MANIPALCIGNA LIFETIME HEALTH GLOBAL PLAN

Policy Contract

B PREAMBLE

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

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

C DEFINITIONS

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

C.I STANDARD DEFINITIONS

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

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

- **AYUSH Hospital** An AYUSH Hospital is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:
  i) Central or State Government AYUSH Hospital; or
  ii) Teaching hospitals attached to AYUSH College recognized by Central Government / Central Council

of
Indian Medicine and Central Council of Homeopathy; or

iii) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

a) Having at least five in-patient beds.

b) Having qualified AYUSH Medical Practitioner in charge round the clock.

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

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

- **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 the treatment may have been taken.

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

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

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

- **Congenital Anomaly** Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

  a. Internal Congenital Anomaly - which is not in the visible and accessible parts of the body.

  b. External Congenital Anomaly - which is in the visible and accessible parts of the body.

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

  a. has qualified nursing staff under its employment

  b. has qualified Medical Practitioner (s) in charge

  c. has a fully equipped operation theatre of its own where surgical procedures are carried out

  d. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

- **Day Care Treatment** Day Care Treatment refers to 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 hrs

because of technological advancement, and

ii) Which would have otherwise required a hospitalization of more than 24 hours.

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

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

- **Dental Treatment** Dental Treatment is a treatment related to teeth or structures supporting teeth, carried out by a dental practitioner including examinations, fillings, (where appropriate), crowns, extractions and surgery.

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

- **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.

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

- **Hospital** Hospital means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:

  i. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

  ii. has qualified nursing staff under its employment round the clock;

  iii. has qualified Medical Practitioner(s) in charge round the clock;

  iv. has a fully equipped operation theatre of its own where surgical procedures are carried out

  v. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

- **Hospitalization** Hospitalization or Hospitalised 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 sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

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

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

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

- **In-patient 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.

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

- **Medical Advice** Medical Advice means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

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

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

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

  a. Is required for the medical management of the Illness or injury suffered by the Insured;

  b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care

in scope, duration or intensity.

c. Must have been prescribed by a Medical Practitioner.

d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

- **Non-Network Provider** Non- Network Provider means any hospital, day care centre or other provider that is not part of the network.
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- **Notification of Claim** Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

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

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

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

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

  ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

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

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

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

  - Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

  - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

- **Reasonable and Customary Charges** 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** 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** Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

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

C.II SPECIFIC DEFINITIONS

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

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

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

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.

- **Associated Medical Expenses** Associated Medical Expenses shall include nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anesthetist/ Specialist, excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

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

- **Base Sum Insured**[1] is the coverage amount that is opted at the time of inception or modified at the time of renewal whichever is later. It is the amount for which premium is computed and charged with respect to Base covers offered in this policy. It forms a part of Sum Insured[1]. Base Sum Insured[1] resets after the completion of each policy year.

  Base Sum Insured[1] can be utilised only for claims under the below covers wherein medical expenses are incurred with respect to medical treatment is taken in India.

  a) Hospitalisation Expenses
  b) Day Care Treatment
  c) Pre - hospitalization
  d) Post – hospitalization
  e) AYUSH Treatment
  f) Road Ambulance Cover
  g) Donor Expenses
  h) Domiciliary Expenses
  i) Robotic and Cyber Knife Surgery
  j) Modern and Advanced Treatments
  k) HIV/AIDS and STD Cover
  l) Mental Care Cover
  m) Non-Medical Items

- **Benefit Amount or Benefit Limit** is the maximum amount we shall be liable to pay for the duration as specified in the particular benefit in the event of claims made from that benefit.

- **Common Carrier** means any land, sea or air conveyance operated under a license issued by a government authority having jurisdiction for the transportation of fare paying passengers. Such conveyance must have a

  fixed published time-table schedule and fixed established routes. Private taxis, taxis booked through cab aggregators, self-driven or hired road carriers and chartered aircrafts do not fall under the definition of Common Carrier.

- **Company / Insurer** Company / Insurer mean ManipalCigna Health Insurance Company Limited.

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

- **Covered Relationships** Covered Relationships shall include self (the policy holder himself), spouse (same or opposite gender legally wedded), children, sibling of the Policyholder who are children of same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, Uncle, Aunt, Niece and, Nephew.

- **Eligibility** Eligibility means the provisions of the Policy that state the requirements to be complied with.

- **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.

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

- **Floater or Floater basis** means a Policy described as such in the Policy Schedule where-in a common Sum Insured/benefit limit is available on a floating/shared basis amongst the Insured Persons.

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

- **Individual Policy** is a policy where-in exactly one Insured is covered under the Policy. Such Insured person shall have a distinct Individual Sum Insured along with other benefit limits solely for himself.

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

- **Indian Resident** An individual will be considered to be a resident of India, if he is in India for a period or periods amounting in all to one hundred and eighty-two days or more, in the immediate preceding 365 days.

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

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

- **IRDAI** IRDAI means the Insurance Regulatory and Development Authority of India.

- **Multi-Individual Policy** is a policy where-in more than one Insured is covered under a single Policy, each on a distinct Individual Sum Insured/benefit limit basis. In such policies, Insured members do not share a common Sum Insured/Benefit limits. Base Sum Insured/benefit limits of a particular benefit applicable to each member in a Multi-Individual policy may be different and the same shall be explicitly specified in the Policy Schedule against the relevant benefit and Insured Person.

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

- **Outpatient** Outpatient means a patient who undergoes OPD treatment.

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

together.

- **Policy Anniversary** Policy Anniversary is the same date each year during the Policy Term as the Date of Commencement of Policy. Note : If the date of Commencement of Policy is on 29th February, the Policy Anniversary will be taken as the last date of February.

- **Policy Type** means either an Individual Policy or a Multi Individual Policy or a Family floater policy as specified in the Policy Schedule.

- **Policy Period or Policy Tenure** means the period between the inception date and the earlier of expiry date of the policy as specified in the Schedule or the date of cancellation of this policy.

- **Policy Schedule** Policy Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, Premium, Policy Tenure, the Sum Insured and the 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** Policy Year means a period of 12 consecutive months within the Policy Period commencing from the Policy Anniversary Date.

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

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

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

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

- **Sum Insured [SI]** represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy in a Policy Year except for claims made under the below covers whose benefit amounts are over and above Sum Insured. (Note: The term Sum Insured may refer to either or both of Sum Insured[1] and Sum Insured[2] and shall be as per the relevant context)
  1) Adult Health Check-Up
  2) Premium Waiver Benefit
  3) Air Ambulance Cover
  4) Medical Devices
  5) Domestic Second Opinion
  6) Bariatric Surgery Cover
  7) Convalescence Benefit
  8) Major Illness Hospi Cash

9) Chemotherapy and Radiotherapy Cash
10) Accidental Hospi Cash
11) Breast Cancer Screening
12) Cervical Cancer Screening
13) Cervical Cancer Vaccination
14) Ovarian Cancer Screening
15) Psychiatric and Psychological Consultations
16) Osteoporosis Screening
17) Gynaecological Consultations
18) Domestic Concierge services
19) Tele-consultations
20) Any Add-ons/Riders opted

- **Sum Insured[1] [SI[1]] means, the aggregate limit of indemnity consisting of**
  a. Base Sum Insured[1]
  b. Restoration

  Sum Insured[1] thus represents the maximum, total and cumulative liability of the Company for any and all claims

  made under the Policy in a Policy Year except for claims made under the below covers whose benefit amounts are over and above Sum Insured[1]

  1. Adult Health Check-Up
  2. Premium Waiver Benefit
  3. Air Ambulance Cover
  4. Medical Devices
  5. Domestic Second Opinion
  6. Bariatric Surgery Cover
  7. Convalescence Benefit
  8. Major Illness Hospi Cash
  9. Chemotherapy and Radiotherapy Cash
  10. Accidental Hospi Cash
  11. Breast Cancer Screening
  12. Cervical Cancer Screening
  13. Cervical Cancer Vaccination
  14. Ovarian Cancer Screening
  15. Psychiatric and Psychological Consultations
  16. Osteoporosis Screening
  17. Gynaecological Consultations
  18. Domestic Concierge services
  19. Tele-consultations
  20. Any Add-ons/Riders opted

  Sum Insured[1] applicable for a policy year shall be as specified in the Policy Schedule. Sum Insured[1] can be utilised only for claims under the below covers wherein medical expenses are incurred with respect to

medical treatment is taken in India.

a) Hospitalisation Expenses
b) Day Care Treatment
c) Pre - hospitalization
d) Post – hospitalization
e) AYUSH Treatment
f) Road Ambulance Cover
g) Donor Expenses
h) Domiciliary Expenses
i) Robotic and Cyber Knife Surgery
j) Modern and Advanced Treatments
k) HIV/AIDS and STD Cover
l) Mental Care Cover
m) Non-Medical Items

In case of Individual/Multi-Individual Policies Sum Insured[1] shall be on per Insured Person basis. In case of Family Floater policies, a common Sum Insured[1] shall be available on a floater basis amongst all the Insured Persons. Claims made during the policy year shall reduce the Sum Insured[1] and the balance shall be available for subsequent claims that may arise during the remainder of that policy year. The Sum Insured[1] works on a per policy year basis. Sum Insured[1] resets after the completion of each policy year.

- **Sum Insured[2] [SI[2]] means,** is the coverage amount that is opted at the time of inception or modified at the time of renewal whichever is later for coverage outside of India but within the opted area of cover. It therefore represents our maximum liability in a Policy Year for claims made under the below covers

a. Global Hospitalisation for Major Illness
b. Global Pre - hospitalization
c. Global Post – hospitalization
d. Global Ambulance Cover
e. Medical Evacuation
f. Medical Repatriation
g. Repatriation of Mortal Remains
h. Global Travel Vaccination
i. Global Robotic and Cyber Knife Surgery
j. Global Modern and Advance Treatments
k. Global Out-Patient Expenses

Sum Insured[2] applicable for a policy year shall be as specified in the Policy Schedule. Sum Insured[2] can be utilised only for claims under the above covers wherein medical expenses are incurred with respect to medical treatment taken outside of India but in the opted area of cover. In case of Individual/Multi-Individual Policies Sum Insured[2] shall be on per Insured Person basis. In case of Family Floater policies, a common Sum Insured[2] shall be available on a floater basis amongst all the Insured Persons. Claims made during the policy year shall reduce the Sum Insured[2] and the balance shall be available for subsequent claims that may arise during the remainder of that policy year. Sum Insured[2] works on a per policy year basis. Sum Insured[2] resets after the completion of each policy year.

