EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS BASE COVER
I. Preamble & Operating Clause

This Policy is a contract of insurance between You and Us which is subject to (a) the terms, conditions and exclusions of this Policy and (b) the receipt of Premium against each Benefit of the applicable in full and (c) the Disclosure to information norm (including by way of the Proposal or Information Summary Sheet) in respect of all Insured Persons and (d) the Policy Schedule/ Certificate of Insurance.

II. Definitions

Age
Age or Aged means the completed age as on the last birthday.

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

Ambulance
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.

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

Annual Renewal Date
Annual Renewal Date means the anniversary of the Inception date each year or any other date which We agree with you in writing.

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

Area of Cover
Area of Cover means the geographic coverage area as defined under the Policy and as particularly specified for the Insured Person in the Policy Schedule/ Certificate of Insurance.

AYUSH Treatment
AYUSH Treatment refers to the medical and/or Hospitalization Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems provided the treatment has been undergone in (in India): i) Teaching hospitals of AYUSH Colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH) ii) AYUSH Hospitals having registration with a Government authority under appropriate Act in the state/ UT and complies with the following as minimum criteria: a. Has at least fifteen in-patient beds b. Has minimum five qualified and registered AYUSH doctors c. Has qualified paramedical staff under its employment round the clock d. Has dedicated AYUSH therapy sections; e. Maintains daily record of patients and makes this accessible to the insurance company’s authorized personnel.

Benefit
Benefit means any benefit under the Policy, as opted and available for the Insured Person and specified in the list of benefits in the Policy Schedule/ Certificate of Insurance.

Cancer of specific severity
A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma. The following are excluded:

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below

ix. All tumors in the presence of HIV infection.
Cashless facility

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.

Certificate of Insurance/ Policy Certificate

Certificate of Insurance/ Policy Certificate means the certificate issued to the Insured Person confirming the Insured Person’s cover under the Policy.

Complementary treatment

Complementary treatment means:

- Physiotherapy: Treatment of an Illness, Injury or deformity through physical methods such as massage, heat treatment, etc.
- Acupressure: The application of pressure (as with the thumbs or fingers) to the same discrete points on the body stimulated in acupuncture that is used for its therapeutic effects (such as the relief of tension or pain).
- Acupuncture: Acupuncture is a form of alternative medicine in which thin needles are inserted into the body for treatment of various physical and mental conditions.
- Chiropractic: A specialty supplementary to medicine devoted to the care of the feet and the treatment of minor foot complaints such as ingrowing toenails, bunions, plantar warts, foot strain, flat feet and the care of the feet of diabetics.
- Osteopathy: A system of medicine based on the theory that disturbances in the musculoskeletal system affect other bodily parts, causing many disorders that can be corrected by various manipulative techniques in conjunction with conventional medical, surgical, pharmacological and other therapeutic procedures.
- Homeopathy: A system of complementary medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment.
- Ayurveda: A science of life based on the Vedas, the Hindu books of knowledge and wisdom. It is the traditional Hindu system of medicine (incorporated in Vedas), which provides an integrated approach for prevention and treatment of illness through lifestyle interventions and natural therapies.
- Acupuncture: Acupuncture is a form of alternative medicine in which thin needles are inserted into the body for the treatment of various physical and mental conditions.
- Chiropody: A specialty supplementary to medicine devoted to the care of the feet and the treatment of minor foot complaints such as ingrowing toenails, bunions, plantar warts, foot strain, flat feet and the care of the feet of diabetics.
- Chiropractic: A system that, in theory, uses the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body, particularly the spinal column and the nervous system, in the restoration and maintenance of health.
- Osteopathy: A system of medicine based on the theory that disturbances in the musculoskeletal system affect other bodily parts, causing many disorders that can be corrected by various manipulative techniques in conjunction with conventional medical, surgical, pharmacological and other therapeutic procedures.
- Homeopathy: A system of complementary medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment.

Condition Precedent

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

Congenital Anomaly

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure, or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

Contribution

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured Person to share the cost of an indemnity claim on a ratably proportion of the Sum Insured. This clause shall not apply to any Benefit offered on a fixed benefit basis. This clause shall not apply to any Benefit offered on a fixed benefit basis.

Co-pay/ Co-Payment

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

Cosmetic Surgery

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

Critical Illness

Critical Illness shall mean illnesses listed below or as customized for a Policy and specified under the Policy Schedule/ Certificate of Insurance.

- Cancer of specific severity
- Myocardial Infarction (First Heart Attack - of Specific Severity)
- Open Chest CABG
- Open Heart Replacement or Repair of Heart Valves
- Coma of Specified Severity
- Kidney Failure Requiring Regular Dialysis
- Stroke Resulting in Permanent Symptoms
- Major Organ/ Bone Marrow Transplant
- Permanent Paralysis of Limbs
- Motor Neuron Disease with Permanent Symptoms
- Multiple Sclerosis with Persisting Symptoms
- Primary Pulmonary Hypertension
- Aorta Graft Surgery
- Deafness (Loss of Hearing)
- Blindness (Loss of Sight)
- Aplastic Anaemia
- Coronary Artery Disease
- End Stage Lung Disease
- End Stage Liver Failure
- Third Degree Burns (Major Burns)
- Full thickness Burns
- Acute Liver Failure
- Alzheimer’s Disease
- Bacterial Meningitis
- Benign Brain Tumour
- Apallic Syndrome
- Parkinson’s Disease
- Medullary Cystic Disease
- Muscular Dystrophy
- Loss of Speech
- Systemic Lupus Erythematosus
- Loss of Limbs
- Major Head Trauma
- Brain Surgery
- Cardiomyopathy
- Creutzfeldt-Jacob Disease (CJD)
- Terminal Illness

Day Care Centre

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:-

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

In respect of US based admissions, this also includes Surgical Procedures carried out in the Medical Practitioner’s surgery.

Day Care Treatment

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

i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than 24 hours.

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

Deductible

Means is a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified currency amount in case of indemnity policies and for a specified number of days/hours, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Dental Treatment

Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Dentist

Dentist - a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided.

Dependent

Dependent means the member’s spouse or unmarried, civil/ contractual partner or child or parent who has been enrolled in the Policy.
Dependent Child
Dependent Child refers to a child (natural or legally adopted), who is under Age 25 years, either in full-time education or residing at the same residence as the member at the commencement of any treatment and is financially dependent on the member. For the purpose of coverage under this Policy, the Age limit for a Dependent child shall be 25 years, however with respect to coverage under specific sections separate Age limits shall be defined under the each Benefit.

Eligible Female
Eligible Female is a person who is a female member or a female Spouse or unmarried, civil/contractual partner of a member.

Emergency
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.

Emergency Care
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.

Employee
Employee means any member of Your staff who is proposed and sponsored by You who becomes an Insured Person.

Exclusions
Exclusions mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.

Grace Period
Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

HDU
HDU means the High Dependency Unit, an area in a Hospital, usually located closely to the ICU where patients can be cared for more extensively than a normal ward but not to the point of intensive care.

Hospital (India)
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 enactments of the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under enactments specified under the Schedule of Section 56 (1) of the said act Or complies with all minimum criteria as under:
- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the Insurance company’s authorized personnel.

Note: For the purpose of this Policy, a Hospital situated outside India shall refer to any equivalent institution organisation established for in-patient care and day care and treatment of injury or illness and which has been registered or licensed as a medical or surgical hospital or clinic as per the applicable law, rules and/or regulations in the country in which it is located and where the patient is under the care or supervision of a Medical Practitioner or Qualified Nurse and does not include a nursing home.

Hospitalization
Hospitalization 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.

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

Medical Advice
Medical Advice means any written consultation or advice for whom the insurance is proposed and the appropriate

Medical Assistance
Medical Assistance Service is a service which provides medical advice, evacuation, assistance and repatriation.

Medical Expenses
Medical Expenses means those expenses that an Insured Person incurs for medical treatment on account of illness or Injury 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.

Medical Practitioner
A Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or appropriate authority of the country where Insured Person is availing treatment outside India/ Country of origin and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

Medically Necessary
Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

Inception Date
Inception Date means the inception date of this Policy as specified in the Policy Schedule when the coverage under the Policy becomes effective for the Insured Persons and their dependents (if any).

Injury
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.

Medical Expenses
Medical Expenses means:
• medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
• Expenses towards lawful medical termination of pregnancy during the policy period.

Maternity Expense
Maternity Expense means:
- has qualified medical practitioner(s) in charge round the clock;
- maintains daily records of patients and makes these accessible to the Insurance company’s authorized personnel.

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

Medical Assistance
Medical Assistance Service is a service which provides medical advice, evacuation, assistance and repatriation. This service can be multi-lingual and assistance is available 24 hours per day.

