MANIPALCIGNA PROHEALTH SELECT

Policy Contract

B. Preamble

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

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

C Definitions

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

C.I Standard Definitions

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

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

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

4. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a

qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i) Having at least five In-patient beds;

ii) Having qualified AYUSH Medical Practitioner in charge round the clock;

iii) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv) Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

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

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

10. **Co-payment** is 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.

11. **Cumulative Bonus**

    Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

12. **Day Care Treatment** refers to medical treatment, and/or surgical procedure which is:
    a. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b. 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. For the list of Day Care Treatments please refer Annexure II attached to and forming part of this Policy.

13. **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:-
    a. Has qualified nursing staff under its employment

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

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

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 removed 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 an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

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.

    Provided the coverage will be offered during the grace period, if the premium is paid in instalments during the policy period.

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 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;
    ii. has qualified nursing staff under its employment round the clock;
    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 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, check-ups, and/or tests
        ii. it needs on-going or long term control or relief of symptoms
        iii. it requires your rehabilitation or for you 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 issuance 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. **Medical Practitioner** is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the

scope and jurisdiction of license.

31. **Medically Necessary Treatment or Medically Necessary** 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.

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 disease and specific waiting periods from one health insurance policy to another with the same insurer.

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

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

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

36. **OPD Treatment Outpatient Treatment (OPD)** is 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.

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

38. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, 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.

39. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

40. **Pre-hospitalization Medical Expenses** are Medical Expenses incurred during pre-defined number of days immediately before the Insured Person is Hospitalised, 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.

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

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

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 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 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 treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

C.II Specific Definitions

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

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

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

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

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

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

7. **Covered Relationships shall include** self (the policy holder himself), legally married spouse, children, brother and sister of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and Nephew.

8. **Dependent Child** A dependent child refers to a child (natural or legally adopted), who is financially dependent on the Policy Holder, does not have his / her independent source of income, is up to the age of 23 years.

9. **Emergency** shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a medical practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the insured person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.

10. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Inception Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during each Policy Year.

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

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

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

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

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

16. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule and Annexures which form part of the Policy contract including endorsements, as amended from time-to-time which form part of the Policy Contract and shall be read together.

17. **Policy Period or Policy Tenure** means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.

18. **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

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

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

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

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

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

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

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

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

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

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

28. **Third Party Administrator (TPA)** means a company registered with the Authority, and engaged by 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.

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

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

D. Benefits covered under the policy

D.I. Basic covers

D.I.1. Inpatient Hospitalization:

a. We will indemnify Medical Expenses of an Insured Person in case of Medically Necessary Hospitalization arising from an Illness or Injury provided such Medically Necessary Hospitalization is for more than 24 consecutive hours. We will pay the below mentioned Medical Expenses upto the Sum Insured for:.

a. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to eligible Room Category or eligible Room Rent as per the Policy and specified in the Schedule to this Policy.

b. Intensive Care Unit charges for accommodation in ICU,

c. Operation theatre charges,

d. Fees of Medical Practitioner/ Surgeon,

e. Anaesthetist,

f. Qualified Nurses,

g. Specialists,

h. Cost of diagnostic tests,

I. Medicines,

j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

We will indemnify the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Hospitalization Expenses and the necessity being certified by an authorized Medical Practitioner.

The following Modern and Advanced Treatment methods will be indemnified (wherever medically indicated) when availed under In-patient Hospitalization or as a Day Care Treatment (Section D.I.4):

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy - Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Stereotactic radio surgeries

h. Bronchial Thermoplasty

i. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)

j. IONM (Intra Operative Neuro Monitoring)

k. Stem cell therapy - Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Indemnification of Medical Expenses related to any admission (under In-patient Hospitalization, Day Care Treatment or Domiciliary Hospitalization) primarily for enteral feedings will be covered, up to 15 days in a Policy Year provided it is Medically Necessary and is prescribed by a Medical Practitioner.

We will indemnify the Medical Expenses incurred for the Medically Necessary Treatment, taken during In-patient Hospitalization of the Insured Person, from or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof or sexually transmitted diseases (STD). This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time.

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

The proportionate deduction will apply to “Associated Medical Expenses” shall include - Nursing Charges,

Operation Theatre Charges, Fees of Medical Practitioner/Surgeon/ Anesthetist/ Specialist excluding cost of pharmacy

and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

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

Understanding proportionate deduction with a simple example

Mr. Raj was hospitalized for **4 days** in a **Deluxe Room** at XYZ Hospital. However, as per his policy, he was eligible for the most economical **Single Private AC Room**.

Since he chose a higher room category than what his policy allowed, proportionate deduction will apply. This means the claim amount will be calculated based on the ratio between his eligible room rent and the actual room rent charged by the hospital.

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

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

D.I.2. Pre - hospitalization:

We will reimburse, Pre-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital. This benefit is payable only if a claim has been admitted under Section D.I.1. 'In-patient Hospitalization' or Section D.I.4. "Day Care Treatment' and is related to the same illness/injury and if the Pre-hospitalization Medical expenses are incurred during a Policy Year.

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

D.I.3. Post - hospitalization:

We will reimburse, Post-hospitalization Medical Expenses, upto the Sum Insured, incurred during the 180 days immediately post the date the Insured was discharged from the Hospital. This benefit is payable only if a claim has been admitted under Section D.I.1 'In-patient Hospitalization' or Section D.I.4. "Day Care Treatment' and expenses are related to the same illness/condition.

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

D.I.4. Day Care Treatment:

We will indemnify the Medical Expenses incurred for an Insured Person upto the Sum Insured in the event of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in medical technology. Such treatment must be undertaken in a Hospital, Nursing Home, or Day Care Centre.

Special Conditions :

a. The Day Care Treatment is Medically Necessary and undertaken based on the written advice of a Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for the procedure performed as Day Care Treatment.
c. Out-Patient (OPD) Treatment and diagnostic services are not covered under this benefit.
d. Coverage under this benefit shall also include pre-hospitalization and post hospitalization medical expenses, up to the limit specified in the Policy Schedule.
e. For list of Day Care treatments covered under this policy, please refer Annexure II of the policy.

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

D.I.5. Domiciliary Treatment:

We will reimburse Medical Expenses of an Insured Person, up to the Sum Insured, for an Illness or Injury which in the normal course would have required Hospitalization but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

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

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

(a) We will however pay for Pre-Hospitalization and Post-Hospitalization Medical Expenses up to 30 days each in accordance with Section D.I.2 and D.I.3 above.

(b) We shall not be liable under this Policy for any Claim in connection with or in respect of the following:

i. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, Influenza,
ii. Arthritis, gout and rheumatism,
iii. Chronic nephritis and nephritic syndrome,
iv. Diarrhoea and all type of dysenteries, including gastroenteritis,
v. Diabetes mellitus and Insipidus,
vi. Epilepsy,
vii. Hypertension,
viii. Pyrexia of unknown origin.
ix. Any use of artificial life maintenance including life support machine use.

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

D.I.6. Ambulance Cover:

a. We will reimburse Reasonable and Customary expenses up to the amount specified in the Policy Schedule, towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury in case of an Emergency, necessitating the Insured Person's admission to the Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

b. Reasonable and Customary expenses shall include:

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

   ii. 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

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

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

D.I.7. Donor Expenses:

a. We will cover In-patient Hospitalization Medical Expenses towards the donor (in accordance with Section D.I.1 above) for harvesting the organ up to the limits of the Sum Insured, provided that: The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, provided that -

b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice.

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

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

   i. Any Pre or Post - hospitalization Medical Expenses,

   ii. Cost towards donor screening,

   iii. Cost directly or indirectly associated to the acquisition of the organ,

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

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

D.I.8. Restoration:

We will provide for a 100% restoration of opted Base Sum Insured once in a Policy Year, provided that:

(a) The total of the opted Base Sum Insured and earned Cumulative Bonus (or Cumulative Bonus Booster if opted) is insufficient as a result of previous claims in that Policy Year.

