a. Expenses incurred towards the treatment of any Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage, calculated from the date of inception of this Policy with the Insurer.
 - b. In the event of an enhancement of the Base Sum Insured, the above exclusion shall apply afresh to the extent of such increase in the Base Sum Insured.
 - c. Where the Insured Person has been continuously covered without any break, as defined under the portability norms prescribed in the extant IRDAI (Health Insurance) Regulations, the waiting period shall be reduced to the extent of the prior continuous coverage.
 - d. Coverage under the Policy, upon completion of the Pre-existing disease waiting period, shall be subject to the Pre-Existing Disease having been declared at the time of application and accepted by us.
2. **Specified disease/procedure Waiting Period – Code - Excl. 02 (Not Applicable for Infinix Now)**
 - a. Expenses incurred towards the treatment of the below listed diseases, conditions, surgeries, or procedures shall be excluded until the completion of 36 months or 24 months (as per plan variant opted) of continuous coverage, calculated from the date of inception of the first policy with us. This exclusion shall not apply to claims arising due to an accident.
 - b. In the event of an enhancement of the Base Sum Insured, the above exclusion shall apply afresh to the extent of such increase in the Base Sum Insured.

- c. The waiting period for the listed diseases and procedures shall apply irrespective of whether such condition is contracted after policy inception or declared and accepted without any specific exclusion.
- d. If the Insured Person has been continuously covered without any break, as defined under the portability norms prescribed by the extant IRDAI (Health Insurance) Regulation, the applicable waiting period shall be reduced to the extent of such prior continuous coverage.
- e. List of specific diseases/procedures:
 - i. Cataract,
 - ii. Endometriosis, Dilatation and curettage, 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, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal, Removal of Implants and all diseases of Ligament, tendon, meniscal tear (other than caused by accident or malignancy).
 - iv. Varicose Veins and Varicose Ulcers,
 - v. Stones in the urinary genito-urinary 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 & biliary system unless necessitated by malignancy.
 - xi. Ailments listed in Table B under In-patient Hospitalization for Mental Illnesses

3. **30 days Waiting Period - Code- Excl. 03 (Not Applicable for Infinix Now)**

- a. Expenses related to the treatment of any illness within 30 days from the date of commencement of the first policy shall be excluded, except for claims arising due to an accident, provided the same are covered under the Policy.
- b. This exclusion shall not apply where the Insured Person has been covered continuously for a period exceeding 12 months.
- c. The aforesaid waiting period shall apply afresh to any enhancement of the Base Sum Insured, to the extent of such increase in the Base Sum Insured.

4. **Investigation & Evaluation- Code- Excl 04**

- a. Expenses incurred for any hospitalization or admission undertaken primarily for diagnostics and evaluation purposes only shall be excluded.
- b. Expenses incurred towards diagnostic tests or investigations which are not related to, or incidental to, the diagnosis and treatment for which the hospitalization is undertaken shall be excluded.

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

Expenses incurred for any hospitalization or admission undertaken primarily for diagnostic purposes or enforced bed rest, and not for active medical treatment, shall be excluded. This exclusion shall also include:

- i. Custodial care, whether provided at home or in a nursing facility, for personal care or assistance with activities of daily living such as bathing, dressing, or mobility, whether rendered by skilled nurses, attendants, or unskilled personnel.
- ii. Services rendered for terminally ill persons primarily to address physical, social, emotional and spiritual needs, including palliative or hospice care.

6. Obesity/ Weight Control: Code- Excl 06

Expenses incurred towards the surgical treatment of obesity shall be excluded unless all of the following condition are fulfilled.

- a. The Surgery or procedure is recommended by a registered Medical Practitioner.
- b. The surgery or procedure is performed in accordance with established and accepted clinical protocols.
- c. The Insured Person is 18 years of age or older at the time of the procedure.
- d. The Insured Person meets one of the following Body Mass Index (BMI) criteria;
 - i. BMI greater than or equal to 40 or
 - ii. BMI greater than or equal to 35, along with at least one of the following severe co-morbid conditions, and after failure of less invasive methods of weight loss:
 - a) Obesity-related cardiomyopathy
 - b) Coronary heart disease
 - c) Severe Sleep Apnea
 - d) Uncontrolled Type2 Diabetes

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

Expenses incurred towards any treatment, including surgical procedures, undertaken to change or alter the physical characteristics of the body to those of the opposite sex shall be excluded, except for sex reassignment surgery undertaken by transgender persons, where such treatment is otherwise covered under the Policy.

8. Cosmetic or Plastic Surgery: Code- Excl 08

Expenses incurred towards cosmetic or plastic surgery, or any treatment undertaken primarily to alter or enhance appearance, shall be excluded unless such treatment is required for reconstruction following an Accident, Burn(s) or Cancer, or is part of medically necessary procedure undertaken to remove a direct and immediate health risk to the Insured Person. For such treatment to be considered medical necessary, the same must be duly certified by the attending Medical Practitioner.

9. Hazardous or Adventure sports: Code- Excl 09

Expenses incurred towards any treatment necessitated as a result of participation, as a professional, in hazardous or adventure sports shall be excluded. This shall include, but not be limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing, scuba diving, hand gliding, sky diving and deep-sea diving.

10. Breach of law: Code- Excl 10

Expenses incurred towards treatment directly arising from, or consequent upon, any act committed or attempted by an Insured Person in breach of law with criminal intent shall be excluded.

11. Excluded Providers: Code- Excl 11

Expenses incurred towards treatment availed at any hospital, or from any Medical Practitioner or healthcare provider, specifically excluded by the Insurer and disclosed on the Insurer's website and/or notified to the Policyholders, shall not be admissible. Notwithstanding the above, in the event of a life-threatening emergency or following an Accident, expenses incurred up to the stage of stabilization of the Insured Person shall be payable, subject to the terms and condition of the Policy. Please click on the below link for details on excluded providers: [Link: https://www.manipalcigna.com/locate-us](https://www.manipalcigna.com/locate-us)

12. Expenses incurred towards treatment for Alcoholism, drug, or substance abuse, or any addictive condition, and any consequences arising therefrom, shall be excluded Code- Excl 12

13. Expenses incurred towards treatments received at health hydros, nature cure clinics, spas or similar establishments, or in private beds registered as a nursing home attached to such establishments, or where admission is arranged wholly or partly for domestic or non-medical reasons, shall be excluded. Code- Excl13

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

15. Refractive Error: Code- Excl 15

Expenses incurred towards treatment for correction of eye sight due to refractive errors of less than 7.5 diopters shall be excluded.

16. Unproven Treatments: Code- Excl 16

Expenses incurred towards any unproven treatment, services, or supply for or in connection with any such treatment shall be excluded. For the purpose of this policy, "Unproven treatments" are those treatments, procedures or supplies that lack sufficient medical documentation or evidence to support their safety and effectiveness.

17. Sterility and Infertility: Code- Excl 17

Expenses incurred towards the treatment of sterility or infertility shall be excluded.

This includes, but is not limited to:

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

18. Maternity: Code Excl 18

- a. Medical treatment expenses traceable to childbirth, including complicated deliveries and caesarean sections incurred during hospitalization, shall be excluded, except in case of ectopic pregnancy;
- b. Expense incurred towards miscarriage (unless resulting from an accident) and lawful medical termination of pregnancy during the policy period shall be excluded.

B. Specific Exclusions

1. Personal Waiting period

A special waiting period of up to 36 months may be applied to specific medical conditions for an insured person based on underwriting. This will depend on the health details provided in the proposal form and the insured person's existing medical condition. Any such waiting period will be clearly mentioned under the Special Conditions in the Policy Schedule and will be applied only after obtaining consent from the insured person or proposer.

2. Expenses incurred towards Dental Treatment, orthodontic treatment, dentures, or dental Surgery of any kind shall be excluded, unless such treatment is necessitated due to an Accident and requires a minimum of 24 hours Hospitalization. Treatment related to gum disease, tooth disease, or dental damage shall also be excluded, unless such treatment is attributable to an irreversible bone disease involving the jaw that cannot be treated in any other means, and is specifically covered under the Policy.
3. Expenses incurred towards circumcision shall be excluded, unless such procedure is medically necessary for the treatment of an illness or injury not otherwise excluded under the policy, or is necessitated due to an accident.
4. Expenses incurred towards Instruments or devices used for the treatment of Sleep Apnea Syndrome (including C.P.A.P.), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump, or any other external medical devices used during or after treatment shall be excluded.
5. Expenses incurred towards the treatment of any External Congenital Anomaly or defects, and any complications or conditions arising therefrom, shall be excluded.
6. Expenses incurred towards prostheses, corrective devices, or medical appliances that are not required intra-operatively for the illness or injury for which the Insured Person is Hospitalized shall be excluded.
7. Expenses incurred towards any stay in a Hospital where no treatment is undertaken, or where the admission is for any purpose other than receiving eligible medical treatment of a type that ordinarily requires hospitalization, shall be excluded.
8. Expenses incurred towards treatment received outside the geographical limits of India shall be excluded.
9. Expenses incurred towards donor screening, or costs incurred in organ transplant surgery involving organs not harvested from a human body, shall be excluded except for conditions covered under 'Donor Expenses' benefit.

- 10.** Expenses incurred on Non-Allopathic treatments except AYUSH, Hydrotherapy, Acupuncture, Reflexology or Chiropractic treatment.
- 11.** Expenses incurred towards any Illness or conditions caused by, arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof, shall be excluded.
- 12.** Expenses incurred towards any illness, injury, or condition caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including 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, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority, shall be excluded.
- 13.** Non-medical expenses mentioned in List I of Annexure 2.
- 14.** Any deductible amount, if applicable, as specified in the Policy Schedule.
- 15.** 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.
- 16.** Any kind of Out-Patient Treatment expenses including fractures (not requiring any kind of hospitalization)
- 17.** Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.
- 18.** Stem cell harvesting.
- 19.** Vaccination including inoculation and immunisations (except post animal bite treatment).
- 20.** Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.
- 21.** 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.
- 22.** 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/manual.
- 23.** Hospitalization at a healthcare facility which is NOT a
 - Hospital or

- Day Care Centre or
- AYUSH Hospital

- 24.** Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
- 25.** Any treatment or part of a treatment that is not of a reasonable charge or not Medically Necessary.
- 26.** Drugs or treatments which are not supported by a prescription.
- 27.** 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.