Medical Expenses
Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Injury 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.

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

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

b. Chronic condition - A chronic condition is defined as a disease/ illness, or injury that has one or more of the following characteristics:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Inpatient Care
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.

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Medical Assistance Service is a service which provides medical advice, evacuation, assistance and repatriation. This service can be multi-lingual and assistance is available 24 hours per day.

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Medical Practitioner
A Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or appropriate authority of the country where Insured Person is availing treatment outside India/ Country of origin and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

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Medical Practitioner
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Medically Necessary
Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- Must have been prescribed by a medical practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
Minor Surgical Procedures and Associated Treatments are any surgical Treatments or Surgical Procedures that do not require a general anaesthetic or overnight Hospital stay, e.g. surgical treatment of an ingrown toe nail.

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.

New Born Baby means a baby born during the Policy Period and is aged upto 90 days.

Nominee means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased whereas the Beneficiary is not.

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

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

Out-Patient Policy means any policy which undergoes OPD treatment.

Out-Patient Policy comprises of Policy words, Certificates of Insurance issued to the Insured Persons, group Proposal Form/ Enrolment Form and Policy Schedule 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.

Policy Period means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the available Sum Insured under a Benefit or a set of Benefits, the Policy Period and the Sub-limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Policy Year means a period of 12 consecutive months within the Policy Period commencing from the Inception Date or any subsequent Policy anniversary.

Portability (Applicable only to India Cover) means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the Insured Person for pre-existing conditions and time bound exclusions if the Policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer.

Pre-Existing Disease means any condition, ailment or related condition(s) for which there were signs or symptoms, and / or was diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

Premium shall have to be paid in Indian Rupees and made in favour of ManipalCigna Health Insurance Company Ltd.

Private Room means a single occupancy accommodation in a private hospital.

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India; or is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided when outside of India.

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.

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

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

Minor Surgical Procedures and Associated Treatments

Network Provider

New Born Baby

Nominee

Non-Network Provider

OPD treatment

Out-Patient Policy

Policy Period

Policy Schedule

Policy Year

Portability (Applicable only to India Cover)

Pre-Existing Disease

Premium

Private Room

Qualified Nurse

Reasonable and Customary Charges

Renewal

Room Rent

Service Partner

Specialist

Sub Limit

Sum Insured

Surgery or Surgical Procedure

Surgical appliance and/or Medical Appliance:

TPA

Unproven/ Experimental Treatment

We/Our/Us

You/Your/Policyholder

III. Benefits under the Policy

The Certificate of Insurance will specify which Benefits are in force for the Insured Person during the Period of Insurance. Claims made under any applicable Benefit, for the Period of Insurance will be subject to the terms, conditions and exclusions of this Policy, the availability of the Sum Insured for that Benefit, any applicable Sub-Limits and subject alone to the availability of the aggregate limit of the Policy (if applicable and specified in the Policy Schedule/Certificate of Insurance). Claims will be payable in excess of the applicable Deductible specified in the Policy Schedule/ Certificate of Insurance, if any. Where an event qualifies for an indemnity under more than one Benefit with respect to the same risk insured event the Insured Person will be entitled for reimbursement under one of the Benefits.

All claims paid under the Policy will impact the Sum Insured available under the Policy for that Benefit or set of Benefits. All claims on a Cashless Facility basis must be made in accordance with the procedure set out in Section VII. 4, and all reimbursement claims must be made in accordance with the procedure set out in Section VII. 5, unless specified otherwise.

A claim is payable subject to occurrence of a covered event during the Policy Period unless specified otherwise.

A. Base Covers

BASE 1 (Mandatory)

1. In-patient Hospitalization and Day Care

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment at a Hospital, for more than 24 consecutive hours/ Day Care, arising from an injury due to an Accident or an illness contracted during the Policy Period, up to the Sum Insured specified under the Policy Schedule/ Certificate of Insurance:

- Room charges up to:
ICU or for shifting the Insured Person from one Hospital to another Hospital for better
shifting an Insured Person to the Hospital for admission in the Emergency ward or
We will pay the Reasonable and Customary Charges for costs incurred towards
2. Private Ambulance

VII 4 & 5.

Wherever Deductible is opted under any Optional Cover, the opted amount of
under Base and/or Optional Covers.

1. Co-pay

We will pay the Reasonable and Customary Charges for the following Out-Patient
BASE 2
expenses, in respect of an Insured Person, arising from an injury due to an Accident or
an Illness contracted during the Policy Period, if opted and specified under the Policy Schedule/ Certificate of Insurance.

i. Consultations with Medical Practitioners and Specialists;

2. Initial Waiting period for Hospitalization

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to:

A. Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person
since the Inception Date of the first Policy or coverage for the Insured Person and
claims shall be assessed accordingly.

1. Pre-existing Diseases Waiting Period

A Waiting Period specified in the Policy Schedule or Certificate of Insurance shall apply to all Pre-Existing Diseases/ Illness / Injury / conditions for each Insured Person.

2. Specific Illness Waiting period

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to:

i. Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps /internal tumors/
diseases,
i. only if cover Base 1 is opted under the Policy.

2. Initial Waiting Period for Hospitalization

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to:

2. Initial Waiting Period for Hospitalization

A Waiting Period specified in the Policy Schedule/ Certificate of Insurance shall apply to:

V. Waiting Period & Permanent Exclusions

A. Temporary Exclusions

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

1. Permanent Exclusions

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

2. Deductible

The Deductible will apply to all indemnity claims made under the Base Covers as well as
Optional Covers available under the Policy. If the Co-pay is in force, We will be liable
to pay only the difference percentage of the admissible claim amount that We assess
for the payment in respect of the Policy and the balance opted Co-pay percentage shall
be borne by the Insured Person.

The Policy Schedule/ Certificate of Insurance will specify the applicable Co-pay under
Base and/or Optional Covers.

Wherever Co-pay is opted under any Optional Cover, the opted percentage of Co-pay
shall be applicable for the Optional Cover and the Co-pay opted under the Base Cover
shall not be applicable for such Cover.

2. Deductible

The Deductible will apply to all indemnity claims, made under Base as well as Optional
Covers. If the Deductible is in force, We will be liable to pay only the difference amount
of the admissible claim amount that We assess for the payment in respect of the Policy
and the balance opted Deductible amount shall be borne by the Insured Person.

The Policy Schedule/ Certificate of Insurance will specify the applicable Deductible
under Base and/or Optional Covers.

Wherever Deductible is opted under any Optional Cover, the opted amount of
Deductible shall be applicable for the Optional Cover and the Deductible opted under the
Base shall not be applicable for such Cover.

There are Optional covers available with the Policy. Refer Policy Terms & Conditions - Optional Covers annexed herewith for Optional Covers.
27. Any treatment for or in connection with non-medical counselling or
- other disorders which medically qualify as developmental disorders
- developmental language disorders
- developmental arithmetic disorders
- developmental reading disorders

26. Any treatment for or in connection with developmental disorders namely:
- non-Emergency, routine or minor medical problems, tests and exams where
- a condition which would allow for treatment at a future date convenient to
- medical care or services scheduled for the patient’s or provider’s convenience which are not considered an Emergency

25. Any treatment that arises from or is any way connected with Injury, sickness, or disablement as a result of taking part in a sporting activity on a professional or semi-professional basis, or solo scuba-diving or scuba diving at depths below 30 meters unless the diver is PADl (qualified or equivalent) for that depth. Injury caused while engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.

24. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

23. Any surgical and non-surgical treatment of obesity, including morbid obesity (unrelated to be life threatening) and weight control programs or complications thereof.

22. Any cosmetic or plastic surgery or cosmetic procedure that improves physical appearance, unless it is Medically Necessary for normal functioning of an organ or a body part or as a consequence of an Accident or Cancer or burns or specific disease of breast which itself would have been covered under the Policy.

21. Any surgical and non-surgical treatment of obesity, including morbid obesity (unrelated to be life threatening) and weight control programs or complications thereof.

20. Any expenses for ship-to-shore evacuations.

19. Any treatment for or in connection with non-medical counselling or activities for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

18. International services expenses for Emergency Repatriation and Evacuation for:
- non-Emergency, routine or minor medical problems, tests and exams where
- a condition which would allow for treatment at a future date convenient to
- medical care or services scheduled for the patient’s or provider’s convenience which are not considered an Emergency

17. Any form of non-emergency travel costs in respect of an Emergency Repatriation or Repatriation specifically payable under International Emergency Services, which is not specified in the Policy Schedule/ Certificate of Insurance or not incurred and applicable in advance by Us.

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

15. Injury caused whilst flying or taking part in aerial activities (including cabin) except as an authorised passenger in a regular scheduled airline or air charter company.