Claims made under the below covers shall NOT reduce Sum Insured[2] as their benefit amounts are over and

above Sum Insured[2]

1. Adult Health Check-Up
2. Premium Waiver Benefit
3. Air Ambulance Cover
4. Medical Devices
5. Domestic Second Opinion
6. Bariatric Surgery Cover
7. Convalescence Benefit
8. Major Illness Hospi Cash
9. Chemotherapy and Radiotherapy Cash
10. Accidental Hospi Cash
11. Breast Cancer Screening
12. Cervical Cancer Screening
13. Cervical Cancer Vaccination
14. Ovarian Cancer Screening
15. Psychiatric and Psychological Consultations
16. Osteoporosis Screening
17. Gynaecological Consultations
18. Domestic Concierge services
19. Tele-consultations
20. Global Hospi Cash
21. Global Convalescence Benefit
22. Global Chemotherapy and Radiotherapy Cash
23. Travel Expenses Benefit
24. Global Second Opinion
25. Any Add-ons/Riders opted

- **Therapy** Therapy is the treatment of disease or disorders, as by some remedial, rehabilitating, or curative process with mental or physical illness without the use of drugs or operations.

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

- **Waiting period** Waiting period means a time bound exclusion period related to condition(s) specified in the Policy Schedule or Policy which shall be served before a claim related to such condition(s) becomes admissible.

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

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

D BENEFITS COVERED UNDER THE POLICY D.I LIMIT AND SCOPE OF COVER

The Global Plan is available to all Insured Persons provided they are resident of India at inception of the Policy and at subsequent renewals of this plan.

D.I.1 Sum Insured

1. **Sum Insured[1] -** Sum Insured[1] is applicable to coverage available under benefits from D.II.1 to D.II.15.
2. **Sum Insured[2] -** Sum Insured[2] is applicable to coverage available under benefits from D.II.17 to D.II.26

D.I.2 Deductible (optional)

A deductible is an amount you agree to pay each policy year before certain policy benefits become active for that policy year. Deductible in this policy shall be on an annual aggregate basis. The deductible amount opted by the policy holder shall be as specified in the Policy Schedule. For a claim to be payable in a policy year, the applicable deductible must first be exhausted for that Policy year as per Policy Type and details provided below. Once the deductible is exhausted, the claim will be eligible for payment as per the policy. Such exhaustion of deductible amount shall be calculated on an annual aggregate basis taking into consideration admissible made during that Policy Year.

Specific Conditions applicable to Deductible

a. If opted deductible amount is less than or equal to ₹4 Lakh, then
   a. deductible shall NOT apply to claims arising under Sum Insured[2]. Therefore, exhaustion of deductible is not required for claims arising outside of India (within the area of cover).
   b. However, the opted deductible shall apply to claims arising under Sum Insured[1] and for claims to be payable exhaustion of deductible is required. Such exhaustion shall be calculated on an annual aggregate basis taking into consideration admissible claims made within India ONLY under the below listed coverages during a Policy Year. Also, such Deductible will only be

applicable for the below coverages

i. Hospitalisation Expenses
ii. Day Care Treatment
iii. Pre - hospitalization
iv. Post – hospitalization
v. AYUSH Treatment
vi. Road Ambulance Cover
vii. Donor Expenses
viii. Domiciliary Expenses
ix. Robotic and Cyber Knife Surgery
x. Modern and Advanced Treatments
xi. HIV/AIDS and STD Cover
xii. Mental Care Cover
xiii. Non-Medical Items

b. If opted deductible amount is more than ₹4 Lakh then
   a. for claim to be payable under the policy, exhaustion of deductible is required. Such exhaustion shall be calculated on an annual aggregate basis taking into consideration admissible claims made ONLY under the below coverages during a Policy Year. Also, such

Deductible will only be applicable for the below coverages

i. Hospitalisation Expenses
ii. Day Care Treatment
iii. Pre - hospitalization
iv. Post – hospitalization
v. AYUSH Treatment
vi. Road Ambulance Cover
vii. Donor Expenses
viii. Domiciliary Expenses
ix. Robotic and Cyber Knife Surgery
x. Modern and Advanced Treatments
xi. HIV/AIDS and STD Cover
xii. Mental Care Cover
xiii. Non-Medical Items
xiv. Global Hospitalisation for Major Illness
xv. Global Pre - hospitalization
xvi. Global Post – hospitalization
xvii. Global Ambulance Cover
xviii. Medical Evacuation
xix. Medical Repatriation
xx. Repatriation of Mortal Remains
xxi. Global Travel Vaccination
xxii. Global Robotic and Cyber Knife Surgery
xxiii. Global Modern and Advance Treatments
xxiv. Global Out-Patient Expenses

c. The Deductible can be opted either at Policy inception or at the time of renewal at policy level (on all or none basis).
d. The opted deductible can be reduced OR increased OR waived at renewals subject to underwriting. If deductible amount of ₹25,000 was opted and was waived at a subsequent renewal, then, no fresh waiting period shall apply in such case. However, if deductible amount greater than ₹25,000 was opted and the same was reduced or waived at a subsequent renewal, then, all waiting period applicable under the policy shall apply afresh for such reduced amount.
e. In case of an Individual/Multi Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.
f. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year.

For the purpose of applying the Aggregate Deductible and assessing claim admissibility, all claims must be submitted in accordance with Sections G.I.4 and G.I.5 of the Claims Process. All other terms, conditions, waiting periods, and exclusions of the Policy shall apply

D.I.3 Major Illness

All benefits under covers specified under section D.II.17 to D.II.26 will be limited to the Major Illness/es opted and specified under the Policy Schedule.

Options of Major Illness/es available are listed below:

i. Cancer Treatment (as defined below) or

ii. All Major Illnesses (as defined below)

If (i) above, is opted under a Policy, all claims under covers specified under section D.II.17 to D.II.26 will be limited to the 'Cancer Treatment' only.

For the purpose of this Policy, 'Major Illness' shall mean any Illness, medical event or Surgical Procedure as listed and defined below:

1. **Cancer Treatment**

We will be covering Primary Treatment of a malignant tumour 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 & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma, any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues, any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia. Any tumour in the presence of HIV infection is excluded under this cover.

2. **Coronary Artery By-Pass Surgery**

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

The following are excluded: Angioplasty and/or any other intra-arterial procedures.

3. **Heart Valve Replacement**

We will be covering the actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

Heart valve replacement surgeries arising out of internal congenital ailments will be covered after a waiting period of 1 year from opting this benefit.

4. **Lung Transplant Surgery in case of End Stage Lung Disease**

We will be covering the actual undergoing of a Lung Transplant Surgery due to End stage lung disease,
causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO_2 <55mmHg);

iv. Dyspnea at rest.

The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

5. **Kidney Transplant Surgery in case of End Stage Renal Failure**

   We will be covering the actual undergoing of a Kidney Transplant Surgery due to End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.

   The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

6. **Liver Transplant Surgery in case of End Stage Liver Disease**

   We will be covering The actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following:

   i. Permanent jaundice; and

   ii. Ascites; and

   iii. Hepatic Encephalopathy.

   The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. Liver failure secondary to drug or alcohol abuse is excluded.

7. **Heart Transplant**

   We will be covering the actual undergoing of a transplant of human heart due to irreversible end-stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

8. **Cardiac arrest (excluding angioplasty)**

   Cardiac arrest is defined as confirmation by a cardiology medical specialist of a definite diagnosis of sudden cardiac arrest that results in unconsciousness, loss of effective circulation and the undergoing of cardio- pulmonary resuscitation to sustain life.

   Diagnosis must be evident by electrographic changes. For the above definition, following is not covered:

   i. Cessation of cardiac function induced to perform a surgical or medical procedure.

9. **Bone Marrow Transplant**

   We will be covering the actual undergoing of a transplant of human Bone Marrow using haematopoietic stem
   cells. The diagnosis and undergoing of a transplant has to be confirmed by a specialist medical practitioner.

   The following are excluded:

   i. Any transplant when the transplant is conducted as a self - transplant.

10. **Neurosurgery**

    We will be covering any:

    i. Surgical intervention of the brain or any other intracranial structures;

    ii. Surgical Treatment of benign solid tumours located in the spinal cord.

11. **Surgical Treatment for Benign Brain Tumour**

We will be covering surgical treatment of Benign solid brain tumour limited to:

i. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy;

ii. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.

This brain tumour must result in at least one of the following and must be confirmed by the relevant medical
specialist:

a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days; or

b. Undergone surgical resection or radiation therapy to treat the brain tumour. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, tumors of skull bones and tumors of the spinal cord.

12. Pulmonary artery graft surgery

We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

13. Aorta Graft Surgery

The undergoing of surgery for disease or trauma to the aorta with excision and surgical replacement of a portion of the diseased or damaged aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

i. Any other surgical procedure, for example but not limited to, the insertion of stents or endovascular repair.

14. Stroke Treatment

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

We will be covering surgical treatment of Stroke limited to:

a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy;

b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke.

The following are excluded:

a. Transient ischemic attacks (TIA);

b. Traumatic injury of the brain;

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

15. Surgical treatment of Coma

We will be covering surgical treatment of Coma limited to Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.

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

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

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

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

d. The condition has to be confirmed by a specialist medical practitioner.

The following are excluded:

Coma resulting directly from alcohol or drug abuse is excluded.

16. Skin Grafting Surgery for Major Burns

We will be covering the undergoing of skin transplantation due to accidental major burns where major burns
is as defined below:

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

Skin grafting surgery for Major Burns should be medically required and not aesthetic/cosmetic in nature.

17. Surgery for Pheochromocytoma

We will be covering the actual undergoing of surgery to remove the tumour. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

18. Permanent Paralysis of Limbs

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

19. Motor Neuron Disease with Permanent Symptoms

We will be covering surgical treatment for Motor neurone disease diagnosed by a specialist consultant as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis.

There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

20. Multiple Sclerosis with Persisting Symptoms

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

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

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

II. Other causes of neurological damage such as SLE and HIV are excluded.

21. Fulminant Viral Hepatitis

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

a. rapid decreasing of liver size; and

b. necrosis involving entire lobules, leaving only a collapsed reticular framework; and

c. rapid deterioration of liver function tests; and

d. deepening jaundice; and

e. hepatic encephalopathy.

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

22. Bacterial meningitis

Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction.There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

23. Alzheimer's Disease

We will be covering the Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain).

The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease.

24. Cerebral aneurysm - with surgery or radiotherapy

We will be covering Cerebral aneurysm and Surgical treatment diagnosed by appropriate medical consultant supported with evidence of cerebral angiogram and/or magnetic resonance angiography and/or CT scan. Treatment for a cerebral aneurysm using any one of the following:

i. Craniotomy

ii. Stereotatic radiotherapy

iii. Endovascular treatment by using coils to cause thrombosis (embolisation)

For the above definition the following are not covered:

i. Cerebral arteriovenous malformation.

25. Parkinson's disease - resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical

impairment of motor function with either associated tremor or muscle rigidity.
For the above definition the following are not covered:

i. Parkinsonian syndromes/Parkinsonism

26. Pneumonectomy - Removal of an entire lung

The undergoing of surgery to remove an entire lung for disease or trauma. The following is not covered:

i. Partial removal of a lung (lobectomy) or lung resection or incision.

The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.

27. Surgical removal of an eyeball

Surgical removal of a complete eyeball as a result of injury or disease. For the above definition the following
is not covered:

i. Self- inflicted injuries

The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.