(b) The Restored amount shall not be available for claims towards an Illness / Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person.

(c) The Restored amount will be available only for claims made by Insured Persons in respect of future claims that become payable under Section D.I of the Policy and shall not apply to the first claim in the Policy Year.

(d) The Restored amount will not be considered while calculating the Cumulative Bonus or Cumulative Bonus Booster (if opted).

(e) Such restoration of amount will be available only once during a Policy Year to each insured in case of an individual Policy and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

(f) If the Policy is issued on a floater basis, the Restored amount will also be available on a floater basis.

(g) If the Restored amount is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

(h) For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:

i. The Base Sum Insured
ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)

(i) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
i. The Base Sum Insured
ii. Cumulative Bonus (if earned) or Cumulative Bonus Booster (if opted & earned)
iii. Restored Sum Insured

(j) Restoration shall not apply to Worldwide Emergency Cover and for ₹0.5 & 1 Lac Sum Insured under ProHealth Select (A).

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

D.I.9. AYUSH Cover

We will indemnify In-patient hospitalization expenses up to the limits of Sum Insured, for an Insured Person towards non-allopathic treatments such as Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy for Hospitalization arising due to Accident or Illness provided such treatment is taken in an AYUSH hospital.

The following exclusions will apply in addition to the exclusions under section E:

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

D.II.Value added covers

D.II.1. Cumulative Bonus

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

<u>Special Conditions for Cumulative Bonus</u>

a) A bonus of 5% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period.

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

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

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

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

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

g) If the Policy Period is two/three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.

h) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.

i) If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the opted Base Sum Insured in to two or more Family Floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

j) If the opted Base Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the Base Sum Insured of the last completed Policy Year.

k) If the Base Sum Insured of the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Base Sum Insured of the last completed Policy year.

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

D.II.2. Healthy Rewards

You can earn reward points equivalent to 1% of premium paid including taxes as applicable and levies for each Policy. In addition to this You can accumulate rewards by opting for an array of Our wellness programs listed below, that will help You to assess Your health status and aid in improving Your overall well-being. Each specific program can be opted only once by a particular Insured Person.

There will be no limitation to the number of programs one can enroll for in a single Policy Period. However, the maximum earning of Healthy Rewards on a Policy will be limited to 10% of premium paid in that Policy Period.

Details of reward points that can be accrued are listed below.

Program Type	Points to be earned as a percentage of previous Policy Period Premium
Health Risk Assessment (HRA)	0.50%
Targeted Risk Assessment (TRA)	0.50%
Online Lifestyle Management Program (LMP)	1%
Chronic Condition Management Programs	1%
Participating in ManipalCigna Sponsored Programs and Worksite or Online/Offline Health Initiatives	2%
Health Check Up	0.50%

Reward Points, wherever offered under any specific Sponsored Program will be the same for all customers. Each earned reward point will be valued at 1 Rupee. Accumulated reward points can be redeemed in the following ways -

- A discount in premium from 1st Renewal of the Policy.
- As equivalent value while availing services through any of Our Network Providers as defined in the Policy.
- Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))

Details of Healthy Rewards earned on each Policy will be updated in our records against the policy as and when earned. Accrual for reward points will be the same for 1, 2 & 3 year policies.

Policyholder/Insured can approach Us for redemption anytime during the policy period. For availing a discount on renewal premium, the same will be available only at the time such renewal is due.

Any earned reward points will lapse at the end of the grace period if the policy is not renewed with us.

The notifications related to wellness programs will be communicated via SMS, email and the program specific phone/web application. Details about reward points will be available on program app or shared through SMS or renewal notice sent to customers.

D.III. OPTIONAL COVERS

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

D.III.1. Deductible:

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.

Key Service Terms

1. **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.
2. **Changes at renewal:** You can increase, reduce, or remove the deductible only once at renewal, subject to underwriting approval.
    a. If you reduce or remove the deductible, waiting periods will apply again on the reduced portion.
    b. If you remove the deductible, you cannot choose this benefit again in future renewals
3. **Benefits where deductible does NOT apply:** You can claim the below benefits without exhausting the deductible:
    a. Healthy Rewards
    b. Health Check-Up
    c. Health-maintenance Benefit
    d. Add-on/Riders
4. **Policy Terms Apply:** All other policy terms, conditions, waiting periods, and exclusions will continue to apply.
5. **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. Pre-Hospitalization Medical Expenses
    iii. Post-Hospitalization Medical Expenses
    iv. Day Care Treatment
    v. Domiciliary Hospitalization
    vi. Ambulance Cover
    vii. Donor Expenses
    viii. AYUSH Treatment
    ix. Disease Specific Sub-limit

    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.

D.III.2. Voluntary Co-Pay (Applicable only for ProHealth Select (A)) :

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

Co-pays shall apply to all sections other than Add on Riders, Health Maintenance Benefit and Health Check Up benefits if opted.

Co-pay will be applied on the admissible claim amount.

D.III.3. Cumulative Bonus Booster

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

a) A bonus of 10% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

b) A bonus of 25% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

c) A bonus of 50% of your Base Sum Insured will be provided at the end of every Policy Year, if the Policy is renewed with Us before the end of the Grace Period. Maximum bonus that can be accumulated shall be 100% of Base Sum Insured.

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

<u>Special conditions applicable to Cumulative Bonus Booster</u>

a) When the Policyholder chooses the Cumulative Bonus Booster at renewal, any Cumulative Bonus already earned under this Policy will be carried forward. From that renewal onwards, the regular Cumulative Bonus under Section D.II.(1) will stop applying, and any future bonus accumulation will happen as per the terms of the Cumulative Bonus Booster benefit.

b) All clause applicable under Cumulative Bonus section D.II. (1) shall apply to this benefit as well

D.III.4. Removal of Room Rent Limit

We will provide for an option to remove the Room Rent limit applicable on the Inpatient Hospitalization and upgrade to a Single Private AC Room. All terms and conditions of Inpatient Hospitalization under Section D.I.1 shall apply.

D.III.5. Re-Assurance

Under Re-Assurance, We will provide an automatic extension of Policy Renewal for a period of 2 (two) Policy Years from the date of expiry of the current policy, if during the Policy Period an Insured Person is diagnosed with any of the Critical Illnesses named below or suffers from Permanent Total Disability described below due to an Accident, provided that the Insured Person is not added in to the Policy mid-term and has attained 18 years of age at the inception of the Policy Year in which the event occurred.

This automatic extension will be available only once in the lifetime of an Insured Person, in respect of either a Critical Illness or a Permanent Total Disability Event which qualifies for coverage as per the criteria specified under this Policy, irrespective of the sequence of its occurrence.

Reassurance can be availed by each Insured Person separately in case of an individual policy and once during the lifetime of a Policy in case of floater policies covering all Insured Persons under the Floater. Where this extension is triggered for a child attaining age 24 years during subsequent renewals, both the parent and split policy of the child will be eligible for this automatic extension.

a) Critical Illnesses

If an Insured Person is diagnosed to be suffering from a Critical Illness (as listed below) while the Policy is in force as a first incidence the Policy will automatically extend for a period of 2 Policy Years.

For the purpose of this Policy, Critical Illness shall mean any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence at least 90 days after the Inception of Policy Period. If such Critical Illness is acquired as a result of a pre-existing condition, then the standard waiting periods for pre-existing diseases shall apply.

1. **Cancer of specified severity**

A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukemia less than RAI stage 3

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

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

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

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

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

   b. new characteristic electrocardiogram changes

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

ii. The following are excluded:

   a. Other acute Coronary Syndromes

   b. Any type of angina pectoris.

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

3. Open Chest CABG

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

ii. The following are excluded:

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

4. Open Heart Replacement or Repair of Heart Valves

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

5. Coma of Specified Severity

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

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

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

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

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

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

8. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

   The following are excluded:

   i. Other stem-cell transplants

   ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

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

11. Multiple Sclerosis with Persisting Symptoms

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

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

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

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

b) Permanent Total Disability

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, the Policy will automatically extend for a period of 2 Policy Years provided that the Policy is in force at the time of such event.