14. Injury caused indirectly or indirectly caused or contributed to whilst engaging in or taking part in war, warlike operations (whether war be declared or not or while carrying out army, naval or air services operations of any country), civil war or related activities, rebellion, act of foreign enemies, hostility or attacks by armed forces.

13. Any treatment to change the refraction of one or both eyes, including refractive keratotomy (RK) and photorefractive keratotomy (PRK).

12. Treatment of the Illness/Injury for which the Insured Person was Hospitalised.


10. Any claim relating to events occurring before the Inception Date or otherwise outside the Policy Period.

9. Any expenses incurred before a New Born baby.

8. Vitamin and tonics unless forming part of Treatment for Illness or Injury and prescribed by a Medical Practitioner.

7. Certifications / diagnosis / treatment from a person not registered as a Medical Practitioner under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he/she is licensed for, or any diagnosis or treatment that is not scientifically recognised.

6. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-cell Lymphotropic Virus type III (HTLV-III or HTLV-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants, Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof.

5. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis and any condition directly or indirectly caused by or associated with them.

4. Medical Expenses incurred towards the Insured Person when he/she is outside the Area of Cover specified under the Policy Schedule/ Certificate of Insurance.

3. Any treatment for or in connection with non-medical counselling or activities for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

2. Any claim relating to events occurring before the Inception Date or otherwise outside the Policy Period.

1. Any treatment received in convalescent homes, convalescent hospitals, sanatorium treatments, private duty nursing, respite care, rundown condition or where treatment will not result in recovery or restoration of the previous state of health.

0. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

30. Costs of Routine medical, eye examinations, cost of spectacles, laser Surgery for cosmetic purposes or corrective Surgeries or contact lenses,

29. Costs of Ear examinations, hearing tests

28. Costs of hearing aids or cochlear implants

27. Incidental costs including newspapers, taxi fares, telephone calls, guests’ meals and hotel accommodation

26. Costs for Non-Surgical & Minor Surgical Procedures & treatment conducted on Out-patient basis

25. Costs associated to palliative care or hospice care.

24. Expenses in respect of accompanying person including cost of accommodation.

23. Costs of Nurse visit at home to provide nursing services.

22. Any Illness or Hospitalization arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.

21. Any claim relating to events occurring before the Inception Date or otherwise outside the Policy Period.


19. Any External Congenital Anomalies or any consequence thereof.

18. Maternity, child birth natal care and any related expenses and any related complications, Medically Necessary termination of pregnancy, including any changes affecting other chronic conditions of the Insured Person as a result of the pregnancy. Pregnancy related counselling, cost of vitamins, supplements, and unrelated tests.

17. Any expenses incurred towards a New Born baby.

16. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-cell Lymphotropic Virus type III (HTLV-III or HTLV-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants, Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof.

15. Any sexual transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis and any condition directly or indirectly caused by or associated with them.

14. Any treatment received in convalescent homes, convalescent Hospitals, sanatorium Treatment, rehabilitation measures, private duty nursing, respite care, rundown condition or where treatment will not result in recovery or restoration of the previous state of health.

13. Any treatment for or in connection with non-medical counselling or activities for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

12. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

11. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

10. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

9. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

8. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

7. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

6. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

5. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

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1. Any treatment for or in connection with non-medical counselling or ancillary services for learning disabilities, developmental delays, autism or developmental disabilities or disorders eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).
is in force for the group. We will indemnify the Medical Expenses incurred in the applicable Area of Cover for the listed Benefits in respect of the Insured Person.

1. South Asia (Indian Sub-continent), Asian Middle East, African countries
2. Asia Pacific excluding Hong Kong, Singapore
3. Asia Pacific including Hong Kong, Singapore
4. India, Europe, Canada, Latin America and Caribbean island countries
5. Worldwide excluding United States
6. Worldwide including United States

For a specific group, the Area of Cover may be limited to any particular country or region which is a part of any one or a part of combination of above list of Area of Covers.

VII. Claims procedure

1. Condition Precedent

The fulfillment 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 by You/Insured Person, including complying with the following steps, shall be the Condition Precedent to the admissibility of a claim.

Completed claim forms and the necessary processing documents must be furnished to Us within the time specified by Us. If You/Insured Person fails to furnish this documentation within the time required shall not invalidate nor reduce any claim if You / Insured Person can satisfy Us that it was not reasonably possible for You/Insured Person to submit the forms/documents within such time.

Processing of claims for Cashless facility and/or for reimbursement and providing access to the Network Provider will be through Our Service Partners. Details of the Service Partners will be available on the health card issued by Us to the Insured Person as well as on Our website. The Service Partners provide access to domestic as well as global Network Providers and will facilitate claims for Cashless Facilities. The Service Partner may also support Us in assessing of reimbursement claims. In India the claims will be serviced by an approved Third Party Administrator (TPA) while all claims outside of India will be managed by a wholly owned non-insurance Cigna Corporation subsidiary that provides international medical assistance services.

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

2. Policy Holder’s / Insured Persons Duty at the time of Claim

The updated applicable list of Network Providers is available on Our website. Details of applicable Network Providers may also be obtained from Our call centre or contacting Our Service Partner. In advance of availing Cashless facilities from a Network Provider, the updated list may be checked to ensure that the Network Provider can provide a Cashless facility in respect of the treatment required for the Insured Person.

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

- Forthwith intimate, file and submit the Claim in accordance with the Claim Procedure defined under Section VII.3, VII.4, VII.5, as mentioned below.
- Follow the directions advice or guidance provided by a Medical Practitioner.
- If so requested by Us, 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.
- The Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- 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.

Claim Process

3. Claim Intimation

Upon the discovery or occurrence of an Illness /Injury or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

The following details are to be provided to Us / Our TPA / Our Service Partner at the time of intimation of Claim:

i) Policy Number
ii) Name of the Policyholder
iii) Name of the Insured Person in whose relation the Claim is being lodged
iv) Nature of Illness / Injury
v) Name and address of the attending Medical Practitioner and Hospital
vi) Date of Admission
vii) Any other information as requested by Us

4. Cashless Process

Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider for Illness / Injury or any other contingency that is covered under the Policy.

For all Cashless Facility pre-authorizations, Insured Person will, in any event, be required to settle all non-admissible expenses, expenses towards sub-limit, Co-Payment and / or Deductibles (if applicable), directly with the Hospital/ Network Provider.

Conditions -

- Cashless facility is available only at Our Network Providers.
- For availing Cashless facility, the Insured Person must present the health card as provided by Us, along with a valid photo identification proof Member ID/ Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by Us.

i. For Planned Hospitalization:

a. The Insured Person should approach the Network provider at least 3 days prior to the admission for Hospitalization.

b. The Network Provider will issue the request for authorization letter.

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

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

e. If the information provided in the request is sufficient to ascertain the authorization We shall issue the authorization Letter to the Network Provider. Wherever additional information or documents are required We will call for the same from the Network provider and upon satisfactory receipt of last necessary documents the authorization will be issued. All authorizations will be issued within a period of 6 hours from the receipt of last complete documents.

f. The authorization letter will include details of Amount Sanctioned, any specific limitation on the claim, any applicable sub-limits, Co-pays or Deductibles and non-payable items if applicable.

g. The authorization letter shall be valid only for period of 15 days from the date of issue of the authorization.

ii. In case of Emergency Hospitalization

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

b. The Network Provider shall forward the request for authorization within 48 hours of admission to the Hospital as per the process under VII.4 i. but not later than actual discharge from the Hospital.

c. It is agreed and understood that We may continue to discuss the Insured Person’s condition with the treating Medical Practitioner till it receives Our recommendations on eligibility of coverage for the Insured Person.

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

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

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

i. The Network Provider shall request Us for an enhancement of authorization limit as described under VII.4 c. Incl. copies 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 24 (twenty-four) hours of receiving the request for enhancement from Network Provider.

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 at Section VII.4 i. above.

At the time of discharge:

The Network Provider may forward a final request for authorization for any residual amount to Us along with the Insured Person’s discharge summary and the billing format in accordance with the process described at Section VII.4 i. above.

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

Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury as the case may be which are covered under the Policy. For all cashless authorizations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits, Co-Payments and Deductible (if applicable), directly with the Hospital.