Section 4: GENERAL TERMS AND CLAUSES

I. Standard General Terms and Clauses

All standard general terms and clauses applicable to this product are provided in Annexure 3, which forms an integral part of these Terms and Conditions.

II. Specific General Terms and Clauses

1. Material Change

We require you to share all information related to the questions in the Proposal Form, as fully and accurately as you can. This helps us understand your insurance needs, assess the risk, and offer the right policy terms. This is not only important when you buy the Policy for the first time but is also important if you later choose to renew, extend, make changes to, endorse, or revive the Policy. If your health changes after post inception of this Policy, please let us know. Once you share this information with us, we assure you that we will not reassess your risk for that disclosed health change. We will also not charge any extra premium for it.

An extra premium or fresh assessment may apply only if you choose to make changes to your Policy, such as increasing the coverage amount, adding a member, opting new benefits etc.

In short, we simply ask you to keep us informed so that your Policy remains clear, fair, and worry-free.

2. Alterations in the Policy

Your policy and its related documents together form your complete insurance contract. If any change is made to your policy, we will approve it in writing and confirm it through an endorsement that would be issued to you. This ensures that every change is clearly recorded and shared with you.

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.

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.

5. Geography

The geographical scope for all benefits (base and optional) under this Policy is restricted to incidents, medical expenses and treatments incurred or availed within India. All admitted or payable claims shall be settled in India and in Indian rupees only.

6. Records to be maintained

Please keep all medical documents and material information related to your claim complete, accurate, and safe. We or our representatives may request to review them when needed.

We may also ask you to share relevant information during the Policy Period and for up to three years after the Policy expires, or until all claims under the Policy are fully settled.

7. Grace Period

- To continue your policy without a break, please pay the renewal premium on or before the policy expiry date. If you miss the due date, you can still renew the policy within the Grace Period.
- If the premium payment mode is 'Single', kindly note that we will not be able to cover any claim for an illness, injury, accident, condition, or service that occurs or is availed during the Grace Period.
- If the premium payment mode is 'instalment', coverage shall be available during the Grace Period.
- Only if you renew within the Grace Period, your continuity benefits will remain protected.
- Grace period available shall be as per premium payment mode as detailed in the below table

Premium Payment mode	Grace Period	Coverage available during grace period
Single	30 days	No
3 monthly instalments	15 days	Yes
6 monthly instalments	15 days	Yes
9 monthly instalments	15 days	Yes
12 monthly instalments	15 days	Yes
24 monthly instalments	15 days	Yes
36 monthly instalments	15 days	Yes

8. Renewal Terms

- Your policy can typically be renewed for life, as long as both you and the insurer agree to continue the coverage. Simply submit the renewal request and pay the renewal premium for your policy to remain active.

- ii. You can continue renewing your policy without any concerns, provided the information shared with us is accurate and complete. Renewal may only be declined in cases of misrepresentation, proven fraud, or non-disclosure of important facts.
- iii. If this product or any plan variant under Infinix is discontinued or withdrawn in the future, you will have the option to renew your coverage under the closest available policy or plan variant offered by us. The benefits available under the renewed policy will be governed by the terms and conditions of that policy.
- iv. To keep our policies aligned with applicable regulatory guidelines, we may occasionally update the renewal premium or coverage terms. Please be assured that your renewal premium will not be affected by your individual claims experience. We will inform you of any such changes at least 45 days before they take effect.
- v. 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 any of the above request. The terms and conditions of the existing Policy will not be altered.
- vi. In case of any increase in risk, for instance addition of a new Insured Member, enhancement of Base Sum Insured, or removal/reduction of deductible, all applicable waiting periods will apply afresh to the enhanced portion of such risk, unless expressly specified otherwise under the terms of the relevant benefit.
- vii. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under this Policy will be applicable considering such Policy Year as the first year of Policy with the Company.

You may pay the premium through National Automated Clearing House (NACH) / Standing Instruction (SI) subject to the below guidelines:

- i. The 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. A New Mandate Form must be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.
- iv. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/Standing Instruction facility.

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

9. Premium calculation & Zone Classification

Premium will be calculated based on the Base Sum Insured opted, Plan variant opted, age of each insured member, risk classification, optional covers chosen, claims history, and zone classification. The zone classification will be determined based on the proposer's address details provided in the Proposal Form.

Please ensure that the address details provided are accurate and complete. If any difference or mismatch is identified during claim assessment, it may result in delays, disputes, or rejection of the claim. If any of your address changes at any time, please inform us in writing as soon as possible. This will help us stay in touch with you and ensure smooth claim processing.

Zone	Region / District / State
Zone 1	Mumbai, Navi Mumbai, Thane
Zone 2	Delhi, Faridabad, Gautam Buddha Nagar, Ghaziabad, Greater Noida, Gurugram
Zone 3	Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal, Medchal Malkajgiri
Zone 4	Ahmedabad, Gandhi Nagar, Surat, Vadodara
Zone 5	Aligarh, Alwar, Baghpat, Bharatpur, Bhiwani, Bulandshahar, Dhoom, Hathras, Jansath, Jhajjar, Jind, Karnal, Mahendragarh, Mathura, Meerut, Muzaffarnagar, Panipat, Rewari, Rohtak, Sonipat, Amroha, Charki Dadri, Nuh, Palwal, Hapur
Zone 6	Chandigarh, Amritsar, Gurdaspur, Rupnagar (Ropar), Ludhiana, Fatehgarh Sahib, S.A.S. Nagar (Mohali), Patiala, Dhanbad, Bokaro, Dausa, Dholpur, Jaipur, Karauli, Sawai Madhopur, Tonk, Jhunjhunu, Bihar State, Daman & Diu UT, Dadara & Nagar Haveli UT, Rest of Andhra Pradesh State, Rest of Telangana State, Rest of Gujarat State, Rest of Haryana State
Zone 7	Pune, Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Raigad
Zone 8	Chennai
Zone 9	Bangalore
Zone 10	Kolkata
Zone 11	Rest of India
Note: Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts.	

10. Discounts under the Policy

You can avail the following discounts.

Key service terms applicable for all the discounts below

- a. Discounts in this section shall be provided on Total premium.
- b. All the below discounts are applicable at policy level.
- c. The maximum discount that may be availed under this Section is 40%, excluding No Claim Discount.
- d. Mutually exclusive: You can choose only any one discount from the below list
 - 1) Direct discount or
 - 2) Worksite marketing discount or
 - 3) Employee discount or
 - 4) Discount in lieu of Commission

i. **Standing Instruction Discount (Not Available with Infinix Active)**

Never miss a renewal & enjoy savings with automatic payments.

Get 2.5% off on your renewal premium whenever a payment is made through a standing instruction.

You can choose this option either when buying the policy (at inception) or at renewal.

The discount shall continue, as long as the payment is made through Standing Instruction authorization.

This discount shall not be available if premium is paid in instalments.

ii. **Long Term Policy Discount**

Stay covered longer and pay less.

Everytime you opt for a 2-year policy enjoy a discount of 10% on the premium of the 2nd policy year.

Everytime you opt for a 3-year policy enjoy a discount of 10% on the premium of the 2nd policy year and 12.5% discount on the premium of the 3rd policy year.

iii. **Direct Discount**

Buy online, save 5% — and keep saving at renewal too.

Get a 5% discount when You buy the Policy (at inception) online through Our direct channels - website, mobile app or eligible technology platforms, wherein they undertake digital marketing for us or assist with technology systems reducing IT costs. If this discount was provided at inception only then this discount shall continue at renewal as well, as long as the Policy is renewed online through our direct channels.

iv. **ManipalCigna GMC Discount**

Insured with Us through Group Insurance as well? - Enjoy a 10% premium discount on this Policy too.

If any Insured Person under Infinix is also insured under any of our Group Mediclaim Policy schemes at the time of buying this policy (at inception), You can get a 10%

discount on premium at inception of this policy and the discount shall continue at renewals provided that atleast one Insured Person continues to remain insured under a Group Mediclaim Policy.

You can choose only either one of the below

- a. ManipalCigna GMC Discount **OR**
- b. Loyalty Discount

v. NRI/OCI Discount (Not Available Infinix Active)

Overseas today, protected in India always — with a special NRI/OCI discount.

Non-Resident Indians (NRIs) and Overseas Citizens of India (OCIs) can avail a discount of 25% on the premium

Key Service Terms applicable to NRI/OCI Discount

1. This discount is available only if Unlimited Base Sum Insured is opted.
2. This discount can be opted for only at the time of policy inception. At policy inception, the Proposer must submit the NRI/OCI declaration and relevant details/documents required as part of the proposal form for all proposed Insured persons. Discount shall be provided only if all Insured persons are eligible for NRI/OCI discount.
3. To continue availing the NRI/OCI Discount, the policyholder will be required to submit a declaration at each renewal. As part of the declaration he would be required to confirm the current NRI/OCI status of all Insured members and also confirm that all Insured members are residing overseas. For NRI/OCI customers, eligibility for this discount at policy inception and renewal will depend on all Insured Person(s) having resided in India for less than 182 days in the immediately preceding financial year. The discount will continue to be available as long as these criteria continues to be met.
4. The NRI/OCI discount shall be available only if all Insured Persons continue to satisfy the applicable eligibility criteria. If, at any renewal, the declaration reveals that any Insured Person is ineligible, the discount shall stand withdrawn for the entire policy from such renewal and shall not be reinstated in subsequent renewals.
5. If the NRI/OCI Discount was availed at renewal and, during the renewed Policy Period, an Insured Person returns to India and submits an admissible claim, the claim will be paid in accordance with the terms of the Policy without recovering any additional premium towards the NRI/OCI Discount.
6. If You have availed the NRI/OCI Discount at renewal and, during the renewed Policy Period, a claim is submitted, We shall review the declaration provided at renewal as part of the claim assessment. If it is established that the declaration was false or incorrect, it shall be treated as material misrepresentation. In such cases, the claim will not be payable, and the Policy may be terminated in accordance with the applicable Policy terms and conditions.
7. Documents required for availing/validating NRI/OCI Discount and claims assessment
 - a) PAN card
 - b) Either of the below documents
 - 1) Passport entry/exit stamps and last page proving customer stayed outside India for at least 182 days in previous financial year
 - 2) E-passport along with document stating date of entry and exit from India

- 3) Overseas residence proof (Active Rent Agreement)
- 4) Utility bill issued in the name of the customer within the last 3 months.
- 5) Active Work Permit
- 6) Active Employment Card
- 7) IT Return - Highlighting NRI/OCI Applicability.
- 8) If premium is paid from NRE/NRO account → 1-month bank statement with premium debit highlighted
- 9) Proof of Permanent Residency
- 10) Any other document that can reasonably establish the required information and is accepted by us as valid proof

Note: Proposal processing shall be subject to successful verification of the submitted NRI/OCI and payment-related documents.

vi. Employee Discount (Not Available with Infinix Active)

A special 10% premium discount for ManipalCigna employees.