Coverage for Permanent Total Disability due to Accident will start from day one.

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
8. Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever Automatic Renewal shall apply only to the base cover & any Optional Covers excluding Add On Riders, on the same terms as per the expiring policy and any change in terms or coverage or addition of Insured Persons at the time such Renewal is due shall be subject to underwriting as per the standard renewal process and payment of any additional premium if any change is accepted by Us.

All Claims under this benefit can be made as per process defined under Section G.I.18

D.III.6.Health Check Up (Applicable only for ProHealth Select (A)):

(a) We will provide for Health check-up for each and every Insured Persons who is 18 years or above at the start of a Policy Year. Health Check Ups will be and arranged by Us and conducted at Our Network Providers. Any claim under this benefit shall not impact Cumulative Bonus. Health Check-Ups will be available once each year.

(b) Copies of all reports will be provided to You, while a copy of the same will be retained by Us.

Pro Health Select	Sum Isured (in ₹)	Age	List of tests
(A)	0.5, 1, 2, 3	From 18	Vitals, ECG, Total Cholesterol,
(A)	4 ,5, 7, 10 Lacs	18 to 40 Years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC,SGPT
		More than 40 Years	Vitals, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT For females only – TSH
(A)		18 to40years	Vitals, ECG, Total Cholesterol, FBS,Sr. Creatinine, CBC, SGPT, CBCESR, Lipid Profile, SGOT, GGT
	15, 20, 25 Lacs	More than 40 years(For males only)	Vitals, ECG, Total Cholesterol, (FBS, Sr. Creatinine, CBC, SGPT,CBC-ESR Lipid Profile,SGOT, GGT, TMT
		More than 40 years (For females only)	Vitals, ECG, Total Cholesterol, FBS Sr. Creatinine, CBC, SGPT, CBC-ESR, Lipid Profile, SGOT, GGT, TSH, TMT,

Full explanation of Tests is provided here: MER - Medical Examination Report, FBS - Fasting Blood Sugar, GGT - Gamma-Glutamyl Trans peptidase, ECG - Electrocardiogram, CBC-ESR - Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT - Test Serum Glutamic Pyruvate Transaminase, HbA1C - Glycosylated Haemoglobin Test, RUA - Routine Urine Analysis, SGOT - Serum Glutamic Oxaloacetic Transaminase, TSH

- Thyroid Stimulating Hormone, TMT - Tread Mill Test, USG- Ultrasound Sonography, PSA - Prostate Specific Antigen, Pap smear - Papanicolaou test

(c) Coverage under this value added cover will not be available on reimbursement basis. All Claims under this benefit can be made as per the process defined under Section G.I.12

(d) You understand and agree that the list of medical tests covered above are indicative and We may add, modify or amend this list on approval from the Head of Underwriting.

D.III.7. Worldwide Emergency Cover (Applicable only for ProHealth Select (A)):

We will cover Medical Expenses of the Insured Person incurred outside India up to the Sum Insured provided that:

(a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India and is payable under Section D.I.1 of the Policy.

(b) The Medical Expenses payable shall be limited to Inpatient Hospitalization only.

(c) Any payment under this Benefit will only be made in India, in Indian rupees on a re-imbursement basis and subject to Sum Insured. Cashless Facility may be arranged on a case-to-case basis. Insured person can contact Us at the numbers provided on the Health Card for any claim assistance.

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

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

(f) Exclusion E.II.7 does not apply to this benefit

All Claims under this benefit can be made as per the process defined under Section G.I 5 & 13.

D.III.8. Disease Specific Sub limit (Applicable only for ProHealth Select (A))

You may choose to opt for Disease Specific Sub Limit on an optional basis under the ProHealth Select (A).

The balance amount, if any, subject to the applicability of sub-limits on expenses on treatment of Named ailments/Procedures, our liability to make payment shall be limited to such extent as applicable.

Maximum payable per surgery or medical management cost per policy year **Sub-Limit (Amount in ₹)**			
Ailments/ Surgeries / Medical	**Option 1**	**Option 2**	**Option 3**
1 Catract (Per eye)	7,500	15,000	22,500
2 Surgeries fo Non-malignant Tumors/Cysts/Nodule/Polyp/Benign Prostate Hypertrophy	15,000	30,000	45,000
3 Stone in Urinary/Biliary System	20,000	40,000	60,000
4 Hernia (per side)	12,500	25,000	37,500
5 Appendicitis	10,000	20,000	30,000
6 Hysterectomy	15,000	30,000	45,000
7 Any Joint Replacement	40,000	60,000	80,000
8 Piles/Fissures/Fistula	10,000	20,000	30,000
9 Medical Management or Surgeries related to Ischemic Heart Disease / Cardiac	40,000	60,000	80,000
10 Treatment for Injuries/ Breakage of Bones	27,500	55,000	80,000
11 Cerebrovascular Medical Management/Surgery	25,000	50,000	75,000
12 Cancer/Oncology (Medical & Surgical)	40,000	60,000	80,000
13 Abscess/Ligament Tear	20,000	40,000	60,000
14 Treatment towards Kidney damage or renal failure	40,000	60,000	80,000

Wherever the above-mentioned sub-limits are applied, co-payment for the treatment taken at higher zone as

mentioned under section F.II.12(4) shall also apply.

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

D.III.9 Health Maintenance Benefit (Applicable only for ProHealth Select (A))

We will reimburse costs towards Reasonable and Customary Charges incurred by the Insured Person for Medically Necessary charges incurred on an Out Patient basis upto the amount specified under this benefit.

We will cover costs incurred towards:

- Diagnostic tests, preventive tests, drugs, prosthetics, medical aids, prescribed by the specialist Medical Practitioner up to the limits specified in the Policy Schedule.
- Towards Dental Treatments and Alternative Forms of Medicines wherever prescribed by a Medical Practitioner.

Any unused HMB limit at the end of a Policy Year shall lapse and will not be carried forward. A new HMB limit shall be reinstated at the commencement of each new Policy Year.

D. III.10 . Rider/Add On Benefit:

Along with this Policy, You can also avail the ManipalCigna Critical Illness and ManipalCigna Health 360 add on Cover. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All applicable Rider terms and conditions, including medical check-up requirements, shall apply.

D.IV Rider/Add On Benefit

D.IV.1 ManipalCigna Critical Illness Add-on cover

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

For the purpose of this Benefit, Critical Illness will be as listed under the ManipalCigna Critical Illness Add on Cover Policy documents.

D.IV.2 ManipalCigna Health 360

Along with this Product You can also avail the ManipalCigna Health 360 Add On Cover. Please ask for the Terms & Conditions and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider including medical check-up requirement will apply.

1. **Shield:**

   Coverage for listed Non-medical items up to base policy Sum Insured and Durable Medical Equipment up to maximum of Rs.1 Lac

2. **OPD:**

   Package 1: Coverage for doctor consultations on cashless basis within the OPD Sum Insured

   Package 2: Coverage for doctor consultations and prescribed diagnostics on cashless basis within the OPD Sum Insured

   Package 3: Coverage for doctor consultations, prescribed diagnostics and pharmacy on cashless basis within the OPD Sum Insured. Pharmacy limit is 20% of the OPD Sum Insured

E. Exclusions

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

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

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

1. Healthy Rewards

2. Health Check-Up
3. ReAssurance

E.I Standard Exclusions

E.I.1. Pre-Existing Diseases - Code- Excl 01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of Pre-existing disease waiting for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

E.I.2. Specified disease/procedure waiting period - Code- Excl 02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures provided:
   I) Cataract,
   ii) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
   iii) Knee Replacement Surgery (other than caused by an Accident),Non-infectious Arthritis, any internal congenital anomalies, 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,
   iv) Varicose Veins and Varicose Ulcers,
   v) Stones in the urinary uro-genital and biliary systems including calculus diseases,
   vi) Benign Prostate Hypertrophy, all types of Hydrocele,
   vii) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids 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 tumours/skin tumours, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases,
   x) Any surgery of the genito-urinary system unless necessitated by malignancy.