Submission of Claim Documents:

The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us. The following claim documents should be submitted to us within 15 days from the date of discharge from Hospital –

a. Claim Form Duly Filled and Signed
b. Original pre-authorization request
c. Copy of pre-authorization approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original copy of consultations
5. Claim Reimbursement Process

a. Collection of Claim Documents

Wherever Insured Person has opted for a reimbursement of expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 90 days from the date of discharge from the Hospital. The Insured Person can obtain a claim form from any of Our branch offices or download a copy from Our website www.manipalcigna.com:

a. Original copy of consultations
b. Claim form duly completed and signed;
c. KYC documents (photo ID proof, address proof, recent passport size photograph) of patient
d. Hospital discharge summary;
e. Operation theatre notes (if applicable);
f. Hospital main bill;
g. Hospital break up of bill;
h. Original investigation reports, X Ray, MRI, CT Films, HPE, ECG;
i. Medical Practitioner’s reference slip for investigation;
j. Pharmacy bills;
k. MLC/FIR report/post mortem report, if applicable.

5. Claim Reimbursement Process

b. Submission of claim documents as specified in Section VII.5 a. above, then in addition to the documents mentioned above, reasons for such delay shall also be provided to Us in writing. We will condone delay on merit for delayed claims where the delay has been proved to be for reasons beyond Insured Person’s control.

6. Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents. Any deficiency of documents shall be intimated to Insured Person and the Network Provider, as the case may be within 5 days of their receipt.

b. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person of the same and every 10 (ten) days thereafter.

c. We will send a maximum of 3 (three) reminders following which We will send a closure letter.

d. We shall settle the claimable amount arrived post scrutinizing the claim documents excluding the deficiency intimated to You.

e. In case a reimbursement claim is received when a pre-authorization letter has been issued for the same claim, before approving such claim a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the all the dues in respect of the Insured Person have been settled with the Network Provider. Once such check and declaration is received from the Network Provider, the claim will be processed.

7. Claim Assessment

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

f. Original discharge/death summary;
g. Operation theatre notes (if any);
h. Original Hospital main bill and break-up of the bill;
i. Original investigation reports, X Ray, MRI, CT Films and HPE;
j. Medical Practitioner’s reference slips for investigations/pharmacy;
k. Original pharmacy bills, prescriptions, and invoices;
l. MLC/FIR report/post mortem report (if conducted).
m. Bills from registered service provider (Ambulance Cover)

The documents listed above will apply for claims in India, however for claims arising due to Hospitalization of Insured Person outside of India the requirements may vary based on the applicable agreements between the Service Partner and the Network Provider and any applicable provisions of local laws, regulations or rules. We may call for any additional documents as required based on the circumstances of the claim.

There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case 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 and Conditions.

We, at Our sole discretion, reserve the right to modify, add or restrict any Network Provider for Cashless facilities available under the Policy. Before availing the Cashless facility, You / Insured Person is required to check the applicable/latest list of Network Provider on the Company’s website or by calling Our call centre.

5. Claim Reimbursement Process

We shall settle or reject the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of the IRDAI (Protection of Policyholders’ interests) Regulations 2017 and the IRDAI (Health Insurance) Regulations, 2016. In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate (in India). However, where the circumstances of a claim warrant an investigation at Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle or reject the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days We shall be liable to pay interest at a rate 2% above the bank rate (in India) from the date of receipt of last necessary document to the date of payment of claim.

10. Settlement & Repudiation of a claim

We may allow a closed claim to be reopened depending on the validity and the circumstances of the claim.

9. Claims Investigation

We may investigate claims at Our own discretion to determine validity of a claim. Such investigation shall be concluded within 15 days from the date of assigning the claim for investigation and not later than 30 days from the date of receipt of last necessary document. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by Us.

11. Representation against Rejection

Where a rejection is communicated by Us, the Insured Person may, if so desired within 15 days from the date of receipt of the claims decision represent to Us for reconsideration of the decision.

12. Claims falling in 2 policy periods

Where a Hospitalization claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles & Co-pays for each Policy Period subject to limit of Sum Insured provided that You have renewed the Policy with Us for the subsequent year.

13. Payment Terms

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

b. If the 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 claims within India.

c. For Cashless Claims, the payment shall be made to the Network Provider where discharge shall be treated as full and final discharge of Liability under the Policy.

d. For Reimbursement Claims, the payment will be made to You/ the Insured Person. In the unfortunate event of an Insured Persons 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, whatever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

14. Wellness, Dental & Vision Benefit Claim

The Insured Person shall avail these Benefits as defined in “Policy Terms and Conditions” for all plans under Policies provided under Section L.12.3, 24.2 & 25, if so elected.

a. Submission of claim

Insured Person can send the Wellness 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.

b. Assessment of Claim Documents

We shall assess the claim documents and ascertain the admissibility of claim.
6. Eligibility

The Policy provides cover on an individual basis where each member has a separate Sum Insured. To be eligible for coverage under the plan, the Insured Person must be:

- A group member/ Employee of the Policyholder or non-employer group enrolled member where the group pertains to members/ Employees of a company.
- The minimum Age of entry for a member and Dependent spouse or unmarried, civil/contractual partner, parent, for entering into this policy is 18 years and the maximum Age of entry is 95 years. Dependent Children can be covered from day 1 of birth up to 25 years of Age.
- Premium will be charged for lifetime if the Insured Person is still employed with/ member of the Group and nominated for coverage.
- New Born Baby will be accepted for cover (subject to the limitations of the newborn benefit) from birth. Acceptance of New Born Baby as Insured Persons is subject to written notification within 30 days of birth and receipt of the agreed premium by Us within a further 30 days following notification.

It is clarified that for the purpose of availing this Policy, the Master Policyholder/ You shall ensure that the minimum number of Employees/members who will form a group under this Policy shall be 7 or as prescribed by the IRDAI from time to time.

This Policy shall be applicable in the Area’s of Cover specified in the Policy Schedule/ Certificate of Insurance.

7. Insured Person

Only those persons named as an Insured Person in the Policy Schedule/ Certificate of Insurance shall be covered under this Policy. Any person may be added as an Insured Person during the Policy Period after his application has been accepted by Us, additional Premium to be paid and We have issued an endorsement confirming the addition of such person as an Insured Person under this Policy.

8. Loading and/or exclusion

On change of the Insured Person’s risk profile or the parameters on which Premium is derived the coverage under this Policy may cease, unless specifically agreed by Us. However, in such cases, We may underwrite the case in line with the underwriting policy of the product.


The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate of Insurance. The Policy takes effect from the date of application to Us. The Policy Period commencing from the actual date of addition to the Policy. It being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the event of Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

10. No Construction Notice

Any knowledge or information of any circumstance or condition in relation to You/ the Insured Person in possession of any official of Us shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the Insured Persons from their duty of disclosure, irrespective of acceptance of Premium by the Us.

11. Geography

The geographical scope of this Policy applies to events limited to the Area(s) of Cover and which are specified in the Policy Schedule/ Certificate of Insurance.

12. Dispute Resolution & Applicable Law

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

13. Premium

The Premium payable under this Policy shall be paid in accordance with the Policy Schedule/ Certificate of Insurance, as agreed between You and Us. No receipt for Premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of Premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by You in so far as they relate to anything to be done or complied with by You shall be a Condition Precedent to Our liability under this Policy.

14. Period of Policy

The monetary limits applicable to this Policy will be expressed in the same currency specified in the Policy Schedule/ Certificate of Insurance. Claims paid in a local currency will be converted at the spot exchange rate on the date of payment of expenses.
17. Addition and Deletion of a Member

We shall include/exclude a group member/Employee of the Policyholder or non-employer group enrolled member or Dependent as an Insured Person under the Policy in accordance with the following procedure:

Additions

• Any person may be added to the Policy as an Insured Person during the Policy Year provided that the application for cover has been accepted by Us, additional premium on pro-rata basis applied on the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person.

Deletions

• Any Insured Person who is covered under the Policy may be deleted upon Your request during the Policy Year. Refund of premium can be made on pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/her Dependents.

Throughout the Policy Period, You will notify Us of all and any changes in the membership of the Policy in the same month in which the change occurs. However, We may commence or terminate cover retrospectively for Insured Persons for a period not exceeding 2 months from the date when You advise Us in writing.

All addition and deletions that lead to either additional Premium being applied will be generated at the time of addition of such employees/ members and/or Dependents and the same will be paid before the actual start date of the cover in respect of those employees/ members. In case of refund of premium being generated on the policy due to deletions the same will be refunded or adjusted against future Premium instalments due on the policy.

18. Changes to the terms and conditions of the Policy

We can end the Policy or change any of the terms and conditions relating to the Policy subject to IRDAI approval. If the Policy changes because of new laws, We will inform the Policyholders in all circumstances. We will give the following notices:

• for changes to the list of Benefits, at least 90 days’ notice in writing if allowed as per IRDAI.
• for changes to the Policy terms and conditions, or ending the policy, at least 90 days’ notice in writing. The change will take place, failing which the Policy will end on the next annual renewal.