D.I.4 Waiver of Deductible

This benefit is available only when the Deductible Option of ₹5L or ₹10L is chosen and must be opted at the time such Deductible Option is first selected under the policy. If waiver of deductible is opted and specified on the Policy Schedule then, the opted deductible shall not apply to the benefits listed below

i. Global Hospitalisation for Major Illness
ii. Global Pre - hospitalization
iii. Global Post – hospitalization
iv. Global Ambulance Cover
v. Medical Evacuation
vi. Medical Repatriation
vii. Repatriation of Mortal Remains
viii. Global Travel Vaccination
ix. Global Robotic and Cyber Knife Surgery
x. Global Modern and Advance Treatments
xi. Global Out-Patient Expenses

However, even after exercising this option, the deductible shall continue to remain in effect for the below listed benefits

i. Hospitalisation Expenses
ii. Day Care Treatment
iii. Pre - hospitalization
iv. Post – hospitalization
v. AYUSH Treatment
vi. Road Ambulance Cover
vii. Donor Expenses
viii. Domiciliary Expenses
ix. Robotic and Cyber Knife Surgery
x. Modern and Advanced Treatments

xi. HIV/AIDS and STD Cover
xii. Mental Care Cover
xiii. Non-Medical Items

D.I.5 Area of Cover (AOC)

The Policy Schedule will specify the 'Area of Cover' applicable for covers specified under section D.II.17 to D.II.26 under the Policy.

Expenses, only incurred within the opted 'Area of Cover', shall be payable under these covers. Area of Cover available under the product:

i. Worldwide excluding India;
ii. Worldwide excluding India, United States and Canada.

We may allow change in 'Area of Cover' at renewal, subject to risk assessment and underwriting. If 'Area of Cover' is upgraded from (ii) to (i) above, the below condition shall apply:

In the first year, after upgrade of the 'Area of Cover', if the treatment is availed in United States or Canada, for each claim arising due to a Pre-existing disease, a co-payment of 50% will be applicable.This condition will be applicable only for the first year following the change of AOC.

D.II BENEFITS UNDER THE POLICY

D.II.1 Hospitalization Expenses

We will indemnify the Medical Expenses of an Insured Person, up to the Sum Insured[1] specified in the Policy Schedule, in case of a Medically Necessary Hospitalization arising from a Disease/Illness or Injury, provided that

i. such Medically Necessary Hospitalization is in India and
ii. such Medically Necessary Hospitalization is for more than 24 consecutive hours and
iii. the admission date of the Hospitalization is within the Policy Period.

We will indemnify Medical Expenses for:

a. Reasonable and Customary charges for Room Rent for accommodation in Hospital room up to room category as per the Sum Insured[1].
b. Intensive Care Unit charges,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon,
e. Anaesthetist,
f. Qualified Nurses,
g. Specialists,
h. Cost of diagnostic tests,
i. Medicines,
j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

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

Under Hospitalization expenses, when availed under Inpatient care, we will indemnify the expenses

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

If the Insured Person is admitted to a room category higher than that specified in the Policy Schedule, the Policyholder/Insured Person shall bear a proportionate share of the total Associated Medical Expenses (including room rent, applicable taxes and surcharge). Such proportionate share will be calculated based on the ratio of the room rent entitlement to the room rent actually incurred.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.2 Day Care Treatment

We will indemnify Medical Expenses of an Insured Person in case of a Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization, due to advancement in technology and which is undertaken in a Hospital/ nursing home/ Day Care Centre, within the Policy Period, on the recommendation of a Medical Practitioner. Any treatment in an Outpatient department (OPD) is not covered under this benefit.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.3 Pre - hospitalization

We will reimburse, Pre-hospitalization Medical Expenses, upto the Sum Insured[1], incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital

The benefit is payable subject to hospitalization claim being admissible under Section D.II.1 'Hospitalization
Expenses' or Section D.II.2 'Day Care Treatment' and is related to the same Illness condition.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.4 Post - hospitalization

We will reimburse, Post-hospitalization Medical Expenses, upto the Sum Insured[1], incurred during the 180 days immediately post the date the Insured was discharged from the Hospital. The benefit is payable subject to hospitalization claim being admissible under Section D.II.1 'Hospitalization Expenses' or Section D.II.2 'Day Care Treatment' and is related to the same Illness condition.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.5 AYUSH Treatment:

We will indemnify the Medical Expenses of the Insured Person in case of a Medically Necessary treatment taken during In-patient Hospitalization for AYUSH Treatment, for an Illness or Injury that occurs during the Policy Year, provided that the date of admission in the Hospital falls within a Policy Year.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

Specific Conditions applicable to AYUSH Treatment

a. Claim under this cover is payable maximum up to the Sum Insured[1] will reduce the same.
b. Exclusion pertaining to Non-Allopathic treatments (in section E) shall be superseded to the extent of coverage provided under AYUSH Treatment
c. All claims under this Benefit can be made as per the process defined under Section G.I.4 & 5.

Specific Exclusions applicable to AYUSH Treatment

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

D.II.6 Road Ambulance Cover

We will indemnify the Reasonable and Customary expenses incurred towards transportation of an Insured Person by a registered healthcare or Road Ambulance service provider, to a Hospital for treatment of an Illness or Injury, covered under the Policy, necessitating the Insured Person's admission to the Hospital.

Specific Conditions applicable to Road Ambulance Cover

a. The necessity of use of a Road Ambulance must be certified by the treating Medical Practitioner.
b. Under this benefit we shall reimburse road ambulance expenses incurred:
    1. For transferring the Insured Person from site of incident to the nearest Hospital AND/OR
    2. For transferring the Insured Person from one Hospital to another nearest Hospital due to the non-availability of the required treatment in the existing Hospital. AND/OR
    3. For transferring the Insured Person from one Hospital to a diagnostic centre and back, if advised by the treating medical practitioner, for availing diagnostic facility not available at the existing Hospital.
c. Road ambulance services shall be applicable within India, and only where both the pick-up and drop-off locations fall within India
d. The road ambulance service must be availed during the Policy Period.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same. All Claims under this benefit can be made as per the process defined under Section G.I.4 & 5.

D.II.7 Donor Expenses

We will indemnify In-patient Hospitalization Medical Expenses incurred during the Policy Period, upto the Sum Insured[1], in respect of organ harvesting from the donor where an Insured Person shall be the recipient, subject to the following conditions:

a. The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules, – and under the following circumstances:
b. The organ donated is for the use of the Insured Person who has been prescribed to undergo an organ transplant on Medical Advice;
c. A claim is admissible under Section D.II.1 'Hospitalization Expenses', for the Insured Person;

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

Specific Exclusions applicable to Donor Expenses

i. Cost towards donor screening,
ii. Cost associated to the acquisition of the organ,
iii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
iv. Stem cell donation whether or not it is Medically Necessary treatment except for Bone Marrow Transplant.
v. Expenses related to organ transportation or preservation.
vi. Expenses towards any Pre or Post - hospitalization Medical Expenses towards the donor.

D.II.8 Domiciliary Expenses

We will reimburse the Medical Expenses of an Insured Person incurred towards treatment of a disease, Illness or Injury which in the normal course would otherwise have been covered for Hospitalization under the Policy but is taken at home on the advice of the attending Medical Practitioner, under the following circumstances:

i. The condition of the Insured Person does not allow a hospital transfer: or
ii. Hospital bed was unavailable provided that the treatment of the Insured Person continues at least 3 days in which case the reasonable cost of any Medically Necessary treatment for the entire period shall be payable.

Specific Conditions applicable to Domiciliary Expenses

a. We will pay for pre-hospitalization & post-hospitalization medical expenses up to 60 days and 180 days respectively.
b. All domiciliary expenses including pre-hospitalization & post-hospitalization medical expenses shall be payable ONLY if commencement of the domiciliary Hospitalization is within the Policy Period

Specific Exclusions applicable to Domiciliary Expenses

a) Asthma, bronchitis, tonsillitis, and upper respiratory tract infection including laryngitis and pharyngitis,
cough and cold, influenza,
b) Arthritis, gout and rheumatism,
c) Chronic nephritis and nephritic syndrome,
d) Diarrhoea and all type of dysenteries, including gastroenteritis,
e) Diabetes mellitus and insipidus,
f) Epilepsy,
g) Hypertension,
h) Pyrexia of unknown origin.
i) Any use of artificial life maintenance including life support machine use.

Benefit under this cover is payable maximum up to 10% of the Base Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.9 Adult Health Check-up

If at the start of the Policy year, the Insured Person is of Age 18 years or above, then he/she may avail a comprehensive health check-up at Our Network as per eligibility details mentioned in the table below. Health Check Ups will be arranged by Us and conducted at Our Network. This benefit will be available once a Policy Year starting from the first Policy Year.

Original copies of all reports will be provided to You.

Health Check-up list		
Base Sum Insured[1] (in INR)	**Age of the Insured Person at Policy year start date**	**List of tests**
50 Lacs/ 75 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, BUN, Sr. Creatinine, SGPT, Lipid Profile, SGOT, GGT, TSH
50 Lacs/ 75 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, BUN, Sr. Creatinine, SGPT, Lipid Profile, SGOT, GGT
50 Lacs/ 75 Lacs	>35 years (Females)	CBC-ESR, FBS, Lipid Profile, TSH, Uric acid, HbA1c, Liver Function test, Kidney Function Test, Vit D3
50 Lacs/ 75 Lacs	> 35 years (Males)	CBC-ESR, FBS, Lipid Profile, TSH, Uric acid, HbA1c, Liver Function test, Kidney Function Test, Vit D3, PSA
100 Lacs/ 150 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, BUN, Lipid Profile, TSH, Liver Function test, Kidney Function test
100 Lacs/ 150 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, BUN, Lipid Profile, Liver Function test, Kidney Function test
100 Lacs/ 150 Lacs	> 35 years (Females)	CBC-ESR, FBS, HbA1c, Lipid Profile, TSH, Uric acid, Liver Function test, Kidney Function Test, Sr. Electrolyte, Vitamin D3, Vit B12
100 Lacs/ 150 Lacs	> 35 years (Males)	CBC-ESR, FBS, HbA1c, Lipid Profile, TSH, Uric acid, Liver Function test, Kidney Function Test, Sr. Electrolyte, PSA, Vitamin D3, Vit B12
200 Lacs/ 300 Lacs	18 to 35 years (Females)	CBC-ESR, FBS, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, Vitamin D3
200 Lacs/ 300 Lacs	18 to 35 years (Males)	CBC-ESR, FBS, Kidney Profile, Lipid Profile, Liver Profile, Vitamin D3
200 Lacs/ 300 Lacs	> 35 years (Females)	CBC-ESR, FBS, HbA1C, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, Uric Acid, Sr. Electrolyte, Vitamin D3, Vitamin B12, CA-125
200 Lacs/ 300 Lacs	> 35 years (Males)	CBC-ESR, FBS, HbA1C, Kidney Profile, Lipid Profile, Liver Profile, Thyroid Profile, PSA, Uric Acid, Sr. Electrolyte, Vitamin D3, Vitamin B12

Full explanation of Tests is provided here: Vitals - Height, Weight, Blood Pressure, Pulse, BMI, Chest Circumference & Abdominal Girth, FBS - Fasting Blood Sugar, GGT - Gamma-Glutamyl Transpeptidase, ECG - Electrocardiogram, CBC-ESR - Complete Blood Count-Erythrocyte Sedimentation Rate, SGPT - Test Serum Glutamic Pyruvate Transaminase, SGOT - Serum Glutamic Oxaloacetic Transaminase, TSH - Thyroid Stimulating Hormone, TMT - Tread Mill Test, PSA - Prostate Specific Antigen, HBA1C-Hemoglobin A1C, CBC
- Complete Blood Count, USG - Ultrasound/Sonography.