Get a 10% discount on the premium if the Policyholder of this policy is a ManipalCigna employee at the time of buying (at inception) this policy. It will not be available if the Policyholder joins ManipalCigna at a later renewal. Once this discount is provided at inception it will continue to remain applicable at renewals.

vii. No Claim Discount (Not Available with Infinix Active)

If You renew with Us in this Policy, You'll be eligible for a discount on Your renewal premium based on the number of expiring **continuous claim-free policy years**, as shown below:

Expiring Claim free policy years	Discount
1 year	2.5%
2 years	5%
3 years	7.5%

Key Service Terms:

1. If you make a claim, your claim-free year count will reset to zero. It will start building again from the next policy year.
2. Use of the following benefits will **not** affect Your eligibility for claim-free discount:
 - Tele-Consultation
 - Health Check-Up
 - Wellness Program
 - Discounts and Health Services from Network Providers
 - Emotional quotient
 - NutriBoost

3. Once the **eldest member covered under the Policy reaches age of 56 years at the time of renewal**, further movement to a higher discount level will stop for the entire policy.
4. The discount level already earned at age 56 will continue until a claim is made. After a claim made post age 56, the discount will reset to **0** and will **not build up again** in future policy years, irrespective of claim history.
5. This discount is not applicable at the time of porting.
6. If your Policy is split into two or more separate Policies, the No Claim Discount applicable at the time of renewal under the original Policy will continue to apply to each of the split Policies.
7. If a new member is added to the Policy, or if one Policy is merged with another Policy, the No Claim Discount applicable under the merged Policy at the time of renewal will continue to apply at policy level.

Let's understand how No claim discount works with an example

Mr. Sharma had been diligently renewing his health policy every year without making any hospitalization claims.

After **1 claim-free year**, he enjoyed a **2.5% discount** on his renewal premium. After **2 consecutive claim-free years**, the discount increased to **5%**, and by the **3rd year**, it grew to **7.5%**, reducing his premium further.

During this time, Mr. Sharma continued to use services like **tele-consultations and health check-ups**, but these did **not impact his claim-free discount**.

However, in the fourth year, he required hospitalization. After this claim, his **claim-free count reset to zero**, and the discount started afresh from the next policy year.

As Mr. Sharma approached **age 56**, he had already built up a **7.5% discount**. This level continued at renewal, but once he made a claim post 56, the discount **reset to zero permanently**, with no further accumulation.

In short:

- ✓ More claim-free years → higher premium discount
- ✓ Wellness benefits don't affect the discount
- ✗ Any hospitalization claim → discount resets (also, special rule applies after age 56)

viii. Worksite Marketing Discount

Worksite advantage: enjoy a one-time 10% discount when you buy your policy through the Worksite Marketing channel.

Discount of 10% will be applicable for policies sourced through the Worksite Marketing channel. This discount is applicable only once and only at the time of buying (at inception) this Policy.

ix. Discount in lieu of Commission

Start your policy with extra savings — get up to 15% off when the intermediary waives their commission.

A discount up to 15% will be provided on premium at the time of buying (at inception) of the Policy and/or at renewals, in case the intermediary forgoes their commission.

x. Loyalty Discount (Not Available with Infinix Active)

Already covered with us? Get a one-time 5% discount when you buy this policy as a new purchase or port-in.

If you already are a policyholder in an active retail health indemnity policy with us and buy this policy as the Policyholder, you will receive a one-time **5% discount** on the premium. This discount is available for the entire policy period only at the time of buying this policy (new/fresh business) or when you port into this policy from another insurer. This discount will not apply in case of migration. Also, it won't be provided at subsequent renewals.

You can choose only either one of the below

- a. ManipalCigna GMC Discount **OR**
- b. Loyalty Discount

11. Loadings & Special Conditions

We may apply a risk loading on the premium payable (excluding Statutory Levis and Taxes as applicable) 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 additional premium (if any), within the duration specified in the counter offer letter.

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

12. Communications & Notices

To keep all communication clear and properly recorded, any notice or instruction related to your Policy must be shared in writing.

- a. We will send communications to the Policyholder's address mentioned in the Policy Schedule.
- b. You can send communications to us at the address mentioned in the Policy Schedule.
- c. Please send notices directly to us. An insurance agent, broker, or any other person or organisation can accept a notice on our behalf only if we have authorised them to do so in writing.
- d. A notice will be deemed served:
 - i. 10 days after it is posted, or
 - ii. Immediately upon receipt, if sent by hand delivery, fax, or email.

13. 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.

14. Limitation of Liability

If your claim is rejected or partly paid, and you do not take any legal action, other proceeding, or arbitration within 12 months from the date of rejection or settlement, the claim will be treated as closed. After this period, the claim will be treated as closed. We will then no longer be responsible for making any payment for that claim, and the amount cannot be claimed later.

15. Terms and conditions of the Policy

This Terms & Conditions document, the Proposal Form, the Policy Schedule, and the Annexures are all part of your Policy Contract. This also includes any endorsements and changes made from time to time. For complete details and better clarity, please read all these documents together.

16. 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.

17. 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.

Specific conditions applicable to revival of policy

- 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 or service availed 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.

18. 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.

19. Personal Data and Privacy

We may collect, use, store, share and otherwise process your personal, health, medical, wellness, activity, claims and policy-related data for lawful purposes connected with this Policy, including proposal evaluation, underwriting, policy issuance, servicing, renewal, endorsements, claims processing, fraud prevention, grievance handling, regulatory compliance, wellness and value-added services, and communication with You.

Where required for these purposes, we may share such data with our authorised service providers, TPAs, network hospitals, medical practitioners, diagnostic centres, wellness partners, mental-health or nutrition service providers, technology platforms, reinsurers, investigators, auditors, legal advisers, regulators, government authorities and other persons permitted under applicable law.

This may include ABDM/ABHA-enabled services where consented; you can withdraw such consent at any time.

20. Maximum Liability clause

The maximum liability means the maximum amount that We will pay under this policy in a policy year. Our maximum liability for admissible claims in a Policy Year will be the sum total of

- The Base Sum Insured applicable for the policy year as mentioned in your Policy Schedule
- The Benefit amount of each optional covers in force as mentioned in your Policy Schedule

21. Benefit-wise Claim Servicing Mode and Claim Payout Matrix

The table below provides a benefit-wise summary of the applicable claim servicing basis and the source from which the claim amount will be paid under the policy; cashless claim details are provided under Section 5.1.4., and reimbursement claim details are provided under Section 5.1.5. – Reimbursement Claims.

TABLE D			
Sr No.	Name of Benefit	Claim Servicing basis	Claim amount paid from
1	In-patient Hospitalization	Both Cashless and Reimbursement	Base SI
2	Day Care Treatment	Both Cashless and Reimbursement	Base SI
3	Pre-Hospitalization Medical Expenses	Reimbursement only	Base SI
4	Post-Hospitalization Medical Expenses	Reimbursement only	Base SI
5	Domiciliary Hospitalization	Reimbursement only	Base SI
6	Home Treatment	Reimbursement only	Base SI
7	Road Ambulance	Reimbursement only	Base SI

8	Organ Harvesting Expenses	Both Cashless and Reimbursement	Base SI
9	Organ Donor Medical Expenses	Reimbursement only	Base SI
10	Organ Donor Complication Support	Reimbursement only	Over and above BSI
11	Donor Screening Expenses	Reimbursement only	Base SI
12	AYUSH Treatment	Both Cashless and Reimbursement	Base SI
13	Tele-Consultation	Cashless only	Not Applicable
14	Discounts and Health Services from Network Providers	Cashless only	Not Applicable
15	Emotional Quotient	Cashless only	Not Applicable
16	NutriBoost	Cashless only	Not Applicable
17	Accidental Death	Reimbursement only	Over and above Base SI but within PA+ benefit limit
18	Permanent Disability	Reimbursement only	Over and above Base SI but within PA+ benefit limit
19	Health Check-up	Cashless only	Not Applicable
20	High-End Diagnostic Tests	Reimbursement only	Over and above BSI
21	Air Ambulance	Reimbursement only	Over and above BSI
22	Maternity Expenses	Both Cashless and Reimbursement	Over and above BSI but within New Beginnings benefit limit
23	New Born Expenses	Both Cashless and Reimbursement	Over and above BSI but within New Beginnings benefit limit
24	First Year Vaccinations	Reimbursement only	Over and above BSI but within New Beginnings benefit limit
25	Non-Medical Expenses	Both Cashless and Reimbursement	Base SI
26	Durable Medical Equipment	Reimbursement only	Over and above BSI
27	QuickAccess	Both Cashless and Reimbursement	Base SI

22. 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.

23. Utilisation of coverage under this Policy

For every claim that is accepted under the Policy, we will calculate the payable amount step by step. Before the final amount is paid from the Base Sum Insured or the applicable Benefit Limit, certain deductions, limits, or cost-sharing conditions may apply. These will be applied in a fixed order for each accepted claim, as explained below.

- 1) **Proportionate deduction due to room rent eligibility** (if applicable)
- 2) **Annual aggregate deductible** (if applicable)
- 3) **Co-payment** (as applicable, if treatment is taken outside the opted PPN package)

- 4) **Sub-limit** or capping applicable to the specific benefit or sub-benefit
- 5) **Available Base Sum Insured / Benefit Limit** (from which the final payable amount will be utilised after applying the above deductions or limits)

24. 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.