You further understand and agree that We may cancel the Policy by giving 15 days’ notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, fraud, non-disclosure of material fact or for non-co-operation by You/Insured Person without any refund of premium.

19. Multiple Policies

i. In case of multiple policies which provide fixed benefits, on occurrence of the insured event in accordance with the terms and conditions of the Policies, We shall make the claim payments independent of payments received under similar policies.

ii. If two or more policies are taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases where We have issued the chosen Policy, We shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

2. Claims under other Policies may be made irrespective of the exhaustion of Sum Insured in the earlier chosen Policy / policies.

3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

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

20. Nominee

The Insured Person can, on the Inception Date or at any time before the expiry of the Policy make a nomination for the purpose of payment of claims, in accordance with the provisions of Section 39 of the Insurance Act 1938, as amended from time to time.

Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement to the Policy is made by Us.

21. No Constructive Notice

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

22. Contribution

If at the time when any claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same claim (in whole or in part), then We shall not be liable to pay or contribute more than its rateable proportion of any Claim. This clause does not apply to Benefit sections.

Details of applicability towards Contribution are detailed below.

If the Insured Person is covered under two of more policies during the same period from one or more insurers to indemnify treatment costs and the amount of claim is within the Sum Insured limit of any of the policies, the Insured Person will have the right to opt for a full settlement of their claim in terms of any of the policies under which the Insured Person is covered.

Where the amount to be claimed exceeds the Sum Insured under a single policy after considering Deductibles, Co-pays (if applicable), the Insured Person can choose the insurer with which they would like to settle the claim.

Wherever We receive such claims We will have the right to apply the Contribution clause while settling the claim.

23. Subrogation

You and/or any Insured Person will do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Us for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which We are/ or would become entitled upon Us making any payment of a Claim under this Policy, whether such acts or things shall be or shall not be the necessary or reasonable conditions to any payment. Neither You nor any Insured Person shall prejudice these subrogation rights in any manner and provide Us with whatever assistance or cooperation is required to enforce such rights. Any recovery that We make pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and any costs and expenses incurred by Us for effecting a recovery, whereafter We shall pay any balance remaining to the Insured Person. This Section does not apply to Benefit sections.

24. Grace Period & Renewal

The Policy may be renewed by mutual consent and in such event the Premium payable on Renewal of the Policy 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 or from the date of next instalment due date. 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, 1938 shall be applicable.

All renewals within the Grace Period shall be eligible for continuity of cover.

We shall not be bound to give notice that such Premium on Renewal is due. A Policy shall be ordinarily renewable unless any fraud, moral hazard, misrepresentation or non-cooperation by the Insured Person or on his behalf is found either in obtaining insurance or in subsequently in relation thereto.

Where such behaviour has been noticed by an individual employee/ member We will terminate cover for the specific employee/ member and his/her Dependents including further Renewals and the cover for the remaining group members will continue. Where it is found that the Policyholder is involved in such above situations, the complete Policy will be terminated.

Revival Period:

Instalment (less than annual) premium policies may be revived by mutual consent and in such event the Revival premium should be paid to Us within 15 days of the instalment due date. Wherever Premiums are not received within the revival period, the Policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the policy. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policies.

Renewal Terms

Alterations like increase/ decrease in Sum Insured or Optional Covers, can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy.

Where We have discontinued or withdrawn this product/plan or where You will not be allowed to renew as You have moved out of the Group, You will have the option to renew under the nearest substitute Policy being issued by Us, provided Benefits payable shall be subject to the terms contained in such other policy which has been approved by the IRDAI.

We may in Our sole discretion, revise the Premiums payable under the Policy or the terms of cover, provided that all such changes are approved by the IRDAI and are in accordance with the IRDAI rules and regulations as applicable from time to time.

25. Cancellation

Request for Cancellation shall be intimated to Us from Your side by giving 15 days’ notice in which case We shall refund the Premium for the unexpired Policy Period as per the short period scale mentioned below.

Premium shall be refunded only if no claim has been made under the Policy.

<table>
<thead>
<tr>
<th>Policy Period</th>
<th>1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy in Force Upto</td>
<td>Premium Refund %</td>
</tr>
<tr>
<td>30 days</td>
<td>75%</td>
</tr>
<tr>
<td>90 days</td>
<td>50%</td>
</tr>
<tr>
<td>180 days</td>
<td>25%</td>
</tr>
<tr>
<td>181 days and more</td>
<td>Nil</td>
</tr>
</tbody>
</table>

For instalment Premium, We will refund Premium on pro-rata basis after deducting Our expenses.

You further understand and agree that We may cancel the Policy by giving 15 days’ notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, fraud, non-disclosure of material fact or for non-co-operation by You / Insured Person without any refund of Premium.

26. Our Right of Termination

Prior to the termination of the Policy at the expiry of the Policy Period shown in the Policy Schedule, cover will end immediately for all Insured Persons, if:

• If you do not pay the Premiums owed under the Policy within the Grace Period. If the insured person is a non-Indian National returning to their country of domicile member will be

for coverage under the applicable Policy for coverage until the end of the Policy or earlier if specifically terminated by the employer.
there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of Premium, by giving 15 days’ notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

b. there is non-cooperation by You/ Insured Person, with refund of Premium on pro rata basis after deducting Our expenses, by giving 15 days’ notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If treatment has been authorised or a cashless approval has been issued, We will not be held responsible for any treatment costs if the Policy ends or an employee/ member or Dependent leaves group or if the policy is no longer in force, before treatment has taken place. However, We will be liable to pay in respect of all claims where the treatment/admission has commenced before date of termination of such policy.

31. Endorsements

The Policy will allow the following endorsesments during the Policy Year. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later other than for change in date of birth or gender which will be with effect from the Inception Date.

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

Rectification in name of the proposer/ policyholder / Insured Person.
Rectification in gender of the proposer/ policyholder / Insured Person.
Rectification in relationship of the Insured Person with the proposer/ policyholder.
Rectification of date of birth of the insured Person (if this does not impact the premium).
Change in the correspondence address of the proposer/ policyholder / Insured Person.
Change/update in the contact details viz., phone number, E-mail ID, etc.
Update of alternate contact address of the proposer/ policyholder / Insured Person.
Change in Nominee details.
Addition/ Deletion/ updation of GSTIN.
Change in occupation (if this does not impact the premium)
Change/ rectification in Account number.
Change of Policyholder.

b) Financial Endorsements – which result in alteration in premium.

Deletion of Insured Person on death if no claims are paid / outstanding.
Deletion of Insured Person.
Rectification of date of birth of the Insured Person.
Addition of member (New Born Baby/ Newly wedded spouse/ partner).
Addition of member.
Rectification in the correspondence address of the Proposer/ Policyholder / Insured Person.
Rectification in gender of the Proposer/ Policyholder / Insured Person.
Change of Policyholder.
Change in occupation.

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

32. Electronic Transactions

The Insured Person agrees to adhere to the terms and conditions and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication network or by or on behalf of Us for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

These terms and conditions shall be within the approved Policy Terms and Conditions. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI (Protection of Policyholders Interests) Regulations 2017, as may be amended from time to time. All conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form, all necessary disclosures on terms, conditions and major exclusions shall be made known to the Insured Person.

33. Communications & Notices

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

a. You/ Insured Person, at the address as specified in Policy Schedule/ Certificate of Insurance.

b. To Us, at Our address specified in the Policy Schedule/ Certificate of Insurance.

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.

34. Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment (unless assigned by the Policyholder) or other dealing with or relating to this Policy. The payment made by Us to You/ Insured Person or to their Nominee/ legal representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.
35. **Grievances Redressal Procedure**

If You/Insured Person may have a grievance that requires to be redressed, You/Insured Person may contact Us with the details of the grievance through:

- Our website: www.manipalcigna.com
- Email: servicesupport@manipalcigna.com
- Toll Free: 1800-102-4462

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

You/Insured Person may also approach the grievance cell at any of Our branches with the details of the grievance during Our working hours from Monday to Friday.