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

E.I.3. 30-day waiting period - Code- Excl03

a. Expenses related to the treatment of any illness within opted period of continuous coverage from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

E.I.4. Investigation & Evaluation - Code - Excl 04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.
b. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing,dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

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

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

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

E.I.8. Cosmetic or plastic Surgery: Code- Excl 08

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

E.I.9 Hazardous or Adventure sports: Code- Excl 09

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

E.I.10. Breach of law: Code - Excl 10

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

E.I.11. Excluded Providers: Code - Excl 11

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

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

E.I.13. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code - Excl 13)**

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

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

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

E.I.16. Unproven Treatments: Code - Excl 16

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

E.I.17. Sterility and Infertility: Code - Excl 17

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

E.I.18. Maternity: Code - Excl 18

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

E.II. Specific Exclusions

E.II.1.90-day waiting period for Critical Illness under Re-Assurance & Add On Cover (if opted)

Any critical illness contracted and/or signs and symptoms first commenced during the first 90 days from the Inception Date of the policy will not be covered under the critical illness benefit wherever opted.

E.II.2 Personal Waiting Period:

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

E.II.3 External Congenital Anomaly or defects of any complications or conditions arising therefrom

E.II.4. Dental treatment, orthodontic treatment, dentures or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.

E.II.5. Circumcision unless necessary for treatment of an illness or injury not excluded hereunder or due to an accident.

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

E.II.7 Treatment received outside the geographical limits of India other than for coverage under Worldwide Emergency Cover.

E.II.8 All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack or in any other sequence to the loss.

E.II.9 All expenses directly or indirectly, caused by or arising from war or war-like situation, or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

E.II.10 For complete list of non-medical items, please refer to the Annexure IV, List I of “Non-Payable Items” and also on Our website.

E.II.11 Any form of Non-Allopathic treatment (except AYUSH Cover), Hydrotherapy, Acupuncture, Reflexology or Chiropractic treatment.

E.II.12 Pre-existing condition disclosed by the Insured Person will be reviewed according to the company’s underwriting policy.

E.II.13 Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.

E.II.14 Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

E.II.15 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

E.II.16 Any deductible amount or percentage of admissible claim under co-pay or above Sub-Limit if applicable and as specified in the Schedule to this Policy.

E.II.17 Expenses related to cataract treatment involving all types of Multi-focal Lenses (including intraocular lenses), Multi-focal Toric Lenses, and Femto Laser-assisted surgeries are not covered.

E.II.18 Expenses related to any Modern & Advanced Treatments other than those covered under this Policy shall not be payable.

E.II.19 Any kind of Out-Patient Treatment expenses including fractures (not requiring any kind of hospitalization)

E.II.20 Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

E.II.21 Stem cell harvesting

E.II.22 Vaccination including inoculation and immunisations (except post animal bite treatment)

E.II.23 Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.

E.II.24 Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.

E.II.25 Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.

E.II.26 Drugs or treatments which are not supported by a prescription.

E.II.27 Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

E.II.28 Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre or AYUSH Hospital.

E.II.29 Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

E.II.30 Expenses incurred towards artificial life maintenance, including life support, after the patient has been certified to be in a vegetative state by the treating medical practitioner shall not be payable.

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

E.III.1. Treatment received outside India other than for coverage under Worldwide Emergency Cover.(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.7 of the Policy and limits as specified in the Policy Schedule)

F. General Terms and Clauses

Standard General Terms and Clauses

F.I.1 Disclosure of Information

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

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

("Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in

the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

F.I.2 Condition Precedent to Admission of Liability

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

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

i. The Company shall settle or reject the claim, as the case may be, within 15 days (other than cashless) from date of submission of necessary claim documents.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from date of submission of necessary claim documents to the date of payment of claim at a rate 2% above the bank rate.

F.I.4 Complete Discharge

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

F.I.5 Multiple Policies

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

In case of multiple indemnity policies taken by an Insured Person during a period from one or more Insurers, the Insured Person shall have the right to require settlement of his/her claim under any of his/her policies, subject to proper disclosure of information about their multiple indemnity policies to chosen Insurer, either at policy inception, at renewal, or at the time of claim intimation.

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

F.I.5Free Look period

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

The insured person shall be allowed a free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

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

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

F.I.6.Cancellation

i. The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

A. Policy Tenure of 1 Year:

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

Illustration:

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

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

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

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

B. If Policy Tenure is more than 1 years:

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

Illustration:

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

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

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

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

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

F.I.7. Grace Period

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

F.I.8. Premium Payment in Instalments (For Policies other than 'Single/ Yearly' Premium payment modes)

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

- Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.
- If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
- Instalment facility shall not be available for the Policy Tenure more than 1 year.
- The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" Sections in the event of payment of premium within the stipulated grace Period.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

F.I.9Renewal of Policy

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

i. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30, as applicable, days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

F.I.10.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 and the premium paid shall be forfeited.

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

For the purpose of this clause, the expression "fraud" means any of thefollowing acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person,with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

F.I.11. Portability

The Insured Person will have the option to port the Policy to otherinsurers 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 plan with an Indian General/Health insurer the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI Guidelines on portability.

F.I.12. Migration

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

F.I.13. Redressal of Grievance

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

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at-

seniorcitizensupport@manipalcigna.com

Toll Free: 1800-102-4462

Contact No.: 022-61703600

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact

the grievance officer at,
'The Grievance Cell,
401/402, 4th Floor, Raheja Titanium,
Western Express Highway, Goregaon (East),
Mumbai - 400063, Maharashtra, India
or
Email: headcustomercare@manipalcigna.com.
For updated details of grievance officer, kindly refer link -
https://www.manipalcigna.com/grievance-redressal

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

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

You may also approach the Insurance Ombudsman if your complaint is open for more than 30 days from the date of filing the complaint.The office Name and address details applicable for your state can be obtained from - https://www.cioins.co.in Ombudsman

F.I.14. Withdrawal of Policy

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

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

F.I.15. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

F.I.16. 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.

F.I.17. Moratorium Period

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

F.II. Specific terms and clauses

F.II.1. Material Change

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

F.II.2. Records to be maintained

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

F.II.3. Alterations in the Policy

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

F.II.4. 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 change in marital status during the Policy Period.

F.II.5. No Constructive Notice

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

F.II.6. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

F.II.7. Geography

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

F.II.8. Limitation of Liability

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

F.II.9. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.
b. In case the coverage under the Re-Assurance is triggered, Renewals will be effected accordingly for the immediate two Policy Years and customer will not require to pay any premium for such renewals, provided the terms and conditions of the contract are not altered. Post completion of the said period, all renewals

shall be subject to standard renewal terms under this section.

c. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition.

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

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

f. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 45 days prior to date of such revision or modification.

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

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

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

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

k. Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the Policy.

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

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

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

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

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

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

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

F.II.10. Premium calculation

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

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

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

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

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

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

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

Zone Classification

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

The residential address provided by You should be true, correct and complete. Any discrepancy or mismatch identified during claim adjudication may lead to delays, disputes or denial of claim settlement. The policyholder is required to promptly inform the company of any changes to the residential address to ensure uninterrupted communication and smooth claim processing.

Zone	**Region / District / State**
Zone 1	Mumbai, Thane, Navi Mumbai, Delhi and NCR
Zone 2	Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat
Zone 3	**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.	

F.II.11. Loadings, Special Conditions & Discounts

We may apply a risk loading on the premium payable (excluding Statutory Levies 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 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 counteroffer letter or through an electronic mode, as the case may be and You would need to revert with consent and premium, within the duration specified in the counteroffer.

F.II.12. Discounts under the Policy

The Policy will allow the following Discounts.