Coverage under this value added cover will not be available on reimbursement basis and any claim under this section will not reduce Sum Insured[1] or Sum Insured[2].

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.II.10 Robotic and Cyber Knife Surgery

We will indemnify the Medical Expenses incurred towards Medically Necessary Robotic or Cyber knife Surgery of the Insured Person subject to the Illness/ Injury being covered under Section D.II.1 'Hospitalization Expenses' and the necessity being certified by an authorised Medical Practitioner.
Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.11 Modern and Advanced Treatments

We will indemnify the Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatment of the Insured Person subject to Illness/ Injury being covered under Section D.II.1 'Hospitalization Expenses' and the necessity being certified by an authorised Medical Practitioner.

Only the below following Modern and Advanced Treatment methods will be covered when availed under In-patient Hospitalization or as a Day Care Treatment:

a) Uterine Artery Embolization and HIFU
b) Balloon Sinuplasty
c) Deep Brain stimulation
d) Oral chemotherapy
e) Immunotherapy - Monoclonal Antibody to be given as injection
f) Intra vitreal injections
g) Stereotactic radio surgeries
h) Bronchial Thermoplasty
i) Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
j) IONM (Intra Operative Neuro Monitoring)
k) Stem cell therapy - Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.12 HIV/AIDS and STD Cover

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

<u>Specific Conditions applicable to HIV/AIDS and STD cover</u>

i. The purpose of Hospitalization is to avail Medically Necessary treatment.

ii. The necessity of the Hospitalization is certified by an authorised Medical Practitioner.

iii. For conditions other than STD, the Insured Person should be a declared HIV positive.

iv. We will pay for Pre-hospitalization and Post- hospitalization medical expenses maximum up to 60 days and 180 days respectively.

v. Claim shall be payable ONLY if date of admission in the Hospital is within the Policy Period.

Benefit under this cover is payable up to Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.13 Mental Care Cover

We will indemnify the Medical Expenses incurred for the Medically Necessary treatment taken during In-patient Hospitalization of the Insured Person, arising out of a condition caused by or associated to a Mental illness, Stress, Anxiety, Depression or a medical condition impacting mental health in accordance with The Mental Health Care Act, 2017 as amended from time to time.

Specific Conditions applicable to Mental Care Cover

a. The Treatment is prescribed by a Medical Practitioner and the purpose of Hospitalization is to treat the Insured Person towards the Mental illness.

b. Claim shall be payable ONLY if date of admission in the Hospital is within the Policy Period.

Benefit under this cover is payable maximum up to the Sum Insured[1] and any claim under this section will reduce the same.

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

D.II.14 Restoration

In the event of complete or partial utilization of the Base Sum Insured[1] due to any claim admitted during the Policy Year, the Company shall reinstate only the utilized portion of the Base Sum Insured[1] unlimited times in the Policy Year.

Specific conditions applicable to Restoration

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

b. Restored amount cannot be utilized for claims falling under the purview of Any One Illness.

c. Restoration will trigger every time upon complete or partial utilization of the Base Sum Insured[1] by way of claims admissible under ONLY the below coverages.

   i. Hospitalisation Expenses
   ii. Day Care Treatment
   iii. Pre - hospitalization
   iv. Post – hospitalization
   v. AYUSH Treatment
   vi. Road Ambulance Cover
   vii. Donor Expenses
   viii. Domiciliary Expenses
   ix. Robotic and Cyber Knife Surgery
   x. Modern and Advanced Treatments
   xi. HIV/AIDS and STD Cover
   xii. Mental Care Cover

xiii. Non-Medical Items

d. The restored amount shall be available only for subsequent claims that may arise thereafter in the remainder of the Policy Year under the below coverages.
   a) Hospitalisation Expenses
   b) Day Care Treatment
   c) Pre - hospitalization
   d) Post – hospitalization
   e) AYUSH Treatment
   f) Road Ambulance Cover
   g) Donor Expenses
   h) Domiciliary Expenses
   i) Robotic and Cyber Knife Surgery
   j) Modern and Advanced Treatments
   k) HIV/AIDS and STD Cover
   l) Mental Care Cover
   m) Non-Medical Items

e. Any restored amount which is not utilised in a Policy Year shall not be carried forward to any subsequent Policy Year.

f. The restored amount shall be available on an Individual basis in Individual/Multi-Individual policies and on a floater basis in Family Floater policies.

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

D.II.15 Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers any of the below, we will pay the next Renewal Premium of the Policy, for a policy tenure of 1 year.

a. Permanent Partial Disablement, OR
b. Permanent Total Disablement, OR
c. Death due to an injury caused by an Accident within 365 days from the date of the Injury caused by an accident OR
d. He/she is diagnosed with a Critical Illness, listed under this section

<u>Specific Conditions applicable to Premium Waiver Benefit</u>

a. The premium shall be paid towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.
b. If only one person is covered under the Policy, policy will not be renewed in case of death of the Policyholder.
c. The Policyholder is not added in the Policy in the middle of the Policy Year.
d. There should be no change in covers, Sum Insured, benefit structure, limits and conditions applicable under the Policy, at the upcoming renewal.
e. No new member should be added under the renewed Policy.
f. In case of a policy with existing tenure of 2 or 3 years, it will be renewed only for one year, provided

all the terms and conditions, benefits and policy limits remain same.

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

h. Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

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

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

1. Cancer of Specified Severity -

I. 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 leukemia, lymphoma and sarcoma.

II. 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 IN-3.

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification, viii.All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of specified severity) -

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

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

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

3. Open Chest CABG -

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery (s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or

minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

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

4. Open Heart Replacement or Repair of Heart Valves-

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve (s).

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma of specified severity -

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

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

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

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

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

6. Kidney Failure requiring regular dialysis -

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

7. Stroke resulting in permanent symptoms -

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ/Bone Marrow Transplant -

I. The actual undergoing of a transplant of:

1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

2. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs -

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

10. Motor Neuron Disease with permanent symptoms

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor

II. dysfunction that has persisted for a continuous period of at least 3 months.

11. Multiple Sclerosis with persisting symptoms

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

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

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

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

D.II.16 Personal Accident Plus

The Policyholder will have the option to choose from any one of the following options below either at policy inception or any renewal. The details pertaining to the selected option will be specified on the Policy Schedule:

- Option 1: Accidental Death Cover (AD) only [D.II.16.A.]
- Option 2: Permanent Disablement Cover (includes Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD)) only [D.II.16.B.i and D.II.16.B.ii]. Herein Permanent Total Disablement (PTD) & Permanent Partial Disablement (PPD) will be covered upto a common sum insured
- Option 3: Accidental Death Cover [D.II.16.A.] AND Permanent Disablement Cover (includes Permanent Total Disablement & Permanent Partial Disablement) [D.II.16.B.i and D.II.16.B.ii] covered upto a common sum insured

Specific Conditions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. In the lifetime of this policy, our maximum liability in respect of an Insured Person under Personal Accident Plus (which includes AD, PTD and PPD) shall never exceed 100% of the Benefit Amount applicable to the Insured Person

b. In the lifetime of this policy, if we pay a claim equal to our maximum liability then the entire Personal

Accident Plus shall terminate for that Insured Person in respect of whom such claim has been paid.

c. Choice to opt out from this cover or change the coverage option is available only at renewals. The choice of opting in again after opted out shall be subject to underwriting.
d. The geographic scope of Personal Accident Plus (which includes AD, PTD and PPD) cover is restricted to India
e. In case there is a change in occupation of any Insured Person post inception of this benefit, the same should be communicated to us in writing at the immediate upcoming renewal.
f. The Minimum entry age of any Individual at the time of opting for this cover cannot be less than 18 years
g. The Maximum entry age of any Individual at the time of opting for this cover cannot be greater than 65 years
h. All eligible insured persons opting for the Personal Accident Plus cover shall have the same Sum Insured and cover option.

i. If any insured person is above 75 years of age at the time of renewal, then for all future policy years maximum payout under Personal Accident Plus for that insured person will be limited to ₹10 lakh or the applicable Benefit Amount, whichever is lower. Premium shall be charged according to such applicable Benefit Amount.
j. All claims under this benefit shall be made in accordance with the process specified under Sections G.I.5 of this Policy.

D.II.16.A Accidental Death Cover (AD)

If an Insured Person sustains an injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in the Death or Disappearance of the Insured Person within 365 days from the date of the Accident, we will pay the Nominee in Lumpsum 100% of the Benefit Amount stipulated against Accidental Death cover in the Policy schedule

Disappearance Clause

If the Insured Person's body cannot be located within 365 days post happening of the below event it shall be deemed as disappearance

a. Forced landing, stranding, sinking or wrecking of a common carrier in which the insured person were travelling as a fare paying passenger OR
b. Catastrophic event in which the insured person was a victim

To process a claim pertaining to disappearance we will require a missing-person police report and/or any other documents we reasonably request to support the claim. If it was later established that the Insured Person is alive, the settled amount must be repaid to us in full.

D.II.16.B. Permanent Disablement Cover

D.II.16.B.i Permanent Total Disablement (PTD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a Permanent Total Disablement, as listed in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum 100% of the Benefit Amount stipulated against Permanent Total Disablement benefit in the Policy schedule

Listed Permanent Total Disablement (PTD) covered
i. Total and irrecoverable loss of sight of both eyes

ii.	Loss by physical separation or total and permanent loss of use of both hands or both feet
iii.	Loss by physical separation or total and permanent loss of use of one hand and one foot
iv.	Total and irrecoverable loss of sight of one eye and loss of a Limb
v.	Total and irrecoverable loss of hearing of both ears and loss of onGe Limb/loss of sight of one eye
vi.	Total and irrecoverable loss of hearing of both ears and loss of speech
vii.	Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye

Specific Conditions applicable to Permanent Total Disablement (PTD)

i. Claim pertaining to Permanent Total Disablement is admissible only with confirmatory diagnosis of Permanent Total Disablement while the Insured Person is alive.

ii. The Permanent Total Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.

iii. The Permanent Total Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.