If You/Insured Person are not satisfied with Our redressal of Your grievance through one of the above methods, You/Insured Person may contact Our Head of Customer Service at The Grievance Cell, ManipalCigna Health Insurance Company Limited (Formerly known as CignaTTK Health Insurance Company Limited) Reg.Office:401/402,4th Floor, Raheja Titanium, Off Western Express Highway, Goregoan (East), Mumbai- 400 063 or email - headcustomercare@manipalcigna.com or call us at 1800-102-4462 or call at +91 22 6170 3600

If You/Insured Person are not satisfied with Our redressal of grievance through one of the above methods, You/Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

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

36. **Anti-Corruption**

Notwithstanding any provision in this Policy or otherwise, it is agreed that We shall have no liability or obligation where We reasonably believe such would violate any applicable law, regulation or order, including but not limited to, anti-corruption laws and programs imposing financial sanctions on targeted individuals, entities, or nations, including (without limitation) any relevant (1) resolution of the United Nations Security Council and/or any implementation thereof in any jurisdiction, (2) law, regulation, and/or order administered by the Department of Treasury of the United States of America, and/or (3) regulation issued by the European Council and/or any implementation thereof in any jurisdiction. We shall have no liability or obligation and this Policy shall, at Our election, be deemed void where any actions in furtherance of the Policy is prohibited. Furthermore, We are under no obligation to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws. Furthermore, We shall not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United States Department of Treasury’s Office of Foreign Assets Control, or the United Nations Security Council Sanctions Committees.
<table>
<thead>
<tr>
<th>CONTACT DETAILS</th>
<th>JURISDICTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHMEDABAD</strong></td>
<td>Gujarat, Dadra &amp; Nagar Haveli, Daman and Diu.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg., Tita Marg, Relief Road, Ahmedabad-380 001, Tel.: 079-25501201/02/05/06 Email: <a href="mailto:bimalokpal.ahmedabad@ecoi.co.in">bimalokpal.ahmedabad@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>BENGALURU</strong></td>
<td>Karnataka.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Jeevan Soudha Bldg., P.I.D No. 57-57-19-19, 4th Floor, 8th Main Road, JP Nagar, 1st Phase Bengaluru – 560 078, Tel.: 080-26652048/26652049 Email: <a href="mailto:bimalokpal.bengaluru@ecoi.co.in">bimalokpal.bengaluru@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>BHPAL</strong></td>
<td>Madhya Pradesh and Chattisgarh.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Janak Vilas Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003, Tel.: 0755-2769201/202 Fax: 0755-2769203 Email: <a href="mailto:bimalokpal.bhopal@ecoi.co.in">bimalokpal.bhopal@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>BHUBANESHWAR</strong></td>
<td>Orissa.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018, Tel.: 044-24333668/24335284 Fax: 044-24333664 Email: <a href="mailto:bimalokpal.chennai@ecoi.co.in">bimalokpal.chennai@ecoi.co.in</a></td>
<td>Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).</td>
</tr>
<tr>
<td><strong>CHANDIGARH</strong></td>
<td>Punjab, Haryana, Himachal Pradesh, Jammu &amp; Kashmir and Chandigarh.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, S.C.O. No. 101, 102 &amp; 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017, Tel.: 0172-2706196/6468 Fax: 0172-2708274 Email: <a href="mailto:bimalokpal.chandigarh@ecoi.co.in">bimalokpal.chandigarh@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>CHENNAI</strong></td>
<td>Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002, Tel.: 011-23232481/23213504 Email: <a href="mailto:bimalokpal.delhi@ecoi.co.in">bimalokpal.delhi@ecoi.co.in</a></td>
<td>Delhi.</td>
</tr>
<tr>
<td><strong>GUWAHATI</strong></td>
<td>Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 6-2-46,1st Floor,&quot;Moin Court&quot;,Lane Opp Saleem Function Palace, A. C. Guards, Lakdi ka Pool, Hyderabad – 500 004 Tel.: 040-67504123/23312122 Fax: 040-23376599 Email: <a href="mailto:bimalokpal.hyderabad@ecoi.co.in">bimalokpal.hyderabad@ecoi.co.in</a></td>
<td>Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.</td>
</tr>
<tr>
<td><strong>HYDERABAD</strong></td>
<td>Rajasthan.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005, Tel.: 0141-2740363 Email: <a href="mailto:bimalokpal.jaipur@ecoi.co.in">bimalokpal.jaipur@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>ERNAKULAM</strong></td>
<td>Kerala, Lakshadweep, Mahé-a part of Union Territory of Pondicherry.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 2nd Floor, Pulinath Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015, Tel.: 0484-2358759/9338 Fax: 0484-2359336 Email: <a href="mailto:bimalokpal.ernakulam@ecoi.co.in">bimalokpal.ernakulam@ecoi.co.in</a></td>
<td>West Bengal, Sikkim, and Andaman and Nicobar Islands.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Hindustan Bldg. Annexure, 4, C. R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email: <a href="mailto:bimalokpal.kolkata@ecoi.co.in">bimalokpal.kolkata@ecoi.co.in</a></td>
<td>North Bengal, Varanasi, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</td>
</tr>
<tr>
<td><strong>LUCKNOW</strong></td>
<td>Goa, Mumbai Metropolitan Region excluding Navi Mumbai &amp; Thane</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhavan, Phase-II, Naval Kishore Road, Hazratganj, Lucknow-226 001, Tel.: 0522-2231330/1 Fax: 0522-2231310 Email: <a href="mailto:bimalokpal.lucknow@ecoi.co.in">bimalokpal.lucknow@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054, Tel.: 022-26106552/26960 Fax: 022-26106552 Email: <a href="mailto:bimalokpal.mumbai@ecoi.co.in">bimalokpal.mumbai@ecoi.co.in</a></td>
<td>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</td>
</tr>
<tr>
<td><strong>NOIDA</strong></td>
<td></td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.Tel:0120-2154250 / 2154251 / 2154253 Email: <a href="mailto:bimalokpal.noida@ecoi.co.in">bimalokpal.noida@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>PATNA</strong></td>
<td></td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Bldg., Bazar Samiti Road, Bahadurpur, Patna 800006, Tel: 0612-2680952 Email: <a href="mailto:bimalokpal.patna@ecoi.co.in">bimalokpal.patna@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td><strong>PUNE</strong></td>
<td></td>
</tr>
<tr>
<td>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.: 020-41312555 Email: <a href="mailto:bimalokpal.pune@ecoi.co.in">bimalokpal.pune@ecoi.co.in</a></td>
<td></td>
</tr>
</tbody>
</table>
### Annexure II – Non Medical Expenses