Section 5: OTHER TERMS AND CONDITIONS

I. Claim process & management

1. Condition Precedent

For a claim to be admissible under this Policy, You and every Insured Person must comply with all applicable terms and conditions of the Policy, including the requirements set out below:

- a. **Payment of premium:** To keep your Policy active and benefits uninterrupted, please ensure that the premium and any instalments due under the Policy are paid and realised by Us on or before their respective due dates.
- b. **Claim documents, intimation and requirements:** To help Us process Your claim smoothly please intimate us and submit the complete set of supporting documents within the timelines specified below in this Section. In situations where these requirements are not met, and the delay cannot be reasonably justified as described above, it may impact Our ability to assess and admit the claim.
- c. **Claim Processing and Network Hospital Services:** To make Your experience smoother, cashless and reimbursement claim processing, as well as access to our Network Hospitals, may be supported through our service partner or Third Party Administrator (TPA). Information about the applicable TPA will be available on the Health Card issued by Us and on our website. To access the latest list of Network Hospitals kindly refer to Table E. While a TPA may assist in facilitating the claim process, We will continue to be available to support You throughout Your claim journey, including claim intimation, submission of documents, claim settlement, and resolution of any concerns or grievances.

2. Policyholder's / Insured Person's Duties at the Time of a Claim

Before availing cashless services, We recommend checking the latest list of applicable Network Hospital on Our website or contacting Our call centre for assistance.

If an event occurs that may lead to a claim under this Policy, We request You, the Insured Person, or anyone acting on Your behalf to support Us with the following:

a. Claim intimation and submission

Please inform Us about the claim and submit the required claim documents as soon as reasonably possible, in accordance with the Claim Process specified below in this section. Timely information helps Us process Your claim smoothly and efficiently.

- i. Claim Intimation
- ii. Cashless Facility
- iii. Reimbursement Claim Process

b. Medical examination, where required

In certain situations, We may request the concerned Insured Person to undergo a medical examination by a Medical Practitioner nominated by Us to help Us assess the claim. Any such examination will be arranged at Our cost.

c. Sharing records and information

To enable a fair and timely assessment of the claim, We may require access to relevant medical and hospitalization records. Our nominated Medical Practitioner or authorised representative may also review the circumstances of the claim and, where necessary, examine the Insured Person.

d. Assistance during claim assessment

We may seek Your cooperation and reasonable assistance while reviewing a claim. We request You to extend reasonable cooperation to Our authorised representatives and support them in carrying out the activities required to assess the claim. This helps Us understand the circumstances of the claim, determine its admissibility under the Policy, and assess the amount payable, if any.

e. Protecting Your personal and medical information

To help safeguard the privacy and security of Your personal, medical, and claim-related information, We advise You to share such information only through the official communication channels specified in Table E. Sharing sensitive information through unofficial channels or platforms may increase the risk of unauthorised access or disclosure.

3. Claim Intimation

If You or the Insured Person become aware of any Illness, Injury, or event that has resulted in, or may result in, a claim under this Policy, We request that You inform Us through Our call centre or in writing within the timelines specified below. This will help Us support You better and ensure a smooth and timely claim assessment process.

- a. Planned Hospitalization: Inform Us at least 48 hours before the planned date of admission
- b. Emergency Hospitalization: Inform Us within 24 hours from the time of admission.
- c. Details to be provided at the time of intimation of Claim:
 - Policy Number
 - Name of the Policyholder
 - Name of the Insured Person in relation to whom 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

The documents specified above may be securely shared on either of the below

- Our official mobile application – ‘myManipalCigna’ OR
- Claims page on our website (Refer Table E) OR
- Our designated Claims Office Address (Refer Table E)

TABLE E

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
Reimbursement claims	Reimbursementclaim@manipalcigna.com
Toll free (24x7 Claims Healthline No.)	1800-102-4461
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
List of PPN hospitals	https://www.manipalcigna.com/locate-us
For complaints	complaints@manipalcigna.com
Chief Grievance Redressal Officer	Compliance@manipalcigna.com
Grievance Redressal contact number	1800-102-4462 (available between 9:00 AM to 9:00 PM) 022-61703600 (available Monday to Friday between 10 AM to 6 PM)

4. Cashless Facility

You can avail the cashless facility typically only at any of our Network Hospitals. The Company may update the list of Network Hospitals available for cashless treatment from time to time. Before taking cashless treatment, the Policyholder or Insured Person should check the latest list of Network Hospitals on the Company's website or by calling the Company's call centre. You may refer Table E to access the List of our network hospitals or contact our call centre. To help ensure a smooth admission process, please carry the Health Card issued by Us along with a valid government photo identity proof (such as a Voter ID Card, Driving Licence, Passport, PAN Card) at the time of admission.

a) Process for Planned Cashless Hospitalization cases:

- For a planned hospitalization, the Insured Person should approach the Network hospital for medical treatment at least 48 hours prior to admission to the Hospital.
- The Network Hospital will submit a request for an Authorization Letter for the proposed hospitalization in the pre-authorization format prescribed by the regulator.

- iii. The Network Hospital will electronically submit the pre-authorization form to Us within 24 (twenty-four) hours, along with the relevant details, including the contact information of the treating Medical Practitioner and the Insured Person.
- iv. Upon receiving the pre-authorization form and the related medical information from the Network Hospital, We will verify the eligibility of coverage under the Policy.
- v. If the information provided in the request is sufficient for Us to complete the assessment, We will issue the Authorization Letter to the Network Hospital. In case any additional information or documents are required, we may request the same from the Network Hospital. Once the necessary details are received and reviewed, the Authorization Letter will be issued. All authorization decisions will be communicated within 1 (one) hour of receipt of the request.
- vi. The Authorization letter will provide details of the approved amount, any applicable limitations on the claim, co-payments or deductibles, and non-medical expenses, wherever applicable.
- vii. The authorization letter shall be valid only for a period of 15 days from the date of issuance.

b) In cases where the cost of hospitalization exceeds the authorized amount specified in the Authorization Letter:

- i. If an increase in the authorized amount is required, the Network Hospital will submit a request to Us for enhancement of the authorization limit as per terms and process stated in clause 4a) above, along with the relevant details explaining the need for the additional amount.
- ii. We will review the request for enhancement and verify eligibility, subject to the availability of the remaining coverage and limits under the Policy.
- iii. We will assess the request for enhancement and communicate whether the additional expenses can be approved within 1 (one) hour of receiving the request.
- iv. In the event of any change in the treatment plan during the Insured Person's hospitalization, the Network Hospital will be required to obtain a fresh Authorization Letter from Us in accordance with terms and process stated in clause 4a) above.

c) At the time of discharge:

- i. If any additional eligible amount remains to be authorized at the time of discharge, the Network Hospital may submit a final authorization request to Us, along with the discharge summary and billing details, in accordance with terms and process stated in clause 4a) above.
- ii. We will assess the request for the additional expenses and communicate whether they are approved or declined within 3 (three) hours of receiving the final discharge request from the Network Hospital.
- iii. Upon receipt of the final Authorization Letter from Us, the Network Hospital may proceed with the discharge of the Insured Person.

d) Process for Emergency Cashless Hospitalization cases:

- i. The Insured Person may approach the Network Hospital for hospitalization and take the required medical treatment.
- ii. The Network Hospital will submit the authorization request to Us within 24 hours of admission to the Hospital, in accordance with terms and process stated in clause 4a) above.
- iii. To help Us assess the claim accurately, we may continue to engage with the treating Medical Practitioner and review the Insured Person's medical condition until the coverage assessment under the Policy is finalized.

- iv. Once the pre-authorization is issued, the Network Hospital will refund the deposit amount collected from You, except for a nominal amount that may be retained to cover non-covered expenses, if applicable.

Key Service Terms applicable to Cashless facility

- a. Cashless facility is available for eligible medical expenses incurred towards the treatment of a covered Illness or Injury at a Network Hospital, in accordance with the terms and conditions of the Policy. While availing the cashless facility, You may be required to directly settle with the Hospital any expenses that are not covered under the Policy, as well as any applicable sub-limits such as co-payments or deductibles.
- b. There may be situations where the cashless facility cannot be approved, such as when the available Sum Insured is insufficient or when further information is needed to complete the claim assessment. We understand that treatment should not be delayed in such circumstances. You or the Insured Person may therefore proceed with the treatment and make the payment directly to the Hospital. The claim can thereafter be submitted to Us for reimbursement and will be considered in accordance with the terms and conditions of the Policy.
- c. The Network Hospital will submit the claim documents listed in Table F, together with the invoice and discharge voucher duly signed by the Insured Person, directly to Us. The claim documents are required to be submitted within 15 days from the date of discharge from the Hospital to facilitate the claim assessment process.

5. Reimbursement Claims Process

If You wish to claim Your eligible expenses under the reimbursement process, You may submit the following documents through Our mobile application or our website, or at Our designated claims office (details in Table E). The claim documents should be submitted within 15 days from the date of discharge from the Hospital to facilitate timely assessment and processing of the claim. Please keep in mind that any expenses incurred for submitting the claim documents are not covered under the Policy and will need to be borne by You.

6. List of Claim documents required to be submitted at the time of a Claim

TABLE F		
List of Claim documents required to be submitted at the time of a Claim		
S. No.	Name of Benefit	Name of Document
0	Standard claim documents required for all benefits	a. Claim form duly signed (for Your convenience, the Claim Form is available at any of Our Branch Offices and can also be downloaded from Our website https://www.manipalcigna.com/downloads/claims) b. Copy of photo ID of patient verified by the hospital c. KYC documents of Policyholder (Photo ID proof, age proof, address proof, recent passport size photograph) d. Cancelled cheque for NEFT payment of Policyholder e. Payment receipt f. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of Hospitalization in any non-Network Hospital of the