1. Portfolio Discount (Only for ProHealth Select (A)):

a) **Portfolio Gender Mix Discount:** If the proportion of female members In an Affinity portfolio is 20% or more, then discounts will be applicable as per the following table:

Portfolio Gender Mix Discount	
Female Proportion	**Discount**
Proportion < 20%	0.0%
20% <= Proportion < 40%	2.5%
40% <= Proportion < 60%	5.0%
60% <= Proportion < 80%	7.5%
80% <= Proportion < 100%	10.0%

b) **Portfolio Region Mix Discount**: If the proportion of members in an Affinity portfolio outside of Zone 1 is 20% or more, then discounts will be applicable as per the following table:

Portfolio Region Mix Discount		
Population Proportion	**Zone 2**	**Zone 3**
Proportion < 20%	0.0%	0.0%
20% <= Proportion < 40%	2.0%	4.0%
40% <= Proportion < 60%	4.0%	8.0%
60% <= Proportion < 80%	6.0%	12.0%
80% <= Proportion < 100%	8.0%	16.0%

Notes:

i. Zones are defined as under:

Zone 1: Mumbai, Thane, Navi Mumbai, Delhi and NCR

Zone 2: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat

Zone 3: Rest of India excluding locations mentioned under Zone 1 and Zone 2

ii. For a portfolio with exposure to only Zone 1 & Zone 2, discounts asper the Zone 2 column above will be available as per the proportion of the portfolio in Zone 2.

iii. For a portfolio with exposure to only Zone 1 & Zone 3, discounts as per the Zone 3 column above will be available as per the proportion of the portfolio in Zone 3.

iv. For a portfolio with exposure to Zone 1, Zone 2 & Zone 3, then the average of the discounts as per the Zone 2 & Zone 3 columns above will be available as per the total proportion of the portfolio in Zones 2 & 3.

Portfolio discounts will be calculated at the portfolio level based on the base premium rates for ProHealth Select (A)

Applicable portfolio discount will apply on all policies offered to members of the Affinity portfolio.

The maximum Portfolio discount on offer for a single Affinity partner will be limited at 26%.The premium for any of the optional benefits, such as Cumulative Bonus Booster, Room Rent Cap Waiver and Reassurance Health Check-up, Worldwide Emergency Cover, Health Maintenance Benefit,will then be charged relative to the discounted premium rate for the base plan.Any loading for Medical Underwriting at an individual policyholder level will be applicable on the discounted premium rate offered for the portfolio.

2. **Family Discount:** Discount offered is 10% for policies covering more than 2 individuals with individual Sum Insured.

3. **Long Term Discount:** Discount offered is 7.5% for policies with term 2 years and 10% for policies with term 3 years, only upon payment of lump sum premium. The discount is available only with Single Premium Payment Mode.

Family and Long Term Discounts will be available for both ProHealth Select (A) and (B) variants. For the ProHealth Select (A), these discounts will be over and above the 26% cap for Portfolio discounts.

4. Zone Discount (Only for ProHealth Select (B)): Discount offered is 8% for customer from Zone 2 and 16% for customer from Zone 3.

Zone Classification

Zone I: Mumbai, Thane & Navi Mumbai and Delhi & NCR

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Kolkata, Gujarat

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II Identification of Zone will be based on the City of the proposed Insured Persons.

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

(b) Persons paying Zone II premium

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

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

(c) Person paying Zone III premium

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

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

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

***Option to select a Zone higher or lower than that of the actual Zone is available on payment of relevant premium at the time of buying the policy or at the time of renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalization due to an Accident.

F.II.13. 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.

F.II.14. Communications & Notices

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

a. The policyholder's, at the address as specified in Schedule

b. To Us, at the address specified in the Schedule.

c. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

d. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

F.II.15. Electronic Transactions

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

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

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

F.II.16 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 during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.
d. If a 'Good Health Declaration' is sought by us and is later proven to be fraudulent, the entire policy shall be cancelled, and no claims shall be payable.
e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

F.II.17 Coverage Standards & Protocols

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

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

A. Medical Protocols

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

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

These guidelines are designed to help explain:

a. When hospitalization is needed, including guidance on the appropriate level of care (for example: admission in an ICU or non-ICU room)
b. What treatments and procedures are considered appropriate, based on the medical condition and its severity, including recommended medicines and procedures

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

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

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

B. Position statements

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

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

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

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

C. Prolonged Hospitalization extending beyond 10 days

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

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.
b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please

inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.

c. For all Kidney, liver and pancreas transplants, a biopsy of the recipient's organ may be required as part of the medical evaluation process.

d. If treatment is taken at a non-network hospital and we do not receive the required intimation or the biopsy report as outlined above, an additional 20% co-payment may be applicable on the admissible claim amount.

F.II.18 Utilization of Sum Insured

Sequence of utilization of Sum Insured will be as follows:

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

F.II.19 Personal Data and Privacy

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

F.II.20 Pre-Policy medical check up

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

F.II.21 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

G. Other terms and conditions

G.I. Claim process & management

G.I.1. Condition Preceding

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

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

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

Cashless and Reimbursement Claim processing and access to network hospitals is through Our service partner, details of the same will be available on the Health Card issued by Us as well as on Our website :https://www.manipalcigna.com/our-tpas For the latest list of network hospitals, You can log on to Our website.

A TPA will be used for Network Access and facilitate claim processing. All customer contact points will be with Us including claim intimation, submission, settlement and dispute resolutions.

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

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

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

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

(b) Follow the directions, advice or guidance provided by a Medical Practitioner. We shall not be obliged to make any payment (s) that are brought about or contributed to, as a consequence of failure to follow such directions, advice or guidance.

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

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

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

G.I.3. Claim Intimation

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

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

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

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

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

G.I.4. Cashless Facility

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

(a) For Planned hospitalization

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

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

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

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider or common empanelment of hospital/healthcare providers, We will verify the eligibility of cover under the Policy.

v. Wherever the information provided in the request is sufficient to ascertain the authorisation, We shall issue

the authorisation Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 1 hour from the receipt of last complete documents.

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

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

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

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

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

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

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

At the time of discharge:

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

ii. We shall accept or decline such additional expenses within 3 (Three) hours of receiving the complete documents for final discharge from Network provider.

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

(b) In case of Emergency Hospitalization

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

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

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

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

v. The Network Provider or common empanelment of hospital/ healthcare providers shall refund the deposit amount to You barring a token amount to take care of non-covered expenses once the pre-authorization is issued.

Note: Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital or common empanelment of hospital/healthcare providers as specified by Insurance Council for Illness or Injury which are covered under the Policy. For all Cashless authorizations, You will, in any event, be required to settle all non-admissible expenses, Co-payment and/or Deductibles (if applicable), directly with the Hospital.