D.II.16.B.ii Permanent Partial Disablement (PPD)

If the Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, and such Injury results in a listed Permanent Partial Disablement, as specified in the table below, within 365 days from the date of the Accident, we will pay in Lumpsum the Benefit Amount stipulated against Permanent Partial Disablement benefit in the Policy schedule in accordance with details specified in the table given below

	Listed Permanent Partial Disablement (PPD) covered	**% of Benefit Amount payable**
i.	Total and irrecoverable loss of sight of one eye	50%
ii.	Loss of one hand or one foot	50%
iii.	Loss of all toes - any one foot	10%
iv.	Loss of great toe - any one foot	5%
v.	Loss of toes other than great, if more than one toe lost, each	2%
vi.	Total and irrecoverable loss of hearing in both ears	50%
vii.	Total and irrecoverable loss of hearing in one ear	15%
viii.	Total and irrecoverable loss of speech	50%
ix.	Loss of four fingers and thumb of one hand	40%
x.	Loss of four fingers	35%

Listed Permanent Partial Disablement (PPD) covered		% of Benefit Amount payable
xi.	Loss of thumb-both phalanges	25%
xii.	Loss of thumb - one phalanx	10%
xiii.	Loss of index finger - three phalanges - two phalanges - one phalanx	 10%, 8%, 4%
xiv.	Loss of middle/ring/little finger - three phalanges - two phalanges - one phalanx	 6%, 4%, 2%

Specific Conditions applicable to Permanent Partial Disablement (PPD)

i. Claim pertaining to Permanent Partial Disablement is admissible only with confirmatory diagnosis of a Permanent Partial Disablement while the Insured Person is alive.
ii. The Permanent Partial Disablement must be established and supported by a disability certificate issued by a Civil Surgeon or an equivalent authority appointed by a District, State, or Government Board.
iii. The Permanent Partial Disablement should have continued for a minimum continuous period of 180 days from the date of commencement of the disablement, and at the end of such period it must be certified in writing by the treating Medical Practitioner that there is no reasonable medical prospect of improvement.
iv. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Benefit Amount shown in the Permanent Disablement Table. The cumulative sum in such cases shall be capped at 100%.
v. If in a policy year we pay a claim equal to 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, the entire Personal Accident Plus section shall automatically terminate for the respective Insured Persons.
vi. If in a policy year we pay a claim of less than 100% of Benefit Amount under the Permanent Partial Disablement (PPD) cover for particular Insured Person, then at the end of such Policy Year only the remaining Benefit Amount shall replenish for the next policy year or the renewed policy if the cover is opted. In such an event the eligible premium shall be paid in full. For any claims that arise in the subsequent policy years, percentage shall be applied on the original benefit amount and the resultant amount shall be deducted from the Benefit amount that was remaining.

Specific Exclusions applicable to Personal Accident Plus (includes AD, PTD and PPD)

a. Expenses incurred towards any Injury caused by, arising from, or attributable to foreign invasion, act of foreign enemies, hostilities or warlike operations (whether war is declared or not, including while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, or confiscation, nationalization, requisition, destruction of, or damage to property by or under the order of any government or local authority
b. Expenses incurred towards any Injury arising from, or attributable to ionizing radiation, contamination by radioactivity from any nuclear fuel (whether in explosive or hazardous form), or nuclear waste from the combustion of nuclear fuel, or resulting from any chemical or biological attack, or any sequence thereof
c. Involvement of Insured person in any unlawful/Criminal activity.

d. Intentional self-injury or attempted suicide.
e. Any Injury sustained while working, storing or transporting explosives.
f. Injury caused due to
   1. Insect bites or
   2. Animal bites or
   3. Animal attacks or
   4. Serpant (snake) bites or attacks
g. Accidental Injury sustained as a result of being under the influence of drugs, alcohol, or other intoxicants or hallucinogens.
h. Accidental injuries sustained in location where a government warning about imminent danger or visiting restriction was issued beforehand
i. Claims arising out of Non-accidental Injuries: Injuries emanating from participation in Adventure Sports (Hazardous Sports, action sports, aggro sports, extreme sports or any such name) irrespective whether the Insured Person is trained or not and also irrespective whether the Insured is a professional or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/activity includes marathons, abseiling, adventure racing, animal conservation/ game reserve, archery, base jumping, bicycle touring, big game hunting, blackwater rafting, biathlon, BMX stunt / obstacle riding, bobsleighing / using skeletons, bouldering, boxing, bullfighting, canyoning, bungee jumping, cave tubing / cave diving, caving / pot holing, clay pigeon shooting, climbing /trekking, expeditions above the height of 7500 ft above sea level, walking for more than 10 kms, cross channel swimming, cycle racing, cyclo cross, drag racing, dry/desert/dune skiing/bashing, endurance testing, fencing, field hockey, flying as a pilot, free diving/ no limits driving, gaelic football, gliding, gymnastics, hang gliding, heptathlon, harness racing, heli skiing/ boarding, high diving (above 5 meters), horse racing, horse riding and jumping, hot air ballooning, hunting on horseback, hunting/shooting, hurling, ice and street hockey, ice climbing, ice skating, ice speedway, jet boating, jet skiing, jousting, flying fox, judo, karate, kayaking, kendo, kite skiing, kite surfing/land boarding / buggying, lacrosse luge / tobogganing, luging, risky manual labour, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing (all types), motor rallying, mountain biking, mountain boarding, mountain running, mountaineering/ rock climbing, deep sea diving, para jumping, orienteering (involving climbing), parachuting, paragliding/ parapenting, parasailing, parascending (over land and water), parkour/parcours/free running, piloting aircraft or learning to pilot an aircraft, point to point, polo, power boat racing, powerlifting, quad biking/all terrain vehicles, rifle range shooting, river boarding, river boardings, river bugging, rock scrambling, rodeo, roller hockey, rugby, running of the bulls, safari tours, sail boarding (racing/high speed/extreme), sailing, sand boarding, scuba diving, shark feeding/cage diving, skate boarding, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, dessert safari, jungle safari, amusement park rides, water park rides, snorkeling, snow mobiling, snow skiing, snowboarding, speed trials/time trials, steeple chasing, surfing, team sports played in competitive contest, tomb stoning/cliff diving/quarry diving, trial bike riding, triathlon, tubing on snow, tubing, wakeboarding, war games (non-armed forces), water skiing or water ski jumping, weightlifting, wrestling, rafting, hiking, kayaking, wind surfing, yachting, zip line, zorbing and hydro-zorbing and similar hazardous sports, action sports, aggro sports, extreme sports or activities of similar nature by whatever name called.

D.II.17 Global Hospitalization for Major Illness

We will indemnify the Medical Expenses for an Insured Person upto Sum Insured[2], in case of a Medically Necessary Hospitalization, arising from the Major illness/es covered under the Policy, provided that the Medically Necessary Hospitalization is for more than 24 consecutive hours OR is a Day Care Treatment and the date of admission in the Hospital is within the Policy Period.

We will indemnify Medical Expenses for:

1. Reasonable and Customary charges for Room Rent for accommodation in Hospital
2. Intensive Care Unit charges,
3. Operation theatre charges,
4. Fees of Medical Practitioner/ Surgeon,
5. Anaesthetist,
6. Qualified Nurses,
7. Specialists,
8. Cost of diagnostic tests,
9. Medicines,
10. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure,

Special Conditions applicable to Global Hospitalization for Major Illness

a. Hospitalisation must be for a Medically Necessary treatment and should be based on the written advice of a Medical Practitioner.
b. For the purpose of this Benefit, the treatment should be taken outside India, within the opted Area of Cover and in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.
c. Under Global Hospitalization for Major illness expenses, when availed under Inpatient care, we will cover the expenses towards artificial life maintenance, including life support machine use, even where such treatment will not result in recovery or restoration of the previous state of health under any circumstances unless in a vegetative state, as certified by the treating Medical Practitioner.
d. Claim under Global Hospitalization for Major Illness is payable maximum up to Sum Insured[2] and any claim under this benefit will reduce the same.

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

D.II.18 Global Pre - hospitalization

We will indemnify, Pre-hospitalization Medical Expenses, upto the Sum Insured[2], incurred during the 60 days immediately prior to the date the Insured was admitted in the Hospital.

Special Conditions applicable to Global Pre-Hospitalization

a. Claim under this benefit is payable subject to hospitalization claim being admissible under Section D.II.17. 'Global Hospitalization for Major Illness' and Pre-hospitalization expenses are related to the same Illness/condition.
b. The Global Pre-hospitalization expenses must be incurred during the Policy Period.
c. The Global Pre-hospitalization expenses must be incurred outside India within the opted Area of Cover. Claim for such Global Pre-Hospitalization expenses shall be payable maximum up to and will reduce Sum Insured[2]. However, if a claim is admissible under D.II.17. 'Global Hospitalization for Major Illness' and Pre-hospitalization expenses for such claim were availed in India then such Pre-Hospitalization expenses shall be payable under Section D.II.3 'Pre-hospitalization'. Such expenses shall be payable maximum up to and will reduce Sum Insured[1].

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

D.II.19 Global Post - hospitalization

We will reimburse, Post-hospitalization Medical Expenses, upto the Sum Insured[2], incurred during the 180 days immediately post the date the Insured was discharged from the Hospital

Special Conditions applicable to Global Post-Hospitalization

a. Claim under this benefit is payable subject to hospitalization claim being admissible under Section D.II.17. 'Global Hospitalization for Major Illness' and Post-hospitalization expenses are related to the same Illness/condition.

b. The Global Post-hospitalization expenses must be incurred during the Policy Period.

c. The Global Post-hospitalization expenses must be incurred outside India within the opted Area of Cover. Claim for such Global Post-Hospitalization expenses shall be payable maximum up to and will reduce Sum Insured[2]. However, if a claim is admissible under D.II.17. 'Global Hospitalization for Major Illness' and Post-hospitalization expenses for such claim were availed in India then such Post-Hospitalization expenses shall be payable from Section D.II.4 'Post-hospitalization'. Such expenses shall be payable maximum up to and will reduce Sum Insured[1].

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

D.II.20 Global Ambulance Cover

We will indemnify expenses incurred towards transportation of the Insured Person in a Ambulance for his admission in a Hospital.

- Under this benefit we shall reimburse Reasonable and Customary road ambulance expenses incurred:

a) For transferring the Insured Person from site of incident to the nearest Hospital AND/OR

b) For transferring the Insured Person from one Hospital to another nearest Hospital due to the non-availability of the required treatment in the existing Hospital. AND/OR

c) For transferring the Insured Person from one Hospital to a diagnostic centre and back, if advised by the treating medical practitioner, for availing diagnostic facility not available at the existing Hospital.