		Company or certificate from Hospital authorities providing facilities available including number of beds g. Legal heir or succession certificate (wherever applicable) h. Proof of settlement in case claim is settled by another insurer i. Original pre-authorization request j. Copy of pre-authorization approval letter (s)
1	In-Patient Hospitalization	a. Hospital Discharge summary b. Operation Theatre notes / Indoor Case Papers c. Hospital Main Bill d. Hospital Break up bill e. All Investigation and diagnostic reports f. Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. g. Doctors reference slip for investigation h. Pharmacy bills, prescription by treating medical practitioner and invoices i. Copy of FIR/ MLC / Panchnama / Police Inquest Report (if conducted) duly attested by the concerned Police Station in case of Accident. j. Day Care Summary / Transfer Summary k. All previous consultation papers indicating history and treatment details for current Illness and advice for current Hospitalization l. Invoice with payment receipt and implant stickers for all implants used during Surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery m. History of alcohol consumption or any intoxication certified by first treating doctor in case of Accident cases n. Settlement letter of previous insurer for deductible cases and multiple policy claims
2	Day Care Treatment	
3	Donor Expenses	
4	Annual Aggregate Deductible	
5	One-time Aggregate Deductible	
6	Non-Medical Expenses	
7	AYUSH Treatment	
8	Pre-Hospitalization Medical Expenses	a. Pharmacy Bills b. Investigations and Diagnostic test reports and bills c. Prescription by treating medical practitioner in support of Pharmacy, Investigations d. Consultation Papers
9	Post-Hospitalization Medical Expenses	
10	Road Ambulance	a. Original Bill as provided by Healthcare or Ambulance Service Provider b. Certification of Medical Practitioner for necessity to use Ambulance
11	New Beginnings	a. Discharge Summary b. All hospital bills and pharmacy invoices of medical expenses incurred c. Treating Doctor prescriptions d. New Born Baby birth certificates e. Document stating date of delivery/termination f. All case papers g. Investigations, scans and diagnostic test papers h. Vaccination bills and certificates

		i. Marriage Certificate / Passport / Aadhaar card / Voter ID card for ascertaining marriage
12	Domiciliary Hospitalization	a. Certificate from treating Medical Practitioner that condition of the Insured Person does not allow a Hospital transfer; or b. Evidence that hospital bed was unavailable in nearest hospitals c. Final Bill and invoice d. Nursing chart/TPR chart e. Investigation reports f. Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. g. Doctors reference slip for investigation h. Pharmacy bills, prescription and invoices i. Active line of treatment report
13	Home Treatment	a. Certificate from treating Medical Practitioner b. All medical Bills and invoices c. Nursing chart/TPR chart d. Investigation and diagnostic test reports e. Active line of treatment report f. Doctors reference slip for investigation g. Pharmacy bills, prescription and invoices h. Documentary evidence sent to us requesting Home Treatment i. Certificate from treating Medical Practitioner
14	Personal Accident Plus	<u>In case of Accidental Death</u> a. MLC/ FIR report, b. Post Mortem Report if applicable and conducted c. Original Death certificate issued by the office of Registrar of Birth & Deaths d. Occupation Certificate e. Death summary issued by a Hospital along with the Injury event f. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased g. Proof of occurrence of the Catastrophic event (in case of disappearance) <u>In case of Permanent Disablement</u> a. MLC/FIR if applicable b. Original treating Medical Practitioner's certificate describing the disablement along with the Injury event; c. Occupation Certificate d. Original Discharge summary from the Hospital; e. Photograph of the Insured Person reflecting the disablement; f. Prescriptions and consultation papers of the treatment;

		g. Disability certificate issued by Civil Surgeon or equivalent as authorized by the Government confirming the disability and its percentage h. Medical Practitioner's certificate confirming the injury, commencement date of the Injury, total duration of the disablement and an advisory for rest or unfit to work for specified number of days i. Any other medical, investigation reports, in-patient or consultation treatment papers, as applicable.
15	Air Ambulance	a. Invoices of air ambulance expenses incurred b. Licence of the service provider c. Details on the site of incident d. Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the Insured Person's requirement for Air Ambulance
16	Durable Medical Equipment	a. Prescription from Treating medical practitioner b. Bill of equipment
17	High-End Diagnostic Tests	a. Prescription from Treating medical practitioner b. Bill and diagnostic report of test undertaken c. Any relevant investigation reports if already available related to the said condition
Notes: a. We may call for any additional documents/information as required based on the circumstances of the claim b. All the above documents shall be required in original, except in case of deductible we require attested photocopy of below documents and settlement letter of previous insurer (partial payment cases).		

We understand that there may be situations where You or the Insured Person may not be able to submit the claim documents within the specified timeline. In such cases, along with the claim documents, We request that You share the reason for the delay with Us in writing. Where the delay is due to circumstances beyond the control of You or the Insured Person, We will review the request on its merits and may condone the delay based on the facts and circumstances of the case.

7. Review and Claim Assessment

- a. Once We receive the claim documents, We will review them and keep the relevant stakeholders, including the Network Hospital (where applicable), informed of any additional information or documents that may be required. To make the process easier for You, We will coordinate with the relevant stakeholders on Your behalf to obtain the required documents wherever possible.
- b. After reviewing the claim documents and the information submitted, We will assess the claim and settle the payable amount in accordance with the terms and conditions of the Policy.
- c. If a reimbursement claim is received for a hospitalization where a Pre-Authorization Letter had previously been issued, we may first verify with the provider whether the Pre-Authorization was utilized and whether all outstanding dues have been settled by the Policyholder. Once the necessary confirmation is received from the provider, we will proceed with the assessment and processing of the claim.

8. Claims Investigation

We may, at Our discretion, depending upon the facts of the case, investigate and determine the validity of claims. Such investigations 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.

9. Pre and Post-hospitalization claims

You must submit the Pre-hospitalization and Post-hospitalization claim documents within 15 days from the completion of the Post-hospitalization treatment or the eligible Post-hospitalization coverage period, whichever is earlier.

10. Representation against Rejection:

If We communicate a claim rejection, and You believe that there is additional information or context that may assist in the review of the decision, You may write to Us and request a reconsideration within 15 days of receiving the rejection. We will carefully review the representation and any supporting information provided by You. To make the claims process as smooth as possible, we will accept the requisite Pre-hospitalization and Post-hospitalization claim documents either along with the applicable Hospitalization claim documents or separately. Upon receipt, we will review and process the claim based on the documents submitted and in accordance with the terms and conditions of the Policy.

11. Payment Terms

- a. If the same illness recurs within 45 days of discharge from the Hospital following a claimed hospitalization, it will be considered a continuation of the earlier claim. In such cases, all limits applicable to “Any One Illness” will be assessed as a single claim.
- b. Once the Sum Insured available for an Insured Person is fully exhausted, no further claims shall be payable for that Insured Person under the Policy.
- c. All claim payments will be made in India and in Indian Rupees.
- d. We may not pay a claim, or part of a claim, if the expenses could have reasonably been avoided or reduced by the Insured Person. This includes situations where the Insured Person does not follow the advice, instructions, or guidance given by a Medical Practitioner.
- e. For cashless claims, We will directly pay the approved claim amount to the Network Hospital. Once the payment is made, the cashless claim settlement will be considered complete and final for the approved amount.
- f. For reimbursement claims, We will pay the approved claim amount directly to You. In the unfortunate event of Your death, We will pay the nominee named in the Policy Schedule. If there is no nominee, We will make the payment to the Legal Heir upon submission of a valid succession certificate or indemnity bond, as applicable. Such payment will be considered as full and final discharge of Our liability under the Policy.

12. Process for availing Health Check-up and Tele-Consultation

- a. You may seek the requisite appointment by calling our call centre or through our mobile application.
- b. Reports of the Medical Tests shall be emailed on your registered email-ID. It can also be collected directly from the centre.

13. Accelerated Instalments

The premium of your policy can be paid either as a single premium OR in accelerated instalments.

If you choose to pay your premium through Accelerated Instalments, the following conditions will apply:

- a. **EMI tenure options**
 - i. 3 monthly instalments
 - ii. 6 monthly instalments
 - iii. 9 monthly instalments
 - iv. 12 monthly instalments
 - v. 24 monthly instalments
 - vi. 36 monthly instalments
- b. **EMI tenure:** The EMI tenure cannot be greater than the Policy Period
- c. **Standing Instruction:** Instalment option is available only if standing instruction / NACH / e-NACH / auto-debit authorization is provided. The amount for which standing instruction is to be taken will be as per the Company's applicable renewal and payment process. Standing Instruction discount shall not be provided if Premium is paid in Instalments.
- d. **Total Premium**

The final premium payable under the Policy, including any applicable loading, will be treated as the Total Premium.
- e. **First EMI**

The first EMI must be paid at the time of Policy issuance.
- f. **EMI Schedule**

EMIs will be payable on a monthly basis as per the EMI option selected by you, such as 3, 6, 9, 12, 24, 36 monthly instalments.

Let's understand with an example the working of accelerated instalments

If you have chosen a 1 year policy tenure (1st January to 31st December) with total premium of ₹1200 and you have opted for 3 monthly instalments, then it means that you will have to pay ₹1200 divided by 3 which equals ₹400 as each instalment. As you have chosen 3 instalments it means that the EMIs shall be due as below

- 1. 1st instalment of ₹400 due on 1st January
- 2. 2nd instalment of ₹400 due on 1st February
- 3. 3rd instalment of ₹400 due on 1st March

Thus, for a **1-year Policy** with a **3-month EMI option**, the monthly instalment will be paid every month starting from the first month of the policy tenure and shall be for the first 3 months of the policy tenure.

Similarly, if you have chosen a 3 year policy tenure (1st January 2026 to 31st December 2028) with total premium of ₹72000 and you have opted for 24 monthly instalments then it means that you will

have to pay ₹72000 divided by 24 which equals ₹3,000 as each instalment. As you have chosen 24 instalments it means that the EMIs shall be due as below

1. 1st instalment of ₹3,000 due on 1st January 2026
2. 2nd instalment of ₹3,000 due on 1st February 2026 and so on
3. 15th instalment of ₹3,000 due on 1st March 2027 and so on
4. 24th instalment of ₹3,000 due on 1st December 2028

Thus, for a **3-year Policy** with a **24-month EMI option**, the monthly instalment will be paid every month starting from the first month of the policy tenure and shall be for the first 24 months of the policy tenure.

g. EMI Option at Renewal

At renewal, the same premium payment option chosen earlier may be offered. You may also request us to approve a change in the payment mode during the renewal journey.

h. Premium Allocation for Multi-Year Policies (for Claim & refund purposes only)

For ease of calculation, the Total Premium will be divided equally across each Policy Year, irrespective of age-wise pricing.

For example, if the Total Premium for a 3-year Policy is ₹3,000, ₹1,000 will be allocated to each Policy Year.

i. Mapping of EMIs to Policy Years (for Claim & refund purposes only)

For multi-year tenure Policies, EMIs will be mapped to the premium payable for each Policy Year.