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

- Claim Form Duly Filled and Signed
- Original pre-authorization request

- Copy of pre-authorization approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes(if any)
- Original Hospital Main Bill and break up Bill
- Original Investigation Reports, X Ray, MRI, CT Films, HPE
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills circumstances of the claim.
- MLC/FIR Report/Post Mortem Report (if applicable and conducted)

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

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

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

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

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents

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

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

a. Common claim documents required for all claims:

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

b. Additional Claim documents required for below benefits:

S. No.	Name of Benefit	Name of Document
1	In-patient Hospitalization	• Hospital Discharge summary • Operation Theatre notes/ ICP papers • Hospital Main Bill • Hospital Break up bill • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices • Copy of FIR/Panchnama / Police Inquest Report (if conducted) duly attested by the concerned Police Station in case of Accident.
2	Day Care Treatment	
3	Donor Expenses	
4	AYUSH Cover	
5	Worldwide Emergency Cover	

6	Pre – hospitalization	• Pharmacy Bills • Diagnostic tests reports in relation to admitted hospitalization expenses • Prescription in support of Pharmacy, Investigations
7	Post – hospitalization	
	Domiciliary Hospitalization	• Certificate from treating Medical Practitioner that condition of the Insured Person does not allow a Hospital transfer; or • Evidence that hospital bed was unavailable in nearest hospitals. • Final Bill and invoice • Nursing chart/TPR chart • Investigation reports • Original investigation reports, X Ray, MRI, CT films, HPE, ECG etc. • Doctors reference slip for investigation Pharmacy bills, prescription and invoices
9	Ambulance Cover	• Original Bill as provided by Healthcare or Ambulance Service Provider • Certification of Medical Practitioner for necessity to use Ambulance
10	Re-Assurance	<u>In respect of Permanent Total Disability</u> • Original treating Medical Practitioner's certificate describing the disablement; • Original Discharge summary from the Hospital; • Photograph of the Insured Person reflecting the disablement; • Prescriptions and consultation papers of the treatment; • Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board. <u>In respect of Critical Illness</u> • Medical Certificate confirming the diagnosis of Critical Illness; • Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy. • Discharge Card/Death Summary from the Hospital, if applicable; • Investigation test reports confirming the diagnosis as specified under the definition of the respective Critical Illnesses; • First consultation letter and subsequent prescriptions; • Indoor case papers if applicable; • Specific documents listed under the respective Critical Illness • In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will also be required wherever conducted.
11	Health Maintenance Benefit	• Invoice/Hospital Bill • Investigation reports • Doctors reference slip for investigation • Pharmacy bills, prescription and invoices

We may call for any additional documents/information as required based on the circumstances of the claim, wherever the case in under further investigation or available documents do not provide clarify.

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

In case You/Insured Person delay submission of claim documents as specified in G.I.5.(a) above, then in addition to the documents mentioned in G.I.5. (a) above, You are also required to provide Us the reason for such delay in writing. In case You delay submission of claim documents, then in addition to the documents mentioned above, You are also required to provide Us the reason for such delay in writing. We will accept such requests for delay up to an additional period of 30 days from the stipulated time for such submission. We will condone delay on merit for delayed Claims where the delay has been proved to be for reasons beyond Your/Insured Persons control.

G.I.6. Scrutiny of Claim Documents

We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider or Common empanelment of hospital/ healthcare providers) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.

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

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

G.I.7. Claim Assessment

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

a) For Policy without Deductible Option

i) Where a room accommodation is opted for higher than the eligible room category/room rent under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

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

b) For Policy with Deductible Option

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Arrived payable claim amount will be assessed against the deductible after applying the Section G.I.7 b (i).

iii) Any Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.b (ii)

c) For Policy without 'Disease Specific Sub-limit' Option

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Any 'Voluntary Co-payment' or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.c (i)

d) For Policy with 'Disease Specific Sub-limit' Option

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all “Associated Medical Expenses”.

ii) Arrived payable claim amount will be assessed against the Disease Specific Sub-limit.

iii) Any 'Voluntary Co-payment' or Zonal Co-payment shall be applicable on the amount payable after applying the Section G.I.7.d (i) & (ii)

e) For Policy with Deductible and 'Disease Specific Sub-limit' option

i) Where a room accommodation is opted for higher than the eligible room rent limit under the Policy, the room rent for the applicable accommodation will be apportioned. Such apportioned amount will apply to all "Associated Medical Expenses".

ii) Arrived payable claim amount will be assessed against the deductible after applying G.I.7.e (i).

iii) Arrived payable claim amount will be assessed against the Sub-limit after applying G.I.7.e (i) &

iv) Any 'Zonal Co-payment' shall be applicable on the amount payable after applying the Section G.I.7. e (i), (ii) & (iii)

The Claim amount assessed under Section G.I.7 a, b, c, d, & e will be deducted from the available covers in the following progressive order -

i) Sum Insured

ii) Cumulative Bonus (or Cumulative Bonus Booster if opted)

iii) Restored Sum Insured

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

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

G.I.8. Claims Investigation

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

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

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

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

G.I.10. Representation against Rejection:

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

G.I.11. Payment Terms

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

We are not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if You/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by You/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

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

For Cashless Claims, the payment shall be made to the Network Hospital or common empanelment of hospital/healthcare provider whose discharge would be complete and final.

For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will

pay the nominee (as named in the Policy Schedule) and in case of no nominee to the Legal Heir who holds a succession certificate or Indemnity Bond to that effect,whichever is available and whose discharge shall be treated as full and final discharge of its liability under the Policy.

Claim process Applicable to the following Sections:

G.I.12. Health Check up

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

(b) We will facilitate Your appointment and We will guide You to the nearest Network Provider for conducting the medical examination. Reports of the Medical Tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement.

G.I.13. Worldwide Emergency Cover

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

b) You shall file a claim for reimbursement in accordance with Section G.I.5 & Section G.I.13 of the Policy. Under special circumstances due to an emergency we, may consider offering a cashless option on a case to case basis.

G.I.14. Deductible

a) Any claim towards Hospitalization during the Policy Period must besubmitted to Us for assessment in accordance with the claim process laid down under Section G.I.4 and Section G.I.5. towards cashless or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the deductible, We will assess and pay such claim in accordance with Section G.I.6. and G.I. 7.

b) Wherever such Hospitalization claims as stated under G.I.14. a) above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer/TPA as the case may be.

G.I.15. Re-Assurance

a) In the event of an Insured Person suffering from any of the named Critical Illnesses, You or the Insured Person, may intimate Us with the following documents.

In respect of Permanent Total Disability

- Claim Form Duly Signed
- Original treating Medical Practitioner's certificate
- describing the disablement;
- Original Discharge summary from the Hospital;
- Photograph of the Insured Person reflecting the disablement;
- Prescriptions and consultation papers of the treatment;
- Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.

In respect of Critical Illness

- Claim form duly filled and signed Part A and B wherever applicable;
- Medical Certificate confirming the diagnosis of Critical Illness;
- Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- Discharge Card/Death Summary from the Hospital, if applicable;

- Investigation test reports confirming the diagnosis as specified under the definition of the respective Critical Illnesses; First consultation letter and subsequent prescriptions;
- Indoor case papers if applicable;
- KYC documents;
- Specific documents listed under the respective Critical Illness
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.
- In the unfortunate event of the death of the insured person post the survival period, any person claiming on in respect of the Insured Person under the Policy must inform Us in writing immediately.

G.I.16. Disease Specific Sub-Limit

Any claim towards Hospitalization during the Policy Period must be submitted to Us for scrutiny in accordance with the claim process laid down under G.I.4 and G.I.5 above, towards cashless or reimbursement respectively in order to assess and determine the applicability of the Sub-limit on such claim. Once the claim has been assessed, if any amount becomes payable within the Sub limit, We will assess and pay such claim in accordance with Section G.I.6 and G.I.7 above.

G.I.17. Health Maintenance Benefit

Reimbursement process:

a) Submission of claim

Insured person can send the Health Maintenance Benefit claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to Our branch office or head office. The Health Maintenance Benefit under opted variant can be claimed only once for one of more Out Patient treatments during the Policy Year up to the extent of Health Maintenance Benefit limit plus any earned Healthy Rewards converted to Health Maintenance Benefit

b) Assessment of Claim Documents

We shall assess the claim documents and assess the admissibility of claim as per the terms & conditions of the Policy.

c) Settlement & Repudiation of a claim

We shall settle claims, including its rejection, within 5 (five) days of the receipt of the request, but not later than 15 days.

G.I.18. Critical Illness Add On Cover (wherever opted)

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

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

- Claim form duly filled and signed Part A and B wherever applicable Medical Certificate confirming the diagnosis of Critical Illness; Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- Discharge Card/Death Summary from the Hospital, if applicable;
- Investigation test reports confirming the diagnosis as specified under the definition of the respective Critical Illnesses;
- First consultation letter and subsequent prescriptions;
- Indoor case papers if applicable;
- KYC documents;

- Specific documents listed under the respective Critical Illness
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.