Specific Conditions applicable to Global Ambulance Cover

a. Claim under this benefit is payable subject to hospitalization claim being admissible under Section D.II.17. 'Global Hospitalization for Major Illness' and if the Ambulance expenses are related to the same Illness/condition.

b. The ambulance service must be undertaken through a registered healthcare or Ambulance service provider

c. Ambulance services shall be applicable only outside India, within the opted Area of Cover, and only where both the pick-up and drop-off locations fall within the opted Area of Cover.

d. The ambulance service must be availed during the Policy Period

e. In case of an Air Ambulance, the transportation should be provided by a medically equipped aircraft which can provide medical care in flight and should have medical equipment's to monitor the vitals and treat the Insured Person suffering from an Illness such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

f. The treating Medical Practitioner must certify in writing that the severity and nature of the Insured Person's Illness qualifies as an Emergency and warrants the Insured Person's requirement for an Ambulance;

g. Claim under Global Ambulance Cover is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.21 Medical Evacuation

In the event of an Emergency during the Policy Period, if an Insured Person is outside India within the opted Area of Cover and adequate medical facilities are not available locally, we will cover the expenses incurred towards arranging emergency evacuation to the nearest medical facility capable of providing appropriate medical care

Specific Conditions applicable to Medical Evacuation

a. Emergency must be caused by a Major Illness/es covered under the policy.
b. The Medical Practitioner must certify that the Medical Evacuation was Medically Necessary to prevent the immediate and significant effects of the Illness which if left untreated could result in a significant deterioration of health and it has been determined that the Treatment is not available locally and it is not medically advisable to travel in a normal common carrier, independently.
c. Medical repatriation must be pre-authorised by our medical team. Where prior authorisation is not reasonably possible, authorisation must be sought at the earliest thereafter. Post-event authorisation shall be granted only if it was not reasonably possible to obtain prior approval.
d. While making our determinations, we will consider the nature of the Emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.
e. The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the evacuation to be considered an Emergency and requiring Emergency evacuation.
f. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to each case.
g. Medical evacuation services shall be applicable only outside India, within the opted Area of Cover, and only where both the pick-up and drop-off locations fall within the opted Area of Cover.
h. Claim under Medical Evacuation is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.22 Medical Repatriation

We will indemnify the Reasonable and Customary Charges incurred towards repatriation of the Insured Person from any place outside India BUT within the opted Area of Cover, on an Emergency basis to:

a. his/her residence in India; OR
b. a Hospital near his residence, in India.

Specific Conditions applicable to Medical Repatriation

a) Emergency is caused by a Major Illness/es covered under the product.
b) Medical repatriation must be certified as Medically Necessary in writing by the treating Medical Practitioner.
c) Medical repatriation must be pre-authorised by our medical team. Where prior authorisation is not reasonably possible, authorisation must be sought at the earliest thereafter. Post-event authorisation

shall be granted only if it was not reasonably possible to obtain prior approval.

d) In making Our determinations, We will consider the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered;

e) Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or
Ambulance depending upon the medical needs and available transportation specific to each case;

f) Claim under Medical Repatriation is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.23 Repatriation of Mortal Remains

If during the Policy Period, the Insured Person suffers a Major Illness covered under the policy and that Illness solely and directly results in death of the Insured Person, at a place outside India but within the opted Area of Cover, We will indemnify the Reasonable and Customary charges towards the transportation of the mortal remains of such Insured Person from the place of death to his/her residence in India.

Specific Conditions applicable to Repatriation of Mortal Remains

Our Medical Assistance service provider may arrange for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Claim under Repatriation of Mortal Remains is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.24 Global Travel Vaccination

We will indemnify the Reasonable and Customary Charges of vaccine(s) incurred towards the Insured Person, provided that the vaccine is approved by World Health Organisation (WHO) and is mandatorily required/prescribed to be undertaken by the Insured Person for visiting a location within the opted Area of Cover outside India.

Specific Conditions applicable to Global Travel Vaccination

a. Vaccination must be undertaken in India. However, we will cover the cost of vaccine (s) taken outside India but within the opted Area of Cover, only if the same is mandatorily required /prescribed to be undertaken by the Insured Person before returning to India post treatment for a Major Illness, covered under the Policy.

b. Claim under Global Travel Vaccination is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.25 Global Robotic and Cyber Knife Surgery

We will indemnify the Medical Expenses incurred towards a Medically Necessary Robotic or Cyber Knife Surgery of the Insured Person, performed outside India within the opted Area of Cover.

Specific Conditions applicable to Global Robotic and Cyber Knife Surgery

a. Claim under this benefit is payable subject to hospitalization claim being admissible under Section D.II.17. 'Global Hospitalization for Major Illness' and Global Robotic and Cyber Knife Surgery expenses are related to the same Illness/condition.

b. Global Robotic and Cyber Knife Surgery must be certified as Medically Necessary in writing by the treating Medical Practitioner and must be undertaken during the Policy Period.

c. Claim under Global Robotic and Cyber Knife Surgery is payable maximum up to Sum Insured[2] and any claim under this section will reduce the same.

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

D.II.26 Global Modern and Advanced Treatments

We will indemnify Medical Expenses incurred towards a Medically Necessary Modern and Advanced Treatments undertaken by the Insured Person, outside India, within the opted Area of Cover

Specific Conditions applicable to Global Modern and Advanced Treatments

a. Only the below listed Modern and Advanced Treatments will be covered when availed under In-patient hospitalization or as a Day Care Treatment.
   1. Uterine Artery Embolization and HIFU
   2. Balloon Sinuplasty
   3. Deep Brain stimulation
   4. Oral chemotherapy
   5. Immunotherapy - Monoclonal Antibody to be given as injection
   6. Intra vitreal injections
   7. Stereotactic radio surgeries
   8. Bronchial Thermoplasty
   9. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   10. IONM (Intra Operative Neuro Monitoring)
   11. Stem cell therapy - Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

b. Global Modern and Advanced Treatments must be certified as Medically Necessary in writing by the treating Medical Practitioner and must be undertaken during the Policy Period.

c. Claim under Global Modern and Advanced Treatments is payable maximum up to Sum Insured[2]

and any claim under this section will reduce the same.

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

D.III OPTIONAL PACKAGES

D.III.1 HEALTH+

This optional package is available to all Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only.

If opted, benefits under the package will be available for each Insured Person on individual basis, for individual as well as family floater policies. The geographical scope of all cover of this package except Non-Medical Items cover is restricted to India ONLY. Any expenses made outside or benefit availed outside India will not be payable.

D.III.1.i Air Ambulance Cover

We will reimburse the Reasonable and Customary expenses incurred towards transportation of an Insured

Person, to the nearest Hospital or to move the Insured Person to and from healthcare facilities within India, by an Air Ambulance:

Specific Conditions applicable to Air Ambulance Cover

i. Air Ambulance is used during medical Emergency of the Insured Person;
ii. The Illness/Injury, causing Emergency, is covered under a benefit specified under D.II.1 to D.II.15 ;
iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment to monitor the vitals and treat the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;
iv. Air Ambulance service is offered by a Registered Ambulance service provider;
v. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Illness/Injury warrants the Insured Person's requirement for Air Ambulance;
vi. Payment under this cover is subject to a claim being admissible under Section D.II.1 'Hospitalization Expenses', for the same Illness Injury;
vii. The benefit is available once in a Policy year for each Insured Person;

Benefit under this cover is payable maximum up to Rs. 10 Lacs and claim under this section will not reduce the Sum Insured[1] or Sum Insured[2].

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

D.III.1.ii Medical Devices and Non-Medical Items

We will indemnify the expense towards

a) Non-Medical items, listed under list I of, Annexure III of this Policy Wording AND
b) Cost of buying or renting medical devices, prescribed to the Insured Person by the treating Medical Practitioner, for a Medically Necessary treatment.

Specific Conditions applicable to Medical Devices and Non-Medical Items

1. Hospitalization claim must be admissible under Section D.II.1 'Hospitalization Expenses' and the expenses on Non-medical items or Medical devices should be related to the same Illness/ Injury.
2. The need for Medical device is prescribed by an authorised Medical Practitioner during hospitalization or within 180 days of the post-hospitalization period. Any purchase of the medical device should be done within 30 days of such recommendation.
3. Our maximum liability for Medical Devices is up to ₹2 Lacs once in 3 Policy Years. For the purpose of this benefit 'once' means one or more claims for Medically Prescribed medical device/s (listed above) provided that it is related to one Hospitalization. Claim under Medical Devices will not reduce the Sum Insured[1] or Sum Insured[2] and any balance amount, if not utilised will not be carried forward.
4. Our maximum liability for Claims under Non-Medical items shall never exceed Sum Insured[1] /Sum Insured[2] as applicable in a Policy Year.
5. Claim paid under Non-Medical items will reduce the Sum Insured[1] if such expenses are incurred with respect to medical treatment taken in India.
6. Claim paid under Non-Medical items will reduce the Sum Insured[2] if such expenses are incurred with respect to medical treatment taken outside India but within the area of cover.
7. Exclusion pertaining to Non-Medical items (in section E) shall be superseded to the extent of coverage provided herein.

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

For the purpose of this benefit, medical devices shall mean-

• Artificial limb, • Cannula, • Catheter, • Colostomy bag, • CPAP machine, • Feeding tube, • Glucose meter, • Heating pad, • Hospital bed, • Infusion pump, • Nebulizer, • Oxygen concentrator,	• Traction splint, • Ventilator, • Wheelchair, • Ankle Rehabilitation, • Back Support Belts, • Gel Heel Pads, • Heel And Elbow Suspension, • Hernia and Abdominal Support, • Hot and Cold Therapy Wraps, • Lancets And Lancing Devices,	• Nebulizer Accessories, • Nebulizers, • Orthopedic Supports and Braces, • Rollators, • Urinary Bag Holders • Urinary Bags, • Prosthetic device, • Pulse oximeter, • Insulin Aids, • Insulin Pen Needles, • Insulin Syringes,

D.III.1.iii Domestic Second Opinion

If an Insured Person is diagnosed with/ advised a treatment listed and defined under Major Illness/es, You may choose to avail a second medical opinion from Our Network of Medical Practitioners in India. The expert opinion would be directly sent to You.

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

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

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

c. This benefit can be availed by each Insured Person once during a Policy Year for one major illness and multiple times for different Major Illness/es.

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

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

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

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

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

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

1.Cancer Treatment
2.Coronary Artery By-Pass Surgery
3.Heart Valve Replacement
4.Lung Transplant Surgery in case of End Stage Lung Disease
5.Kidney Transplant Surgery in case of End Stage Renal Failure
6.Liver Transplant Surgery in case of End Stage Liver Disease
7.Heart Transplant
8.Cardiac arrest (excluding angioplasty)

9.Bone Marrow Transplant
10.Neurosurgery
11.Surgical Treatment for Benign Brain Tumour
12.Pulmonary artery graft surgery
13.Aorta Graft Surgery
14.Stroke Treatment
15.Surgical treatment of Coma
16.Skin Grafting Surgery for Major Burns
17.Surgery for Pheochromocytoma
18.Permanent Paralysis of Limbs
19.Motor Neuron Disease with Permanent Symptoms
20.Multiple Sclerosis with Persisting Symptoms
21.Fulminant Viral Hepatitis
22.Bacterial meningitis
23.Alzheimer's Disease
24.Cerebral aneurysm - with surgery or radiotherapy
25.Parkinson's disease - resulting in permanent symptoms
26.Pneumonectomy - Removal of an entire lung
27.Surgical removal of an eyeball

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.1.iv Bariatric Surgery Cover

We will indemnify the Medical Expenses incurred towards Medically Necessary Hospitalization of the Insured Person for Bariatric Surgery and its complications.