For example: In a 3-year Policy with a 6-month EMI option,

- EMI 1 and EMI 2 shall be mapped to Year 1,
- EMI 3 and EMI 4 to Year 2, and
- EMI 5 and EMI 6 to Year 3.

j. Claim during EMI Period

- i. If a claim is made during the EMI period, the unpaid premium for the relevant Policy Year will be adjusted before the claim amount is paid.
- ii. If the claim amount is sufficient to cover the pending EMI or premium for that Policy Year, such amount will be adjusted from the claim payable. Any EMI fully adjusted against the claim will not be collected again on its scheduled date.
- iii. If the claim amount is not sufficient to cover the pending EMI or premium for that policy year, the claim amount may be adjusted against the upcoming EMI. Any remaining EMI amount will be collected as per the original EMI schedule.
- iv. The adjustment from the claim shall be limited only to the premium pending for the relevant Policy Year.

k. Claim Payout after Premium Adjustment

For an admissible claim, once the applicable pending premium for the relevant Policy Year is recovered or adjusted, the balance claim amount, if any, will be paid to you.

l. Financial Endorsements

If there is any premium-bearing endorsement during the Policy Period, the additional premium or refund will be accounted for in a one-time lumpsum payout.

m. Refund in case of Cancellation

If a refund is payable under the Policy, and no claim has been made or service availed, the refund will be calculated based on the premium received till date and the premium to be retained for the period for which coverage was active. The premium to be retained will be calculated on a proportionate basis for the period from the Policy start date up to the cancellation date.

Refund Amount = Total Premium received till date minus Premium to be retained

n. Advance payment of all remaining instalments

You may choose to pay all the remaining instalments for the entire policy period in advance and in one go. Such payment can be made anytime during the Policy Period. No discount or waiver on interest/loading shall be provided in such circumstances. If policy is cancelled post such advance payment, premium shall be refunded on a pro-rata basis.

14. Eligibility Criteria

1. Entry Age

Minimum	Proposer	Child	Adult
	18 years	91 days	18 years
Maximum	Proposer	Child	Adult
	No limit	No limit	No limit

2. Renewal Age

Proposer	Child	Adult
Lifetime	Lifetime	Lifetime

3. Plan Variants

- i. Now
- ii. Core
- iii. Active
- iv. Core Plus
- v. Spark
- vi. Spark Plus

4. Base Sum Insured Options available under all plan variants other than Infinix Active (₹)

- ₹10Lac
- Unlimited

5. Base Sum Insured Options available under Infinix Active (₹)

- **Minimum:** ₹5Lac
- **Maximum:** ₹1Crore

6. Policy Tenure

- 1 Year
- 2 Year
- 3 Year

7. Policy Type

- Individual policy (1 adult only)
- Family Floater policy (Not available with Infinix Active)

8. Premium Payment Mode

- Single
- 3 monthly instalments
- 6 monthly instalments
- 9 monthly instalments
- 12 monthly instalments
- 24 monthly instalments
- 36 monthly instalments

9. Relationships covered under Individual and Family Floater Policy

- 1) Self
- 2) Legally married Spouse
- 3) Live-in Partner (same-sex or opposite-sex)
- 4) Sons
- 5) Daughters
- 6) Father
- 7) Mother
- 8) Father -in-law
- 9) Mother -in-law
- 10) Son-in-law
- 11) Daughter-in-law
- 12) Grandfather
- 13) Grandmother
- 14) Grandson
- 15) Granddaughter
- 16) Uncle
- 17) Aunt
- 18) Nephew
- 19) Niece
- 20) Brother
- 21) Sister
- 22) Brother-in-law
- 23) Sister-in-law

Section 6: ANNEXURES

Annexure – 1 Contact details of offices of Insurance Ombudsman

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, 1st 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 Email:- oio.bhopal@cioins.co.in	Madhya Pradesh and Chhattisgarh
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, Sonapat 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,	Delhi and following Districts of Haryana - Gurugram, Faridabad, Sonapat and

2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/ 23213504/ 23232481 Email:- oio.delhi@cioins.co.in	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:- io.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: io.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: io.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: io.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, Vasantao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: io.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	

Annexure – 2

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

Sr. 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 / 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

Sr. 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

Sr. No.	Item
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

Sr. 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

Annexure – 3 Standard General Terms and Clauses

1. Disclosure of Information

The Policy shall be null and void, and entire premium paid thereon shall be forfeited to the Company in the event of any misrepresentation or mis-description or 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)

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.

3. Claim Settlement (provision for Penal Interest)

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

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.

5. Multiple Policies

If an Insured Person holds policies from more than one Insurer covering the same risk on an indemnity basis, indemnification for treatment costs shall be provided only in accordance with the terms and conditions of the policy chosen by the Insured.

In the case of multiple indemnity policies held by an Insured Person, they have the right to request settlement of their claim under any one of their policies, provided full disclosure of all existing policies is made to the chosen Insurer at the policy inception or at the time of claim intimation.

Upon claim settlement, the Insurer selected by the Insured shall be considered the Primary Insurer and will be responsible for settling the claim within the limits and terms of the chosen policy. If the available coverage under the chosen policy is insufficient to cover the admissible claim amount, the Primary Insurer shall coordinate with the other Insurer(s) to ensure settlement of the balance amount in accordance with the respective policy contracts.

6. 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 which are found fraudulent later shall be repaid by all recipients(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:

-

- i. The suggestion, as a fact of that, which is not true and which the Insured Person does not believe to be true.
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact.
- iii. any other act fitted to deceive; and
- iv. 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 grounds 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 misstatement of or suppression of such material fact are within the knowledge of the Insurer.

7. Cancellation

The Policyholder may cancel this policy anytime during the policy term by providing 7 days’ written notice. Upon cancellation, the Company shall refund the premium for the unexpired policy period as detailed below:

A. Policy Tenure of 1 Year:

- **No claim made:** 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 the expiry date of coverage.
- **Claim made:** No refund will be given if a claim has been made or any benefit has been availed during the Policy period.

Illustration:

1. Where the 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 the Policyholder as he had made a claim during the Policy Period.

B. If Policy Tenure is more than 1 year:

- **No claim in the current policy year:**
 - i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
 - ii. The date of cancellation will be considered as the expiry date of coverage.
- **Claim made in the current policy year:**
 - i. Premium for the remaining complete policy year(s) will be refunded on cancellation.
- **Claim made in a previous policy year:**
 - i. A proportionate refund of the premium will be issued for the unexpired period upon cancellation.
 - ii. The date of cancellation will be considered as the expiry date of coverage.

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure (in Years)	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023
Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

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

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

C. Company right to cancel:

The company reserves the right to cancel the policy at any time by providing 15 days written notice on the grounds of misrepresentation, non-disclosure of material facts, or proven fraud by the Policyholder/Insured Person subject to the moratorium clause. No refund of premium will be made if the Policy is cancelled on these grounds.

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 Base Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period as per IRDAI guidelines on migration.

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 Base Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period as per IRDAI guidelines on portability.

10. Renewal of Policy

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

- a. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
- b. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- c. 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.
- d. No loading shall apply on Renewals based on individual claims experience.

11. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholder about the same 90 days prior to expiry of the Policy.
- ii. Insured Person will have the option to migrate to similar health insurance products available with the Company at the time of renewal with all the accrued continuity benefits waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

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 moratorium period. The moratorium would be applicable for the Base Sum Insured of the first Policy and subsequently completion of 60 continuous months would be applicable from the date of enhancement of Base Sum 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.

13. Premium Payment in Instalments (Wherever applicable)

If the Policyholder has opted for Payment of Premium on an Instalment basis i.e. 3/6/9/12/24/36 Monthly instalments, as mentioned in the Policy Schedule, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

- i. Grace Period of 15 days would be given for 3/6/9/12/24/36 Monthly instalment modes of payment to pay the instalment premium due for the Policy.
- ii. 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 the 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. In case premium payment mode other than single payment is opted, a premium loading shall apply
- viii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

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 Policyholder shall be notified at least 45 days before the changes are effected.

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 the 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.

16. Redressal of Grievance

If you have a grievance that you wish us to address, you may contact us through any of the following channels:

Online (Website): www.manipalcigna.com

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 61703600

Courier: You may send your grievance to any of our branch offices or corporate office during business hours.

You may also approach the grievance cell at any of the Company's branches with the grievance details.

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

'The Grievance Cell,
ManipalCigna Health Insurance Company Limited,
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 1 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>.

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.

Annexure – 4 Definitions

The words and terms defined below explain what they mean whenever they are used in this Policy. If a word is not defined here, it will have its usual dictionary meaning. Wherever applicable, singular includes plural, all genders are included, and any reference to a law or regulation will also include any changes made to it over time.

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 includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where 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:
 - 1) Central or State Government AYUSH Hospital; or
 - 2) Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
 - 3) 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/instalment premium due date, when the premium due for renewal on a given policy or instalment 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 empaneled Hospital/healthcare providers by the insurer to the extent pre-authorization approved.
8. **Catastrophic event** means only the below listed events which causes widespread loss, damage, or disruption and is declared by an appropriate Government or the governing body of the city in which the Catastrophe has occurred.
 - a. earthquake,
 - b. volcanic eruption,
 - c. tsunami,
 - d. flood,
 - e. typhoon,
 - f. hurricane,
 - g. tornado,
 - h. cyclone,
9. **Condition Precedent** means a policy term or condition upon which the Insurer's Liability under the Policy is conditional upon.
10. **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - i. **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.
 - ii. **External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.
11. **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.
12. **Day Care Centre** means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up with 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:-
 - i. has qualified nursing staff under its employment;
 - ii. has qualified Medical Practitioner (s) in charge;
 - iii. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
13. **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 hours 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.

14. **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.
15. **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.
16. **Disclosure to Information Norm** means the Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
17. **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:
 - i. the condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
 - ii. the patient takes treatment at home on account of non-availability of room in a Hospital.
18. **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.
19. **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.
20. **Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a Hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:
 - i. has qualified nursing staff under its employment round the clock;
 - ii. 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;
 - iii. has qualified Medical Practitioner(s) in charge round the clock;
 - iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
 - v. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
21. **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.

22. **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:
 - i) it needs ongoing or long-term monitoring through consultations, examinations, checkups, and /or tests
 - ii) it needs ongoing or long-term control or relief of symptoms
 - iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - iv) it continues indefinitely
 - v) it recurs or is likely to recur
23. **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.
24. **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.
25. **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.
26. **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.
27. **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.
28. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.
29. **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.
30. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

- i. Is required for the medical management of the Illness or injury suffered by the Insured;
 - ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
 - iii. must have been prescribed by a Medical Practitioner;
 - iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
31. **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 thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
32. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
33. **Network Provider** or **Network hospitals** 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. **Newborn Baby** means baby born during the Policy Period and is aged up to 90 days.
35. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
36. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
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:
- i. that is/are diagnosed by a physician within 36 months prior to the date of commencement of the Policy issued by the insurer; or
 - ii. for which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the date of commencement of the Policy.
39. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:
- i. such Medical Expenses are incurred 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.
40. **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 diseases 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. **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.
- 44. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- 45. **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.
- 46. **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.