In the unfortunate event of the death of the insured person post the survival period, any person claiming in respect of the Insured Person under the Policy must inform Us in writing immediately.

G.I.19 Application of Multiple policy clause

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

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

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

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

b) Retail policy & group policy from the Company:

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

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

G.I.20 Policy Servicing and Claims Servicing **d**etails

Particulars	Details
Official Website	www.manipalcigna.com
Official Mobile Application	myManipalCigna
Designated Claims Office Address	Techweb center 2nd Floor New Link Rd, Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India
Claims page	https://claim.manipalcigna.com/claims/
Claims form (download)	https://www.manipalcigna.com/downloads/claims
Customer Care	customercare@manipalcigna.com
Head Customer Care	headcustomercare@manipalcigna.com

Toll free customer care contact number	1800-102-4462 (available between 9:00 AM to 9:00 PM)
Senior Citizens Support	seniorcitizensupport@manipalcigna.com
For policy servicing	https://eservicing.manipalcigna.com/login
List of network hospitals	https://www.manipalcigna.com/locate-us
List of Unrecognised hospitals	https://www.manipalcigna.com/locate-us
For complaints	complaints@manipalcigna.com
Chief Grievance Redressal Officer	Compliance@manipalcigna.com
Grievance Redressal contact number	022-61703600 (available Monday to Friday between 10 AM to 6 PM)

G.II . Annexure – I:

Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email:- oio.ahmedabad@cioins.co.in	Gujarat, Dadra and Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462001. Tel.: 0755 - 2769201 / 2769202/2769203 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, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044 - 24333668 / 24333678 Email:- oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011 - 46013992/ 23213504/ 23232481 Email:- oio.delhi@cioins.co.in	Delhi and following Districts of Haryana - Gurugram, Faridabad, Sonepat and Bahadurgarh

GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2632204/2602205/2631307 Email:- oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Hyundai Showroom A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 23376991 / 23376599 / 23328709 / 23325325/23312122 Email:- oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email:- oio.jaipur@cioins.co.in	Rajasthan
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email:- oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email:- oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman and Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522 - 4002082 / 3500613 Email:- oio.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W),	List of wards under Mumbai Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S

Mumbai - 400 054. Tel.:- 022 - 69038800/27/29/31/32/33 Email:- oio.mumbai@cioins.co.in	and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: oio.noida@cioins.co.in	State of Uttarakhand and the following districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in	Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: oio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

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

G.III.Annexure - II:

List of Day Care Treatments/Surgeries/Procedure covered under Section D.I.4 including but not limited to the following:

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy
3. Other operations of the auditory ossicles
4. Myringoplasty (post-aura/ endural approach as well as simple Type - I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum pe foration/ reconstruction of the auditor ossicle)
6. Revision of a Tympanoplasty
7. Other microsurgical operations on the middle ear Other

operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain
10. Incision of the mastoid process and middle ear
11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle ear
18. Removal of Keratosis Obturans

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration
23. Foreign body removal from nose

Operations on the eyes

24. Incision of tear glands
25. Other operations on the tear ducts
26. Incision of diseased eyelids
27. Correction of Eyelids Ptosis by Levator Palpebrae Superioris Resection (bilateral)
28. Correction of Eyelids Ptosis by Fascia Lata Graft (bilateral)
29. Excision and destruction of diseased tissue of the eyelid
30. Operations on the canthus and epicanthus
31. Corrective surgery for entropion and ectropion
32. Corrective surgery for blepharoptosis
33. Removal of a foreign body from the conjunctiva

34 Removal of a foreign body from the cornea

35. Incision of the cornea
36. Operations for pterygium
37. Other operations on the cornea
38. Removal of a foreign body from the lens of the eye

39. Removal of a foreign body from the posterior chamber of the eye
40. Removal of a foreign body from the orbit and eyeball
42. Diathermy/Cryotherapy to treat retinal tear
43. Anterior chamber Pancentesis/ Cyclodiathermy Cyclocryotherapy/goniotomy/Trabeculotomy and Filtering and Allied operations to treat glaucoma
44. Enucleation of the eye without implant
45. Dacryocystorhinostomy for various lesions of Lacrimal Gland
46. Laser photocoagulation to treat retinal Tear

Operations on the skin & subcutaneous tissues

47. Incision of a pilonidal sinus
48. Other incisions of the skin and subcutaneous tissues
49. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50. Local excision of diseased tissue of the skin and subcutaneous tissues
51. Other excisions of the skin and subcutaneous tissues
52. Simple restoration of surface continuity of the skin and subcutaneous tissues
53. Free skin transplantation, donor site
54. Free skin transplantation, recipient site
55. Revision of skin plasty
56. Other restoration and reconstruction of the skin and subcutaneous tissues
57. Chemosurgery to the skin
58. Destruction of diseased tissue in the skin and subcutaneous tissues
59. Reconstruction of deformity/ defect in Nail Bed

Operations on the tongue

60. Incision, excision and destruction of diseased tissue of the tongue
61. Partial glossectomy
62. Glossectomy
63. Reconstruction of the tongue
64. Other operations on the tongue

Operations on the salivary glands & salivary ducts

65. Incision and lancing of a salivary gland and a salivary duct
66. Excision of diseased tissue of a salivary gland and a salivary duct
67. Resection of a salivary gland
68. Reconstruction of a salivary gland and a salivary duct
69. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

70. External incision and drainage in the region of the mouth, jaw and face
71. Incision of the hard and soft palate
72. Excision and destruction of diseased hard and soft palate
73. Incision, excision and destruction in the mouth
74. Palatoplasty
75. Other operations in the mouth Operations on tonsils and adenoids
76. Transoral incision and drainage of pharyngeal abscess
77. Tonsillectomy without adenoidectomy
78. Tonsillectomy with adenoidectomy

79. Excision and destruction of a lingual tonsil
80. Other operations on the tonsil and adenoids
81. Traumasurgery and orthopaedics
82. Incision on bone, septic and aseptic
83. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84. Suture and other operations on tendons and tendon sheath
85. Reduction of dislocation under GA
86. Adnoidectomy

Operations on the breast

87. Incision of the breast
88. Operations on the nipple
89. Excision of single breast lump

Operations on the digestive tract, Kidney and bladder

90. Incision and excision of tissue in the perianal region
91. Surgical treatment of anal fistulas
92. Surgical treatment of haemorrhoids
93. Division of the anal sphincter (sphincterotomy)
94. Other operations on the anus
95. Ultrasound guided aspirations
96. Sclerotherapy etc.
97. Laprotomy for grading Lymphoma with Splenectomy/ Liver/ Lymph Node Biopsy
98. Therapeutic laproscopy with Laser
99. Cholecystectomy and choledocho - jejunostomy/ Duodenostomy/Gastrostomy/Exploration Common Bile Duct
100. Esophagoscopy, gastroscopy, dudenoscopy with polypectomy/removal of foreign body/diathermy of bleeding lesions
101. Lithotripsy/ Nephrolithotomy for renal calculus
102. Excision of renal cyst
103. Drainage of Pyonephrosis/Perinephric A scess
104. Appendicectomy with/ without Drainage

Operations on the female sexual organs

105. Incision of the ovary
106. Insufflation of the Fallopian tubes
107. Other operations on the Fallopian tube
108. Dilatation of the cervical canal
109. Conisation of the uterine cervix
110. Theraputic curettage with Colposcopy/ Biopsy/ Diathermy/ Cryosurgery
111. Laser therapy of cervix for various lesions of Uterus
112. Other operations of the Uterine cervix
113. Incision of the uterus (hysterectomy)
114. Local incision and destruction of diseased tissue of the vagina and the pouch of Douglas
115. Incision of the vagina
116. Incision of vulva
117. Culdotomy
118. Operations on Bartholin's glands (cyst)
119. Salpino-Oophorectomy via Laproscopy