Specific Conditions applicable to Bariatric Surgery Cover

i. Surgery must be Medically Necessary and should be certified by an authorised Medical Practitioner;
ii. Date of admission in Hospital must be within the Policy Year.
iii. The Insured Person must satisfy the following criteria as devised by NIH (National Institute of Health):
   a. The BMI should be greater than 37.5 without any co-morbidity; or greater than 32 with co-morbidity and
   b. Is unable to lose weight through traditional methods like diet and exercise.
iv. This cover is available ONLY after a Waiting Period of 2 years from the inception of 'Health+' with Us, with respect to the Insured Person.
v. Benefit under this cover is payable maximum up to Rs. 5 Lacs and claim under this section will not reduce the Sum Insured[1] or Sum Insured[2].
vi. All Claims under this benefit can be made as per the process defined under Section G.I.4 & 5.

D.III.1.v Convalescence Benefit

If the Insured Person is hospitalised for 10 consecutive days or more and the Hospitalization claim is admissible under Section D.II.1 Hospitalization Expenses, We will pay a lump sum amount of `50,000 towards convalescence, provided that Hospitalization is Medically Necessary for at least 10 consecutive days.

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.1.vi Major Illness Hospi Cash

If the Insured Person is hospitalised for a Medically Necessary treatment of a Major Illness, listed under the Policy (under domestic second opinion), We will pay daily cash benefit of ₹2,500 per day for each continuous and completed period of 24 hours of Hospitalization, for a maximum of 10 days per hospitalization event.

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.1.vii Chemotherapy and Radiotherapy Cash

If the Insured Person undergoes Medically Necessary Chemotherapy or Radiotherapy as a Day Care Treatment without 24 hours of Hospitalization, We will pay a cash benefit of ₹2,500 for each session of Chemotherapy or Radiotherapy for maximum of 12 session in a Policy Year.

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.1.viii Accidental Hospi Cash

If the Insured Person is hospitalised for a Medically Necessary treatment of an Injury sustained due an Accident that occurred during the Policy Period, We will pay a daily cash benefit of ₹2,500 for each continuous and completed 24 hour period of Hospitalization, for a maximum of 10 days per hospitalization

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.1.ix Domestic Concierge Services

If an Insured Person is hospitalised for a Medically Necessary treatment of an Illness or Injury covered under the Policy, concierge services may be provided at our sole discretion, subject to prior request and availability of the services. Such services are purely facilitative in nature, optional, and not mandatory for us to provide in every claim or hospitalisation.

This benefit is only a value added service provided by Us and if availed, will not reduce the Sum Insured[1] or Sum Insured[2]. The benefit is available only once in a Policy year for each Insured Person.

These services shall be available only on pre-intimation of a planned Hospitalization and intimation of an Emergency Hospitalization as per the process defined under Section G.I.3.

For availing this service kindly connect with our customer care services at customercare@manipalcigna.com or write to us at headcustomercare@manipalcigna.com.

D.III.1.x Tele-Consultations

Insured Persons may be eligible to avail tele-consultations with Medical Practitioners from our empaneled network only, through telephonic or chat mode, subject to availability and prior appointment. Such consultations shall be limited to select medical specialities as determined by us and shall not be available for all conditions or treatments. Any claim under this section will not reduce the Sum Insured[1] or Sum Insured[2].

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2 WOMEN+

This optional package is available to female of Age 12 years and above at the commencement of Policy with Us with respect to the Insured Person. Selection of this package is allowed at Policy level only.

For cases where female child turns 12 years of Age after the commencement of the Policy, selection of 'Women+' shall be applicable at the first renewal immediately after this instance.

If opted, benefits under the package will be available to each eligible female on individual basis, for Individual as well as family floater policies. The geographical scope of all cover of this package is restricted to India ONLY. Any expenses made outside or benefit availed outside India will not be payable. Claim under any benefit offered under WOMEN+ package will NOT reduce Sum Insured[1] or Sum Insured[2].

D.III.2.i Breast Cancer Screening

One mammography screening per eligible insured female shall be available once during each policy year. If not utilized such screening will not be carried forward to any subsequent policy years. The screening will be arranged by Us and conducted at Our Network facility.

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2.ii Cervical Cancer Screening

One papanicolaou screening, commonly known as pap smear will be available to each eligible Insured female once during each policy year. The screening will be arranged by Us and conducted at Our Network. If not utilized such screening will not be carried forward to any subsequent policy years. Original copy of the report will be provided to You.

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2.iii Cervical Cancer Vaccination

We will indemnify Reasonable and Customary Charges incurred on Cervical Cancer vaccination taken in India by the Insured Person, on the written advice of his treating Medical Practitioner. Cost of each dose of the vaccine will be limited up to ₹2,500 in a policy year. If not utilized this amount will not be carried forward to any subsequent policy years.

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

D.III.2.iv Ovarian Cancer Screening

One Ovarian Cancer screening known as Ultrasound and CA 125 will be available to each eligible Insured female once during each policy year. The screening will be arranged by Us and conducted at Our Network. If not utilized such screening will not be carried forward to any subsequent policy years.

Original copy of the report will be provided to You.

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2.v Osteoporosis Screening

One Osteoporosis screening known as Dexa scan will be available to each eligible Insured female once during each policy year. The screening will be arranged by Us and conducted at Our Network. **If not utilized such screening will not be carried forward to any subsequent policy years.** Original copy of the report will be provided to You**.**

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2.vi Gynaecological Consultations

Each eligible Insured female can avail up to 15 out-patient gynaecological consultations during each policy year. These consultations will be arranged by Us and conducted at Our Network. Any unutilized consultations shall not be carried forward to any subsequent policy years.

For the purpose of this benefit, 'Gynaecological Consultations' shall mean consultation with a gynaecologist to assess well-being and functioning of the female reproductive system and determine the presence of diseases and infections. It may also relate to hormonal imbalance, fertility and to a certain extent preconception, prenatal, and maternal care. Follow-up consultations shall also be covered under this benefit as a separate new consultation session.

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.2.vii Psychiatric and Psychological Consultations

Each Insured female can avail up to a total of 5 out-patient psychiatric/ psychological consultations and psychotherapy session in a policy year. These consultations/ sessions will be arranged by Us and conducted at Our Network. Any unutilized consultations/sessions shall not be carried forward to any subsequent policy years.

All Claims under this benefit can be made as per the process defined under Section G.I.14.

D.III.3 GLOBAL+

This optional package is available to all Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only.

D.III.3.i Global Hospi Cash

If the Insured Person is hospitalised outside India, within the opted Area of Cover, for a Medically Necessary treatment of a Major Illness and the Hospitalization claim is admissible under Section D.II.17 under 'Global Hospitalization for Major Illness', We will pay a daily cash benefit of Rs. 25,000 for each continuous and completed period of 24 hours of Hospitalization during the Policy Period, for a maximum up to 15 days per Hospitalization.

Claims under this section will not reduce Sum Insured[1] or Sum Insured[2].

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

D.III.3.ii Global Convalescence Benefit

If the Insured Person is hospitalised outside India, within the opted Area of Cover, for at least 15 consecutive days, for Medically Necessary treatment of a Major Illness, and the Hospitalization claim is admissible under Section D.II.17 'Global Hospitalization for Major Illness', We will pay in lump sum ₹10,00,000 provided that such Hospitalization continued for atleast 15 consecutive days.

This benefit is available once in a lifetime for each Major Illness covered under the Policy

Claims under this section will NOT reduce Sum Insured[1] OR Sum Insured[2].

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

D.III.3.iii Global Out Patient Expenses

We will cover the below listed Reasonable and Customary charges towards Outpatient expenses [OPD],

incurred outside India, within the opted Area of Cover. Such OPD expenses must necessarily be towards treatment of a covered Major illness/es.

Specific Conditions applicable to Global Out Patient Expenses

a. For the purpose of this benefit Out-patient expenses only include:
    i. Consultations with Medical Practitioners and Specialists,
    ii. Medically prescribed medicines, drugs and dressings;
    iii. Medically prescribed diagnostic tests such as laboratory tests, radiology and pathology, MRI, CAT scan, PET scan.
b. Our maximum liability under this cover shall never exceed ₹1 Lac in a Policy Year
c. Claim payable under Global Out Patient Expenses will reduce Sum Insured[2]
d. If Waiver of Deductible is opted under the Policy, the selected deductible will not be applicable for this cover.
e. For floater policies the cover will be available on floater basis
f. Exclusion pertaining to Out Patients treatment under Section E shall stand superseded to the extent of coverage provided under this benefit

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

D.III.3.iv Global Chemotherapy and Radiotherapy Cash

If the Insured Person undergoes Medically Necessary Chemotherapy or Radiotherapy, outside India, within the opted Area of Cover, as a Day Care Treatment (without 24 hours of Hospitalization), We will pay a cash benefit of ₹25,000, for each such sitting of Chemotherapy or Radiotherapy, for up to a total of 12 sittings per Insured person per Policy Year.

Claims under this section will NOT reduce Sum Insured[1] OR Sum Insured[2].

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

D.III.3.v Travel Expenses Benefit

If the Insured Person travels outside India, for In-patient care hospitalisation of a covered Major Illness/es, We will pay a cash benefit, to account for his travel expenses and associated costs.

Specific conditions applicable to Travel Expenses Benefit

a. The Insured must be travelling for treatment to a place outside of India but within the area of cover
b. This benefit is available only once in the lifetime of each Insured Person for each Major Illness covered under the Policy.
c. Cash benefit as below shall be provided based on Area of Cover:
    i. Worldwide excluding India - ₹ 5 Lacs
    ii. Worldwide excluding India, USA and Canada - ₹ 3 Lacs
d. Claims under this section will NOT reduce Sum Insured[1] OR Sum Insured[2].
e. The claim will be payable only when both onward and return travel dates for medical treatment are within the Policy Period.

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

D.III.3.vi Global Second Opinion

If an Insured Person is diagnosed with/ advised a treatment for a Major Illness/es, covered under the Policy, You may choose to secure a second opinion from Our Network of Medical Practitioners outside India. The expert opinion would be directly sent to You.

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

a. We have received a request from You to exercise this option;
b. That the expert opinion will be based only on the information and documentation provided by You that will be shared with the Medical Practitioner;
c. This benefit can be availed by each Insured Person only once in the lifetime of an Insured Person for each covered Major Illness;
d. This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;
e. The Insured Person is free to choose whether or not to obtain the expert opinion and if obtained then whether or not to act on it;
f. The expert opinion under this Policy shall be limited to the covered Major Illness/es and not be valid for any medico legal purposes;
g. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner;
h. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.
i. Claims under this section will NOT reduce Sum Insured[1] OR Sum Insured[2].
j. The claim will admissible only when both the below dates fall during the Policy Period
    1) Date of first diagnosis of the listed Major Illness and
    2) Date of availing the global second opinion

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

D.IV ADD ON

:For in-depth details of the below add-ons / rider kindly refer to prospectus / policywordings of the same available on our website. Any other Add-ons as launched from time to time may also be available.