II. Specific Definitions

1. **Active line of treatment** refers to continuous medical or surgical management requiring regular professional intervention, supervision, and follow- up to treat the condition and prevent complications. Such treatment must be documented in writing and duly signed by the treating Medical Practitioner.
2. **Admissible Claim** means a claim that fulfils the applicable Policy terms, conditions, exclusions, limits, sub-limits, deductible and co-payment requirements, under the Policy. Kindly note it does not mean that claim is payable.
3. **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.
4. **All or None Basis** means that the specific benefit must be opted by all members together—not individually.
5. **Ambulance** means a vehicle/ carrier operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
6. **Annual Aggregate Deductible** means the fixed amount that the Policyholder/Insured Person must first pay towards eligible claims once in a policy year. Once this deductible amount is fully exhausted through admissible claims in that policy year, the insurer will start paying further covered claims as per the policy terms and limits.
7. **Annexure** means a document attached and marked as Annexure to this Policy.
8. **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'.
9. **Base Sum Insured** is the coverage amount that is opted at the time of inception or modified at the time of renewal whichever is later. It is the amount for which premium is computed and charged with respect to Base covers offered in this policy. Base Sum Insured resets after the completion of each policy year. The applicable Base Sum Insured shall be mentioned in Your Policy Schedule.
10. **Benefit Amount or Benefit Limit** is an amount mentioned in the Policy Schedule. It represents our maximum liability in the event of claims for benefits where in it is specified. Such amount shall be over and above the Base Sum Insured.
11. **Common Carrier** means any land, sea or air conveyance operated under a license issued by a government authority having jurisdiction for the transportation of fare paying passengers. Such conveyance must have a fixed published time-table schedule and fixed established routes. Private taxis, taxis booked through cab aggregators, self-driven or hired road carriers and chartered aircrafts do not fall under the definition of Common Carrier.
12. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
13. **Covered Relationships** shall include self (the policy holder himself), spouse (same or opposite gender legally wedded), children, sibling of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and Nephew.

14. **Customer Information Sheet** a document provided by the Insurer along with the policy document that explains in simple words, basic features of a policy at one place.
15. **Diagnosis** means diagnosis by a registered medical practitioner, supported by clinical, radiological, histological, histo pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to the Company.
16. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.
17. **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.
18. **Empanelled Service Provider** means any person, organization, institution that has been empanelled with Us to provide health related services specified under the benefits to the Insured Person.
19. **Family Floater Policy** means a policy where all the Insured Persons named in the Policy Schedule share one common Sum Insured. This Sum Insured is the maximum amount We will pay for all claims made by any insured family member during a Policy Year.
20. **Floater or Floater basis** means a Policy described as such in the Policy Schedule where-in a common Sum Insured/benefit limit is available on a shared basis amongst the Insured Persons.
21. **Group Mediclaim Policy:** Group Mediclaim policy means a Group Health indemnity insurance policy issued by ManipalCigna. Group policy issued by us having only OPD benefits and/or only Critical Illness benefits and/or only Travel benefits and/or Personal Accident benefits do not fall under the purview of a Group Mediclaim policy.
22. **Inception Date** means the commencement date as specified in the Schedule.
23. **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
24. **Indian Resident** means an individual who was present in India for a total of 182 days or more in the immediately preceding financial year.
25. **Individual Policy** is a policy where-in exactly one Insured is covered under the Policy. Such Insured person shall have a distinct Individual Sum Insured along with other benefit limits solely for himself.
26. **Insured Person / Insured Member** means the person (s) named in the Policy Schedule, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.
27. **IRDAI** means the Insurance Regulatory and Development Authority of India.
28. **Life threatening Medical Emergency** means the occurrence of a sudden, serious and unexpected sickness or injury for which medical treatment must start within 24 hours of the emergency event & in the absence of immediate medical attention, this condition could result in:
 - a. Death;
 - b. Permanent placement of the Insured's health in jeopardy;

- c. Serious impairment of bodily functions; or
- d. Serious and permanent dysfunction of any body organ or part.

Such an emergency must be certified in writing by the treating medical practitioner.

27. **Treating Medical Practitioner or Doctor** means a person who holds a valid registration with the Medical Council of any State or the Medical Council of India or the Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government, and is thereby entitled to practise medicine within the scope and jurisdiction of such registration. Such doctor must be actively involved in the diagnosis, care, and medical management of the Insured Person for the condition in respect of which a claim is made.
28. **Organ Donor** means any 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.
29. **Outpatient** means the section of a hospital/clinic where a patient gets consultation, diagnosis, tests, medicines, or minor treatment without being admitted or staying overnight.
30. **Palliative Care** means specialized medical care provided to an Insured Person with a progressive and irreversible, or end-stage illness, where the primary goal is relief of pain, symptom management, and improvement of comfort and quality of life, rather than curative treatment. It includes medically necessary interventions aimed at managing physical, psychological, or emotional distress associated with the diagnosed condition. Palliative Care shall apply only when the treating medical practitioner (specialist) has certified that the medical condition is non-curable and that the treatment intent is palliative-only, with care focused on comfort, dignity, and supportive management. Palliative Care does not include custodial care, domestic help, rehabilitation, physiotherapy, general nursing, or any service undertaken for convenience, recovery, or curative purposes.
31. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule 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.
32. **Policy Anniversary** is the same date each year during the Policy Term as the Date of Commencement of Policy. Note: If the date of Commencement of Policy is on 29th February, the Policy Anniversary will be taken as the last date of February in the following year.
33. **Policy Type** means either an Individual Policy or a Family floater policy as specified in the Policy Schedule.
34. **Policy Period or Policy Tenure** means the period between the inception date and the earlier of:
 - i. the expiry date of the policy as specified in the Policy Schedule OR
 - ii. the date of cancellation of this policy
35. **Policy Schedule** is a document attached to your policy that provides all key details about your policy such as who is covered, premium, policy period, waiting periods, Base Sum Insured, benefits in force, and any special conditions. It also includes any updates or changes made later (like endorsements). If there is more than one schedule, the latest version will apply.
36. **Policy Year** means each block of 12 consecutive months starting from the Policy Inception Date.
37. **Policy Holder** means the person named in the Schedule as the policyholder who has concluded this Policy with Us.

38. **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.
39. **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.
40. **Road Ambulance** means a vehicle/ carrier operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
41. **Special Conditions or Key Service Terms** refers to a set of conditions applicable that need to be fulfilled for a claim to be admissible under that particular benefit/policy.
42. **A Preferred Provider Network (PPN)** is a specially curated set of hospitals where You can receive eligible treatment without paying any additional PPN co-payment, as long as the hospital is part of the PPN package chosen by You. This product offers three Preferred Provider Network (PPN) packages: Classic, Premier, and Premier Plus. The package chosen by You will be reflected in Your Policy Schedule for easy reference.
For example, if You have selected the Premier PPN Package, You can avail eligible treatment at hospitals covered under the Premier package without any additional PPN co-payment. If You choose to receive treatment at a hospital that is not covered under Your selected PPN package, the applicable co-payment will apply in accordance with the terms and conditions of the Policy. Please also note that the PPN package selected by You may include both Network and Non-Network Hospitals. However, the cashless claim facility is available only at Network Hospitals. If treatment is taken at a hospital that is part of Your selected PPN package but is non Network Hospital, You can still avail the benefits under the Policy, however the claim will be processed only on a reimbursement basis.
43. **Proposer** means the person who applies for and buys the insurance policy by submitting the proposal form and paying the premium. The proposer may or may not be Insured under the policy.
44. **Severe wound** is a post operative severe wound is a surgical wound measuring more than 2 inches (5cm) in length and or involving deep tissue layers, associate with complications such as infection/wound gaping/ excessive discharge/ delayed healing requiring active line of medical treatment
45. **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.
46. **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.
47. **Strict Protocols** are applicable only for eligible, stable patients with oncologist approvals. Limited to approved low-risk injectable chemotherapy drugs. Must be administered by qualified healthcare professionals with required checks. Mandatory emergency preparedness and defined escalation protocol. Strict adherence to documentation, consent, and safety standards

48. **Therapy** is the treatment of disease or disorders, as by some remedial, rehabilitating, or curative process with mental or physical illness without the use of drugs or operations.
49. **TPA Third Party Administrator (TPA)** means a company registered with the Authority, and engaged by an insurer, 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.
50. **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.
51. **Unrecognised hospitals** are hospitals, healthcare centres, diagnostic centres, or other healthcare providers that we have listed as restricted or excluded for claim payment under this Policy. This list may be updated by us from time to time and will be available on our website. If treatment is taken at an Unrecognised Hospital, the expenses will not be payable under this Policy, whether on cashless or reimbursement basis. However, in case of a life-threatening emergency or accident, reasonable and medically necessary expenses will be payable only until the Insured Person is stabilised.
52. **Vegetative State** means a medical condition in which the Insured Person is awake or has sleep-wake cycles, but does not show conscious awareness of themselves or their surroundings and does not respond meaningfully to people, commands, or stimulation. The condition must be certified such by the treating medical practitioner/neurologist and should supported by relevant medical records.
53. **Waiting period** means a time-bound exclusion period related to condition (s) specified in the Policy Schedule or Policy which shall be served before a claim related to such condition (s) becomes admissible.
54. **What's Not Covered or Exclusions** refers to a set of conditions or situations wherein claim shall not be paid under the policy.
55. **We/Our/Us/Insurer/Company** means ManipalCigna Health Insurance Company Limited.
56. **You/Your** means insured person or the policyholder as per the relevant context.