<table>
<thead>
<tr>
<th>SNO</th>
<th>List of Expenses Generally Excluded (“Non-Medical”) in Hospital Indemnity Policy</th>
<th>SUGGESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>HAIR REMOVAL CREAM</td>
<td>Not Payable</td>
</tr>
<tr>
<td>2</td>
<td>BABY CHARGES (UNLESS SPECIFIED/INDICATED)</td>
<td>Not Payable</td>
</tr>
<tr>
<td>3</td>
<td>BABY FOOD</td>
<td>Not Payable</td>
</tr>
<tr>
<td>4</td>
<td>BABY UTILITITES CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>5</td>
<td>BABY SET</td>
<td>Not Payable</td>
</tr>
<tr>
<td>6</td>
<td>BABY BOTTLES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>7</td>
<td>BRUSH</td>
<td>Not Payable</td>
</tr>
<tr>
<td>8</td>
<td>COSY TOWEL</td>
<td>Not Payable</td>
</tr>
<tr>
<td>9</td>
<td>HAND WASH</td>
<td>Not Payable</td>
</tr>
<tr>
<td>10</td>
<td>MOISTURISER PASTE BRUSH</td>
<td>Not Payable</td>
</tr>
<tr>
<td>11</td>
<td>POWDER</td>
<td>Not Payable</td>
</tr>
<tr>
<td>12</td>
<td>RAZOR</td>
<td>Payable</td>
</tr>
<tr>
<td>13</td>
<td>SHOE COVER</td>
<td>Not Payable</td>
</tr>
<tr>
<td>14</td>
<td>BEAUTY SERVICES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>15</td>
<td>BELTS/ BRACES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>16</td>
<td>BUDS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>17</td>
<td>BARBER CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>18</td>
<td>CAPS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>19</td>
<td>COLD PACK/HOT PACK</td>
<td>Not Payable</td>
</tr>
<tr>
<td>20</td>
<td>CARRY BAGS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>21</td>
<td>CRADLE CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>22</td>
<td>COMB</td>
<td>Not Payable</td>
</tr>
<tr>
<td>23</td>
<td>DISPOSABLES RAZORS CHARGES (for site preparations)</td>
<td>Payable</td>
</tr>
<tr>
<td>24</td>
<td>EAU-DE-COLOGNE / ROOM FRESHNERS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>25</td>
<td>EYE PAD</td>
<td>Not Payable</td>
</tr>
<tr>
<td>26</td>
<td>EYE SHEILD</td>
<td>Not Payable</td>
</tr>
<tr>
<td>27</td>
<td>EMAIL / INTERNET CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>28</td>
<td>FOOD CHARGES (OTHER THAN PATIENT’S DIET PROVIDED BY HOSPITAL)</td>
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<tr>
<td>29</td>
<td>FOOT COVER</td>
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<tr>
<td>30</td>
<td>GOWN</td>
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<td>31</td>
<td>LEGGINGS</td>
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<tr>
<td>32</td>
<td>LAUNDRY CHARGES</td>
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<td>33</td>
<td>MINERAL WATER</td>
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<tr>
<td>34</td>
<td>OIL CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>35</td>
<td>SANITARY PAD</td>
<td>Not Payable</td>
</tr>
<tr>
<td>36</td>
<td>SLIPPERS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>37</td>
<td>TELEPHONE CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>38</td>
<td>TISSUE PAPER</td>
<td>Not Payable</td>
</tr>
<tr>
<td>39</td>
<td>TOOTH PASTE</td>
<td>Not Payable</td>
</tr>
<tr>
<td>40</td>
<td>TOOTH BRUSH</td>
<td>Not Payable</td>
</tr>
<tr>
<td>41</td>
<td>GUEST SERVICES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>42</td>
<td>BED PAN</td>
<td>Not Payable</td>
</tr>
<tr>
<td>43</td>
<td>BED UNDER PAD CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>44</td>
<td>CAMERA COVER</td>
<td>Not Payable</td>
</tr>
<tr>
<td>45</td>
<td>CLINIPLAST</td>
<td>Not Payable</td>
</tr>
<tr>
<td>46</td>
<td>CREPE BANDAGE</td>
<td>Not Payable/ Payable by the patient</td>
</tr>
<tr>
<td>Item Description</td>
<td>Payable/Not Payable</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>CURAPORE</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>DIAPER OF ANY TYPE</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>DVD, CD CHARGES</td>
<td>Not Payable (However if CD is specifically sought by Insurer/TPA then payable)</td>
<td></td>
</tr>
<tr>
<td>EYELET COLLAR</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>FACE MASK</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>FLEXI MASK</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>GAUSE SOFT</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>GAUZE</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>HAND HOLDER</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>HANSAPLAST/ADHESIVE BANDAGES</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>INFANT FOOD</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>SLINGS</td>
<td>Reasonable costs for one sling in case of upper arm fractures should be considered</td>
<td></td>
</tr>
<tr>
<td>WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>HOME VISIT CHARGES</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>DONOR SCREENING CHARGES</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>ADMISSION/REGISTRATION CHARGES</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE</td>
<td>Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>EXPENSES FOR INVESTIGATION/TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED</td>
<td>Not Payable - Exclusion in policy unless otherwise specified</td>
<td></td>
</tr>
<tr>
<td>STEM CELL IMPLANTATION/ SURGERY and STORAGE</td>
<td>Not Payable except Bone Marrow Transplantation where covered by policy</td>
<td></td>
</tr>
<tr>
<td>WARD AND THEATRE BOOKING CHARGES</td>
<td>Payable under OT Charges, not payable separately</td>
<td></td>
</tr>
<tr>
<td>ARTHROSCOPY &amp; ENDOSCOPY INSTRUMENTS</td>
<td>Rental charged by the hospital payable. Purchase of Instruments not payable.</td>
<td></td>
</tr>
<tr>
<td>MICROSCOPE COVER</td>
<td>Payable under OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>SURGICAL BLADES;HARMONIC SCALPEL,SHAVER</td>
<td>Payable under OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>SURGICAL DRILL</td>
<td>Payable under OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>EYE KIT</td>
<td>Payable under OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>EYE DRAPE</td>
<td>Payable under OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>X-RAY FILM</td>
<td>Payable under Radiology Charges, not as consumable</td>
<td></td>
</tr>
<tr>
<td>SPUTUM CUP</td>
<td>Payable under Investigation Charges, not as consumable</td>
<td></td>
</tr>
<tr>
<td>BOYLES APPARATUS CHARGES</td>
<td>Part of OT Charges, not separately</td>
<td></td>
</tr>
<tr>
<td>BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES</td>
<td>Part of Cost of Blood, not payable</td>
<td></td>
</tr>
<tr>
<td>ANTISEPTIC or DISINFECTANT LOTIONS</td>
<td>Not Payable - Part of Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES</td>
<td>Not Payable - Part of Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>COTTON</td>
<td>Not Payable - Part of Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>COTTON BANDAGE</td>
<td>Not Payable - Part of Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>MICROPORE/ SURGICAL TAPE</td>
<td>Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>BLADE</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>APRON</td>
<td>Not Payable - Part of Hospital Services/ Disposable linen to be part of OT/ICU charges</td>
<td></td>
</tr>
<tr>
<td>TORNIOQUET</td>
<td>Not Payable (service is charged by hospitals, consumables can not be separately charged)</td>
<td></td>
</tr>
<tr>
<td>ORTHOBUNDLE, Gynaec Bundle</td>
<td>Part of Dressing Charges</td>
<td></td>
</tr>
<tr>
<td>URINE CONTAINER</td>
<td>Not Payable</td>
<td></td>
</tr>
<tr>
<td>LUXURY TAX</td>
<td>Actual tax levied by government is payable. Part of room charge for sub limits</td>
<td></td>
</tr>
<tr>
<td>HVAC</td>
<td>Part of room charge not payable separately</td>
<td></td>
</tr>
<tr>
<td>HOUSE KEEPING CHARGES</td>
<td>Part of room charge not payable separately</td>
<td></td>
</tr>
<tr>
<td>SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED</td>
<td>Part of room charge not payable separately</td>
<td></td>
</tr>
</tbody>
</table>

ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Payable/Not Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES</td>
<td>Exclusion in policy unless otherwise specified</td>
</tr>
<tr>
<td>COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.</td>
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<td>Not Payable except Bone Marrow Transplantation where covered by policy</td>
</tr>
</tbody>
</table>

ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Payable/Not Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>WARD AND THEATRE BOOKING CHARGES</td>
<td>Payable under OT Charges, not payable separately</td>
</tr>
<tr>
<td>ARTHROSCOPY &amp; ENDOSCOPY INSTRUMENTS</td>
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<td>Payable under OT Charges, not separately</td>
</tr>
<tr>
<td>EYE DRAPE</td>
<td>Payable under OT Charges, not separately</td>
</tr>
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<td>SPUTUM CUP</td>
<td>Payable under Investigation Charges, not as consumable</td>
</tr>
<tr>
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<td>Part of OT Charges, not separately</td>
</tr>
<tr>
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</tr>
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</tr>
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<td>Part of Dressing Charges</td>
</tr>
<tr>
<td>URINE CONTAINER</td>
<td>Not Payable</td>
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</table>