Operations on the prostate & seminal vesicles

120. Incision of the prostate
121. Transurethral excision and destruction of prostate tissue
122. Transurethral and percutaneous destruction of prostate tissue
123. Open surgical excision and destruction of prostate tissue
124. Radical prostatovesiculectomy
125. Other excision and destruction of prostate tissue
126. Operations on the seminal vesicles
127. Incision and excision of periprostatic tissue
128. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

129. Incision of the scrotum and tunica vaginalis testis
130. Operation on a testicular hydrocele
131. Excision and destruction of diseased scrotal tissue
132. Other operations on the scrotum and tunicavaginalis testis

Operations on the testes

133. Incision of the testes
134. Excision and destruction of diseased tissue of the testes
135. Unilateral orchidectomy
136. Bilateral orchidectomy
137. Orchidopexy
138. Abdominal exploration in cryptorchidism
139. Surgical repositioning of an abdominal testis
140. Reconstruction of the testis
141. Implantation, exchange and removal of a testicular prosthesis
142. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

143. Surgical treatment of a varicocele and a h drocele of the spermatic cord
144. Excision in the area of the epididymis
145. Epididymectomy

Operations on the penis

146. Operations on the foreskin
147. Local excision and destruction of diseased tissue of the penis
148. Amputation of the penis
149. Other operations on the penis

Operations on the urinary system

150. Cystoscopical removal of stones
151. Catheterisation of bladder

Other Operations

152. Lithotripsy
153. Coronary angiography
154. Biopsy of Temporal Artery for Various lesions

155. External Arterio-venus shunt
156. Haemodialysis
157. Radiotherapy for Cancer
158. Cancer Chemotherapy
159. Endoscopic polypectomy

Operation of bone and joints

160. Surgery for ligament tear
161. Surgery for meniscus tear
162. Surgery for hemoarthrosis/ pyoarthrosis
163. Removal of fracture pins/ nails
164. Removal of metal wire
165. Closed reduction on fracture, luxation
166. Reduction of dislocation under GA
167. Epiphyseolysis with osterosynthesis
168. Excision of Bursirtis
169. Tennis elbow release
170. Excision of various lesions in Coccyx
171. Arthroscopic knee aspiration

G.IV . Annexure - III:

	ProHealth Select	(A)	(B)
	Base Sum Insured (₹ in Lacs)	0.50, 1, 2, 3, 4, 5, 7, 10, 15, 20, 25	2, 3, 4, 5, 7,10,15, 20, 25,
Basic Cover	**Inpatient Hospitalization**	Covered up to 2% of Base Sum Insured for a Hospital Room, up to a max of ₹3,000 OR Up to 4% of Base Sum Insured for ICU up to a max of ₹7,000	
	Pre - Hospitalization	60 days	
	Post - Hospitalization	90 days	
	Day Care Treatment	171 procedures, Covered up to Sum Insured	
	Domiciliary Treatment	Covered up to Sum Insured	
	Ambulance Cover	Covered upto ₹2000 per Hospitalization event	
	Donor Expenses	Covered upto Sum Insured	
	Restoration	Available once in a policy year for unrelated illnesses. Restoration of Sum Insured Available for all Sum Insured's except ₹0.5L and ₹1L	
	AYUSH Cover	Coverage for Hospitalization under Ayurvedic, Yoga & Naturopathy, Unani, Siddha and Homeopathy systems of medicine up to Sum Insured.	
	Cumulative Bonus	5% each year maximum upto 100%.This will not be reduced in case of claim under the Policy.	
Value Added Covers	**Healthy Rewards**	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs These earned Reward Points can be used to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy OR Equivalent value of Health Maintenance Benefit anytime during the Policy. (Applicable if HMB optional cover has been opted under ProHealth Select (A))	Reward Points equivalent to 1% of paid premium, to be earned each year. Rewards can also be earned for enrolling and completing Our Array of Wellness Programs. These earned Reward Points can be used to get a discount in premium from the next renewal OR they can be redeemed for availing services through any of Our network providers as defined in the policy
Optional Covers	**Deductible***	Deductible - ₹1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted	Deductible - ₹1/2/3/4/5 Lacs in all combinations provided the Deductible is not higher than the Sum Insured opted.
	Voluntary Co-pay*	10% or 20% voluntary co-payment for each and every claim as opted on the Policy	Not Available
	Cumulative Bonus Booster (any one of the 4 choices)	a) 10% increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. b) 25% increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. c) 50% Increase in Base Sum Insured, maximum up to 100%, irrespective of a claim under the Policy. d) 10% increase in Base Sum Insured, maximum up to 200% irrespective of a claim under the Policy.	

	Removal of room rent Limit	Coverage up to Single Private AC Room	
	Health Check-up	Every year for all Insured Persons 18 years or above based on the applicable Grid	Not Available
	Re-Assurance	Automatic Extension of Policy for 2 years on diagnosis of a Critical Illness or Permanent Total Disability due to Accident	
	Disease Specific Sub Limits	As per limits specified	Not Available
	Health Maintenance Benefit	Covered up to ₹500 or 1000 as opted	Not Available
	Worldwide Emergency Cover	Covered up to Sum Insured once in a policy year	Not Available
	Add On Cover	ManipalCigna Critical Illness Add On Cover	
		ManipalCigna Health 360 OPD	ManipalCigna Health 360-Shield: Coverage for listed Non-medical items up to base policy Sum Insured and Durable Medical Equipment up to maximum of `1 Lac
			ManipalCigna Health 360- OPD Package 1: Coverage for doctor consultations on cashless basis within the OPD Sum Insured Package 2: Coverage for doctor consultations and prescribed diagnostics on cashless basis within the OPD Sum Insured Package 3: Coverage for doctor consultations, prescribed diagnostics and pharmacy on cashless basis within the OPD Sum Insured. Pharmacy limit is 20% of the OPD Sum Insured

*Voluntary Co-pay and Deductible cannot be taken under a single Policy.

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

G.IV. Annexure - IV

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

Sl. No.	Item
1.	BABY FOOD
2.	BABY UTILITIES CHARGES
3.	BEAUTY SERVICES
4.	BELTS / BRACES
5.	BUDS
6.	COLD PACK / HOT PACK
7.	CARRY BAGS
8.	EMAIL I INTERNET CHARGES
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10.	LEGGINGS
11.	LAUNDRY CHARGES
12.	MINERAL WATER
13.	SANITARY PAD
14.	TELEPHONE CHARGES
15.	GUEST SERVICES
16.	CREPE BANDAGE
17.	DIAPER OF ANY TYPE
18.	EYELET COLLAR
19.	SLINGS
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	TELEVISION CHARGES
23.	SURCHARGES
24.	ATTENDANT CHARGES
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26.	BIRTH CERTIFICATE
27.	CERTIFICATE CHARGES
28.	COURIER CHARGES
29.	CONVEYANCE CHARGES
30.	MEDICAL CERTIFICATE
31.	MEDICAL RECORDS
32.	PHOTOCOPIES CHARGES
33.	MORTUARY CHARGES
34.	WALKING AIDS CHARGES
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36.	SPACER
37.	SPIROMETRE
38.	NEBULIZER KIT
39.	STEAM INHALER
40.	ARMSLING
41.	THERMOMETER

42.	CERVICAL COLLAR
43.	SPLINT
44.	DIABETIC FOOT WEAR
45.	KNEE BRACES (LONG / SHORT / HINGED)
46.	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47.	LUMBO SACRAL BELT
48.	NIMBUS BED OR WATER OR AIR BED CHARGES
49.	AMBULANCE COLLAR
50.	AMBULANCE EQUIPMENT
51.	ABDOMINAL BINDER
52.	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53.	SUGAR FREE Tablets
54.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55.	ECG ELECTRODES
56.	GLOVES
57.	NEBULISATION KIT
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY
List II - Items that are to be subsumed into Room Charges	
Sl. No.	**Item**
1.	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE I ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN

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

16.	X-RAY FILM
17.	BOYLES APPARATUS CHARGES
18.	COTTON
19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE

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