Annexure – 5 Plan Chart

Sr No	Benefit	Now	Core	Active	Core Plus	Spark	Spark Plus
	Base Sum Insured (BSI) (₹)	₹10L and Unlimited	₹10L and Unlimited	₹5L to 1Cr	₹10L and Unlimited	₹10L and Unlimited	₹10L and Unlimited
	Type of Policy	Individual and Family Floater	Individual and Family Floater	Individual only	Individual and Family Floater	Individual and Family Floater	Individual and Family Floater
Base Covers							
1	In-patient hospitalization	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI
2	Room Rent Limit (default)	Single Private AC Room	Single Private AC Room	Single Private AC Room	Single Private AC Room	Single Private AC Room	Single Private AC Room
3	ICU	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals
4	2 hour hospitalization	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI
5	Modern and Advanced Treatments (Listed)	Covered upto BSI	Covered upto BSI	25% of BSI, max upto ₹5L	Covered upto BSI	Covered upto BSI	Covered upto BSI
6	Day Care Treatment (All)	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI
7	Pre-hospitalization Medical Expenses	BSI ₹10L - 60 days BSI Unlimited - 90 days	BSI ₹10L - 60 days BSI Unlimited - 90 days	30 days	BSI ₹10L - 60 days BSI Unlimited - 90 days	BSI ₹10L - 60 days BSI Unlimited - 90 days	BSI ₹10L - 60 days BSI Unlimited - 90 days
8	Post-hospitalization Medical Expenses	BSI ₹10L - 90 days BSI Unlimited - 180 days	BSI ₹10L - 90 days BSI Unlimited - 180 days	60 days	BSI ₹10L - 90 days BSI Unlimited - 180 days	BSI ₹10L - 90 days BSI Unlimited - 180 days	BSI ₹10L - 90 days BSI Unlimited - 180 days
9	Domiciliary hospitalization	Covered upto BSI Pre/Post: 30 days	Covered upto BSI Pre/Post: 30 days	Covered upto BSI Pre/Post: 30 days	Covered upto BSI Pre/Post: 30 days	Covered upto BSI Pre/Post: 30 days	Covered upto BSI Pre/Post: 30 days
11	Road Ambulance	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI
12	Donor Expenses	Covered	Covered	Covered	Covered	Covered	Covered
13	AYUSH Treatment	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI	Covered upto BSI
14	Preferred Provider Network	Classic / Premier / Premier Plus	Classic / Premier / Premier Plus	Classic / Premier / Premier Plus	Classic / Premier / Premier Plus	Classic / Premier / Premier Plus	Classic / Premier / Premier Plus
16	Wellness Program	up to 20% discount	up to 20% discount	Not Available	up to 20% discount	up to 20% discount	up to 20% discount

Sr No	Benefit	Now	Core	Active	Core Plus	Spark	Spark Plus
15	Tele-Consultation	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
17	Discounts and Health Services from Network Providers	Available	Available	Available	Available	Available	Available
18	Home Treatment (for listed conditions only)	SI - ₹10L : Not available SI - Unlimited : Covered Upto BSI	SI - ₹10L : Not available SI - Unlimited : Covered Upto BSI	Covered upto BSI	SI - ₹10L : Not available SI - Unlimited : Covered Upto BSI	SI - ₹10L : Not available SI - Unlimited : Covered Upto BSI	SI - ₹10L : Not available SI - Unlimited : Covered Upto BSI
19	Emotional Quotient	Available	Available	Not Available	Available	Available	Available
20	NutriBoost	Available	Available	Not Available	Available	Available	Available
Optional Covers (All benefits are optional in nature unless expressly stated otherwise. Wherever a benefit is marked as "Inbuilt", it is included by default under the said plan.)							
21	Personal Accident Plus (₹5L to ₹10Cr) (18 to 65 years)	1. Only Accidental Death or 2. Only Permanent Disablement (Permanent Total Disablement + Permanent Partial Disablement) 3. Both Accidental Death & Permanent Disablement	1. Only Accidental Death or 2. Only Permanent Disablement (Permanent Total Disablement + Permanent Partial Disablement) 3. Both Accidental Death & Permanent Disablement	Not Available	1. Only Accidental Death or 2. Only Permanent Disablement (Permanent Total Disablement + Permanent Partial Disablement) 3. Both Accidental Death & Permanent Disablement	1. Only Accidental Death or 2. Only Permanent Disablement (Permanent Total Disablement + Permanent Partial Disablement) 3. Both Accidental Death & Permanent Disablement	1. Only Accidental Death or 2. Only Permanent Disablement (Permanent Total Disablement + Permanent Partial Disablement) 3. Both Accidental Death & Permanent Disablement
22	Health Check-up (Listed Tests & Cashless)	Once every year	Once every year	Not Available	Once every year	Once every year	Once every year
23	High-End Diagnostic Tests (listed)	BSI - ₹10L : Not available BSI - Unlimited : Covered	BSI - ₹10L : Not available BSI - Unlimited : Covered	Not Available	Inbuilt BSI - ₹10L : Covered Upto ₹50,000 BSI -	BSI - ₹10L : Not available BSI - Unlimited : Covered	Inbuilt BSI - ₹10L : Covered Upto ₹50,000 BSI -

Sr No	Benefit	Now	Core	Active	Core Plus	Spark	Spark Plus
		Upto ₹50,000	Upto ₹50,000		Unlimited : Covered Upto ₹50,000	Upto ₹50,000	Unlimited : Covered Upto ₹50,000
24	Air Ambulance	Covered upto ₹10L	Covered upto ₹10L	Covered upto ₹10L	Inbuilt; Covered upto ₹10L	Covered upto ₹10L	Inbuilt; Covered upto ₹10L
25	Annual Aggregate Deductible (₹)	1L/ 2L/ 3L/4L/5L/10L	1L/ 2L/ 3L/4L/5L/10L	1L/ 2L/ 3L/4L/5L/10L	1L/ 2L/ 3L/4L/5L/10L	1L/ 2L/ 3L/4L/5L/10L	1L/ 2L/ 3L/4L/5L/10L
26	One-time Aggregate Deductible (₹)	₹25k/50k/1L	₹25k/50k/1L	Not Available	₹25k/50k/1L	₹25k/50k/1L	₹25k/50k/1L
27	Room Rent Modification	BSI ₹10L : Downgrade to upto Twin Sharing AC Room BSI Unlimited : 1. Upgrade upto any room excluding suite and above 2. Upgrade to Any Room 3. Downgrade to upto Twin Sharing AC Room	BSI ₹10L : Downgrade to upto Twin Sharing AC Room BSI Unlimited : 1. Upgrade upto any room excluding suite and above 2. Upgrade to Any Room 3. Downgrade to upto Twin Sharing AC Room	Downgrade to upto Twin Sharing AC Room	BSI ₹10L : Downgrade to upto Twin Sharing AC Room BSI Unlimited : 1. Upgrade upto any room excluding suite and above 2. Upgrade to Any Room 3. Downgrade to upto Twin Sharing AC Room	BSI ₹10L : Downgrade to upto Twin Sharing AC Room BSI Unlimited : 1. Upgrade upto any room excluding suite and above 2. Upgrade to Any Room 3. Downgrade to upto Twin Sharing AC Room	BSI ₹10L : Downgrade to upto Twin Sharing AC Room BSI Unlimited : 1. Upgrade upto any room excluding suite and above 2. Upgrade to Any Room 3. Downgrade to upto Twin Sharing AC Room
28	Coverage for Non-Medical Expenses (NME) and Durable Medical Equipment (DME)	NME: Covered upto BSI DME: upto ₹1L per policy year	NME: Covered upto BSI DME: upto ₹1L per policy year	NME: Covered upto BSI DME: upto ₹1L per policy year	NME: Covered upto BSI DME: upto ₹1L per policy year	NME: Covered upto BSI DME: upto ₹1L per policy year	NME: Covered upto BSI DME: upto ₹1L per policy year
29	New Beginnings (waiting period 1 year)	Base Benefit Limit(₹) : 5k/10k/20k Bonus: 100% every	Base Benefit Limit(₹) : 5k/10k/20k Bonus:	Not Available	Base Benefit Limit(₹) : 5k/10k/20k Bonus:	Base Benefit Limit(₹) : 5k/10k/20k Bonus:	Base Benefit Limit(₹) : 5k/10k/20k Bonus:

Sr No	Benefit	Now	Core	Active	Core Plus	Spark	Spark Plus
		year post 2nd year	100% every year post 2nd year		100% every year post 2nd year	100% every year post 2nd year	100% every year post 2nd year
30	Reduction of Waiting Period (WP)	Not Applicable	Option to Reduce both PED and Specific Illness WP to 24M	Not Available	Option to Reduce both PED and Specific Illness WP to 24M	Option to Reduce PED WP to 24 months	Option to Reduce PED WP to 24 months
31	QuickAccess	Not Applicable	Listed PEDs: Coverage from 31st day Specific Illness Waiting period: Reduced to 24 months	Not Available	Listed PEDs: Coverage from 31st day Specific Illness Waiting period: Reduced to 24 months	Listed PEDs: Coverage from 31st day	Listed PEDs: Coverage from 31st day
Waiting Periods [WP] (default)							
32	Initial WP	Not Applicable	30 days	30 days	30 days	30 days	30 days
33	PED WP	Not Applicable	36 months	36 months	36 months	36 months	36 months
34	Specific Illness WP	Not Applicable	36 months	36 months	36 months	24 months	24 months
Discounts							
35	Standing Instruction Discount (2.5%)	Available	Available	Not Applicable	Available	Available	Available
36	Long term policy discount 2nd year: 10% 3rd year: 12.5%	Available	Available	Available	Available	Available	Available
37	Direct discount (5%)	Available	Available	Available	Available	Available	Available
38	ManipalCigna GMC discount (10%)	Available	Available	Available	Available	Available	Available
39	NRI/OCI discount (25%)	Available	Available	Not Applicable	Available	Available	Available

Sr No	Benefit	Now	Core	Active	Core Plus	Spark	Spark Plus
40	Employee discount (10%)	Available	Available	Not Applicable	Available	Available	Available
41	No claim discount (upto 7.5%)	Available	Available	Not Applicable	Available	Available	Available
42	Worksite marketing discount (10%)	Available	Available	Available	Available	Available	Available
43	Discount in lieu of commission (upto 15%)	Available	Available	Available	Available	Available	Available
44	Loyalty discount (5%)	Available	Available	Not Applicable	Available	Available	Available
	Note: 1. All Benefits mentioned above are on per policy year basis unless explicitly mentioned otherwise 2. Mutually exclusive discounts: Direct / Worksite marketing / Employee / Discount in lieu of commission 3. Max discount shall be 40% excluding No-claim discount 4. ManipalCigna GMC Discount & Loyalty discount are mutually exclusive						

Annexure – 6 Benefit Illustration

Annexure – Rate Charts

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

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

Insurance is a subject matter of solicitation