ELEMENTS OF ROOM CHARGE

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Payable/Not Payable</th>
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</thead>
<tbody>
<tr>
<td>LUXURY TAX</td>
<td>Actual tax levied by government is payable. Part of room charge for sub limits</td>
</tr>
<tr>
<td>HVAC</td>
<td>Part of room charge not payable separately</td>
</tr>
<tr>
<td>HOUSE KEEPING CHARGES</td>
<td>Part of room charge not payable separately</td>
</tr>
<tr>
<td>SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED</td>
<td>Part of room charge not payable separately</td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>92</td>
<td>TELEVISION &amp; AIR CONDITIONER CHARGES</td>
</tr>
<tr>
<td>93</td>
<td>SURCHARGES</td>
</tr>
<tr>
<td>94</td>
<td>ATTENDANT CHARGES</td>
</tr>
<tr>
<td>95</td>
<td>IM IV INJECTION CHARGES</td>
</tr>
<tr>
<td>96</td>
<td>CLEAN SHEET</td>
</tr>
<tr>
<td>97</td>
<td>EXTRADIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)</td>
</tr>
<tr>
<td>98</td>
<td>BLANKET/WARMER BLANKET</td>
</tr>
<tr>
<td>99</td>
<td>ADMINISTRATION OR NON-MEDICAL CHARGES</td>
</tr>
<tr>
<td>100</td>
<td>ADMISSION KIT</td>
</tr>
<tr>
<td>101</td>
<td>BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES</td>
</tr>
<tr>
<td>102</td>
<td>CERTIFICATE CHARGES</td>
</tr>
<tr>
<td>103</td>
<td>COURIER CHARGES</td>
</tr>
<tr>
<td>104</td>
<td>CONVENIENCE CHARGES</td>
</tr>
<tr>
<td>105</td>
<td>DIABETIC CHART CHARGES</td>
</tr>
<tr>
<td>106</td>
<td>DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES</td>
</tr>
<tr>
<td>107</td>
<td>DISCHARGE PROCEDURE CHARGES</td>
</tr>
<tr>
<td>108</td>
<td>DAILY CHART CHARGES</td>
</tr>
<tr>
<td>109</td>
<td>ENTRANCE PASS / VISITORS PASS CHARGES</td>
</tr>
<tr>
<td>110</td>
<td>EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE</td>
</tr>
<tr>
<td>111</td>
<td>FILE OPENING CHARGES</td>
</tr>
<tr>
<td>112</td>
<td>INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)</td>
</tr>
<tr>
<td>113</td>
<td>MEDICAL CERTIFICATE</td>
</tr>
<tr>
<td>114</td>
<td>MAINTENANCE CHARGES</td>
</tr>
<tr>
<td>115</td>
<td>MEDICAL RECORDS</td>
</tr>
<tr>
<td>116</td>
<td>PREPARATION CHARGES</td>
</tr>
<tr>
<td>117</td>
<td>PHOTOCOPIES CHARGES</td>
</tr>
<tr>
<td>118</td>
<td>PATIENT IDENTIFICATION BAND / NAME TAG</td>
</tr>
<tr>
<td>119</td>
<td>WASHING CHARGES</td>
</tr>
<tr>
<td>120</td>
<td>MEDICINE BOX</td>
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<tr>
<td>121</td>
<td>MORTUARY CHARGES</td>
</tr>
<tr>
<td>122</td>
<td>MEDICO LEGAL CASE CHARGES (MLC CHARGES)</td>
</tr>
<tr>
<td>123</td>
<td>EXTERNAL DURABLE DEVICES</td>
</tr>
<tr>
<td>124</td>
<td>WALKING AIDS CHARGES</td>
</tr>
<tr>
<td>125</td>
<td>BIPAP MACHINE</td>
</tr>
<tr>
<td>126</td>
<td>COMMODE</td>
</tr>
<tr>
<td>127</td>
<td>CPAP/ CPAP EQUIPMENTS</td>
</tr>
<tr>
<td>128</td>
<td>INFUSION PUMP - COST</td>
</tr>
<tr>
<td>129</td>
<td>OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)</td>
</tr>
<tr>
<td>130</td>
<td>PULSEOXYMETER CHARGES</td>
</tr>
<tr>
<td>131</td>
<td>SPACER</td>
</tr>
<tr>
<td>132</td>
<td>SP 02 PROBE</td>
</tr>
<tr>
<td>133</td>
<td>NEBULIZER KIT</td>
</tr>
<tr>
<td>134</td>
<td>STEAM INHALER</td>
</tr>
<tr>
<td>135</td>
<td>ARMSLING</td>
</tr>
<tr>
<td>136</td>
<td>THERMOMETER</td>
</tr>
<tr>
<td>137</td>
<td>CERVICAL COLLAR</td>
</tr>
<tr>
<td>138</td>
<td>SPLINT</td>
</tr>
<tr>
<td>139</td>
<td>DIABETIC FOOT WEAR</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>140</td>
<td>KNEE BRACES (LONG/ SHORT/ HINGED)</td>
</tr>
<tr>
<td>141</td>
<td>KNEE IMMOBILIZER/SHOULDER IMMOBILIZER</td>
</tr>
<tr>
<td>142</td>
<td>LUMBOSACRAL BELT</td>
</tr>
<tr>
<td>143</td>
<td>NIMBUS BED OR WATER OR AIR BED CHARGES</td>
</tr>
<tr>
<td>144</td>
<td>AMBULANCE COLLAR</td>
</tr>
<tr>
<td>145</td>
<td>AMBULANCE EQUIPMENT</td>
</tr>
<tr>
<td>146</td>
<td>MICROSEILD</td>
</tr>
<tr>
<td>147</td>
<td>ABDOMINAL BINDER</td>
</tr>
</tbody>
</table>

**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Payable Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>148</td>
<td>BETADINE / HYDROGEN PEROXIDE/ SPIRIT/ DSINFECTANTS ETC</td>
<td>May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital</td>
</tr>
<tr>
<td>149</td>
<td>PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES</td>
<td>Post hospitalization nursing charges not Payable</td>
</tr>
<tr>
<td>150</td>
<td>NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES</td>
<td>Patient Diet provided by hospital is payable</td>
</tr>
<tr>
<td>151</td>
<td>SUGAR FREE Tablets</td>
<td>Payable - Sugar free variants of admissible medicines are not excluded</td>
</tr>
<tr>
<td>152</td>
<td>CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>153</td>
<td>Digestion gels</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>154</td>
<td>ECG ELECTRODES</td>
<td>Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.</td>
</tr>
<tr>
<td>155</td>
<td>GLOVES</td>
<td>Sterilized Gloves payable / unsterilized gloves not payable</td>
</tr>
<tr>
<td>156</td>
<td>HIV KIT</td>
<td>Payable - payable Pre-operative screening</td>
</tr>
<tr>
<td>157</td>
<td>LISTERINE/ANTISEPTIC MOUTHWASH</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>158</td>
<td>LOZENGES</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>159</td>
<td>MOUTH PAINT</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>160</td>
<td>NEBULISATION KIT</td>
<td>If used during hospitalization is payable reasonably</td>
</tr>
<tr>
<td>161</td>
<td>NOVARAPID</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>162</td>
<td>VOLINI GEL/ ANALGESIC GEL</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>163</td>
<td>ZYTEE GEL</td>
<td>Payable when prescribed</td>
</tr>
<tr>
<td>164</td>
<td>VACCINATION CHARGES</td>
<td>Routine Vaccination not Payable / Post Bite Vaccination Payable</td>
</tr>
</tbody>
</table>

**PART OF HOSPITAL’S OWN COSTS AND NOT PAYABLE**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Not Payable - Part of Hospital’s internal Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>165</td>
<td>AHD</td>
<td>Not Payable - Part of Hospital’s internal Cost</td>
</tr>
<tr>
<td>166</td>
<td>ALCOHOL SWABES</td>
<td>Not Payable - Part of Hospital’s internal Cost</td>
</tr>
<tr>
<td>167</td>
<td>SCRUB SOLUTION/STERILLIUM</td>
<td>Not Payable - Part of Hospital’s internal Cost</td>
</tr>
</tbody>
</table>

**OTHERS**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Not Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>168</td>
<td>VACCINE CHARGES FOR BABY</td>
<td>Not Payable</td>
</tr>
<tr>
<td>169</td>
<td>AESTHETIC TREATMENT / SURGERY</td>
<td>Not Payable</td>
</tr>
<tr>
<td>170</td>
<td>TPA CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>171</td>
<td>VISCO BELT CHARGES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>172</td>
<td>ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]</td>
<td>Not Payable</td>
</tr>
<tr>
<td>173</td>
<td>EXAMINATION GLOVES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>174</td>
<td>KIDNEY TRAY</td>
<td>Not Payable</td>
</tr>
<tr>
<td>175</td>
<td>MASK</td>
<td>Not Payable</td>
</tr>
<tr>
<td>176</td>
<td>OUNCE GLASS</td>
<td>Not Payable</td>
</tr>
<tr>
<td>177</td>
<td>OUTSTATION CONSULTANT’S/ SURGEON’S FEES</td>
<td>Not payable, except for telemedicine consultations where covered by policy</td>
</tr>
<tr>
<td>178</td>
<td>OXYGEN MASK</td>
<td>Not Payable</td>
</tr>
<tr>
<td>179</td>
<td>PAPER GLOVES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>180</td>
<td>PELVIC TRACTION BELT</td>
<td>Should be payable in case of PIVD requiring traction as this is generally not reused</td>
</tr>
<tr>
<td>181</td>
<td>REFERAL DOCTOR’S FEES</td>
<td>Not Payable</td>
</tr>
<tr>
<td>182</td>
<td>ACCU CHECK (Glucometery/ Strips)</td>
<td>Not payable pre hospitalization or post hospitalization / Reports and Charts required / Device not payable</td>
</tr>
<tr>
<td></td>
<td>Item Description</td>
<td>Payable/Not Payable Details</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>183</td>
<td>PAN CAN</td>
<td>Not Payable</td>
</tr>
<tr>
<td>184</td>
<td>SOFNET</td>
<td>Not Payable</td>
</tr>
<tr>
<td>185</td>
<td>TROLLEY COVER</td>
<td>Not Payable</td>
</tr>
<tr>
<td>186</td>
<td>UROMETER, URINE JUG</td>
<td>Not Payable</td>
</tr>
<tr>
<td>187</td>
<td>AMBULANCE</td>
<td>Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable</td>
</tr>
<tr>
<td>188</td>
<td>TEGADERM / VASOFIX SAFETY</td>
<td>Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs</td>
</tr>
<tr>
<td>189</td>
<td>URINE BAG</td>
<td>Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs.</td>
</tr>
<tr>
<td>190</td>
<td>SOFTOVAC</td>
<td>Not Payable</td>
</tr>
<tr>
<td>191</td>
<td>STOCKINGS</td>
<td>Essential for case like CABG etc. where it should be paid.</td>
</tr>
</tbody>
</table>