D.IV.1.ManipalCigna Critical Illness Add On Cover

You can also avail the ManipalCigna Critical Illness Add On Cover and get a lumpsum amount upon the first diagnosis of a listed critical illness.

D.IV.2.ManipalCigna Health 360

You can opt for this Add-on cover which helps modify you room rent limit and also provides coverage for expenses incurred on air ambulance, non-medical items and durable medical equipment, unlimited restoration and OPD.

D.IV.3.ManipalCigna Lifetime Plus

You can opt for this Add-on cover which helps you to modify your Cumulative bonus and also provides coverage for expenses incurred on Maternity, infertility, oocyte donor and worldwide medical emergency hospitalizations.

E EXCLUSIONS

We shall not be liable to make any payment under this Policy 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. All the waiting periods and exclusions shall be applicable individually for each Insured Person and claims shall be assessed accordingly. Section 'E. Exclusions are applicable to all benefits under this policy except the below

a. Adult Health Check-Up
b. Breast Cancer Screening
c. Cervical Cancer Screening
d. Cervical Cancer Vaccination
e. Ovarian Cancer Screening
f. Psychiatric and Psychological Consultations
g. Osteoporosis Screening
h. Gynaecological Consultations
i. Tele-consultations
j. Personal Accident Plus
k. Global Second Opinion
l. Travel Expenses Benefit

E.I STANDARD EXCLUSIONS

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

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

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

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

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

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

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

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

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

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

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

f. List of specific diseases/procedures :

i. Cataract,
ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids
iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal.
iv. Varicose Veins and Varicose Ulcers,
v. Stones in the urinary uro-genital and biliary systems including calculus diseases.
vi. Benign Prostate Hypertrophy, all types of Hydrocele.
vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region.
viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
ix. Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
x. Any surgery of the genito-urinary system unless necessitated by malignancy.

E.I.3 30-day Waiting Period Code- Excl 03

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

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

b. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

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

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

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

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

2. Surgery to be conducted is upon the advice of the Doctor
   The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and

4. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type^2 Diabetes

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

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

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

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

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

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

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

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

E.I.11 Excluded Providers Code- Excl 11

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

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

E.I.13 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13

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

E.I.15 Refractive Error Code- Excl 15

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

E.I.16 Unproven Treatments Code- Excl 16

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

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

Expenses related to sterility and infertility. This includes:

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

E.I.18 Maternity Code Excl 18

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

E.II SPECIFIC EXCLUSIONS

E.II.1 Personal Waiting period

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

E.II.2 External Congenital Anomaly or defects or any complications or condition arising therefrom.

E.II.3 Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

E.II.4 Prostheses, corrective devices and/or Medical Appliances, which are not required intra- operatively for the Illness/ Injury for which the Insured Person was Hospitalised, unless opted.

E.II.5 Treatment received outside India. However this exclusion shall be superseded to the extent of coverage provided under section D.II.17 to D.II.26 and Global+ covers (if the same are opted)

E.II.6 All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack or in any other sequence to the loss.

E.II.7 All expenses caused by or arising from war or war-like situation. or attributable to foreign invasion, act of foreign enemies, hostilities, war-like operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

E.II.8 For complete list of non-medical items, please refer to the Annexure III, list I of "Non-Payable Items" and also on Our website.

E.II.9 Any form of Non-Allopathic Treatments except AYUSH treatment.

E.II.10 Pre-existing condition disclosed by the Insured Person will be reviewed according to the company's underwriting policy.

E.II.11 Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.

E.II.12 Out-patient treatment expenses

E.II.13 Expenses related to an Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

E.II.14 Preventive care, vaccination, inoculation, or immunization, except when administered as part of hospitalization required for post-animal bite treatment.

E.II.15 Expenses related to the provision or fitting of hearing aids, spectacles or contact lenses.

E.II.16 Any treatment and associated expenses for alopecia, baldness including cortico steroids and topical immuno therapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.

E.II.17 Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary.

E.II.18 Drugs or treatments which are not supported by a prescription.

E.II.19 Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

E.II.20 Treatment at a healthcare facility which is NOT a Hospital or Day Care Centre.

E.II.21 Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which

he is licensed.

E.II.22 Dental Treatment, orthodontic treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way, unless specifically covered under the Policy.

E.II.23 Instrument used for Sleep Apnea Syndrome (C.P.A.P.),Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.), Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pumps, or other external devices used during or after treatment.

E.II.24 Costs of donor screening or organs Transplants involving organs not harvested from a human body

E.II.25 Expenses for Multi-Focal Lenses, Multi-Focal Toric lenses, and Femto Laser-Assisted surgeries for cataract treatment.

E.II.26 Expenses related to any Modern & Advanced Treatments other than those covered under this Policy

F GENERAL TERMS AND CLAUSES

F.I STANDARD GENERAL TERMS AND CLAUSES

F.I.1 Moratorium period

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

F.I.2 Disclosure of Information

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

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

("Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

F.I.3 Condition Precedent to Admission of Liability

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

F.I.4 Complete Discharge

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

F.I.5 Claim Settlement (provision for Penal Interest)

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

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

F.I.6 Multiple Policies

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

In case of multiple indemnity policies taken by an Insured Person during a period from one or more Insurers,

the Insured Person shall have the right to require settlement of his/her claim under any of his/her policies, subject to proper disclosure of information about their multiple indemnity policies to chosen Insurer, either at policy inception, at renewal, or at the time of claim intimation.

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

F.I.7 Free Look period

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

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

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

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

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

F.I.8 Cancellation

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

A. Policy Tenure of 1 Year:

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

Illustration:

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

Policy Start Date	01-07-2023

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

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

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

No refund would be given to Policyholder as he had made a claim during the Policy Period.

B. If Policy Tenure is more than 1 years:

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

Illustration:

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

Policy Start Date	01-07-2023
Policy End Date	30-06-2025
Tenure	2
Latest Claim Date	NA
Cancellation Request Date	19-09-2023

Premium Collected	100.00
Unexpired Period (in Days)	650
Premium Refund	88.92 (100*650/731)

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

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

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

F.I.9 Migration

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

F.I.10 Premium Payment in Instalments (Wherever applicable)

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

i. Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.

ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.

iii. Instalment facility shall not be available for the Policy Tenure more than 1 year

iv. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.

v. No interest will be charged if the instalment premium is not paid on due date.

vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

viii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

F.I.11 Renewal of Policy

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

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

F.I.12 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration

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

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

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

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

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

F.I.13 Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.:

F.I.14 Nomination

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

F.I.15 Redressal of Grievance

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

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: 022-61703600

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also
approach the grievance cell at any of company's branches with the details of the grievance.

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

'The Grievance Cell,

401/402, 4th Floor, Raheja Titanium, Western Express Highway, Goregaon (East),

Mumbai - 400063, Maharashtra, India or

Email: headcustomercare@manipalcigna.com.

For updated details of grievance officer, kindly refer link:https://www.manipalcigna.com/grievance-redressal

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

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

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

The office Name and address details applicable for your state can be obtained from - https://www.cioins.co.in/ Ombudsman.

F.I.16 Withdrawal of Policy

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

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

F.I.17 Possibility of Revision of Terms of the Policy Including the Premium Rates

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

F.II SPECIFIC TERMS AND CLAUSES

F.II.1 Material Change

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

F.II.2 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

F.II.3 Parties to the Policy

The only parties to this Policy are the Policyholder and Us.

F.II.4 Notice & Communication

- Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- Such communication shall be sent to the address of the Company or through any other electronic modes
  specified in the Policy Schedule.
- The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.
- 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.
- Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

F.II.5 Alterations in the Policy

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

F.II.6 Change of Policyholder

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

The policyholder may be changed upon request in case of his demise, his moving out of India or in case

of divorce during the Policy Period.

F.II.7 No Constructive Notice

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

F.II.8 Geography and currency conversions

The geographical coverage of this policy and all its benefits except the ones listed below is limited to events/perils occurring within India only. However, all admitted or payable claims shall be settled in India and payable in Indian Rupees only.

Name of benefits where-in coverage is provided outside of India BUT within the opted area of cover

a. Global Hospitalisation for Major Illness
b. Global Pre - hospitalization
c. Global Post – hospitalization
d. Global Ambulance Cover
e. Medical Evacuation
f. Medical Repatriation
g. Repatriation of Mortal Remains
h. Global Travel Vaccination
i. Global Robotic and Cyber Knife Surgery
j. Global Modern and Advance Treatments

k. All benefits under Global+ Package

The payment of any Claim under the above listed Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

F.II.9 Territorial Jurisdiction

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

F.II.10 Grace Period

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

F.II.11 Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and

b. realization of Renewal premium. The Global plan shall be renewed subject to the Insured Person being a resident of India at the time of renewal.

c. We, shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.

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

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

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

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

h. Any enhanced Sum Insured and/or amount of reduction in Deductible during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

i. Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned below shall be waived only up to the lowest Sum Insured of the last 24 consecutive months as applicable to the relevant waiting periods under the product.

j. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, all waiting periods under Section IV.1 to IV.4 will be applicable considering such Policy Year as the first year of Policy with the Company.

k. In case of floater policies, children attaining 31 years at the time of renewal will be moved out of the floater into an individual cover, however all continuity benefits in the policy will remain intact.

l. In case there is any enhancement of risk by way of opting for optional covers, add-ons/riders, upgradation of plan, extension of geographical scope etc. all waiting periods under this policy shall apply afresh to the enhanced portion of the risk.

F.II.12 You may pay the premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that:

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

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

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

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

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

F.II.13 Following discounts are available under the Policy

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

b. Worksite Marketing discount - A discount of 10% will be available on policies which are sourced through worksite marketing channel.

c. Family(Multi-Individual) Discount - A discount of 15% on the premium for covering 2 or more members in the same Policy with multi-individual policy option. The discount is not available on the premium of Health+ and Women+ optional packages.

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

e. Loyalty discount - A discount of 5% on the entire Policy premium from 4th Policy Year to 7th Policy Year
and discount of 10% on the premium of the entire Policy from 8th Policy Year onwards.

All discounts under F.II.13 (a), (b), (d) and (e) are available to both individual as well as floater policies and (c) is available for Individual policies only.

All applicable discounts are multiplicative and will be calculated on the total Policy premium, irrespective of Policy type (individual or family floater)

F.II.14 Premium calculation

Premium will be calculated based on the Plan, Deductible, Sum Insured opted, Policy Tenure, Age, Policy Tenure, Age, Policy Type, Optional Cover, Premium Payment mode, opted Area of Cover and Add on Benefits opted. All Premiums are age based and will vary each year as per the change in age.

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

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

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

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

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

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

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

5. Zone Classification

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

Zone	Region/District/State
Zone 1	Delhi & NCR Districts in Gujarat: Ahmedabad, Gandhinagar, Surat, Vadodara Districts in Maharashtra: Mumbai, Thane, Navi Mumbai Districts in Andhra Pradesh /Telangana: Hyderabad, Khammam, Kothagudem, Hanamkonda, Warangal Districts in Uttar Pradesh: Mathura, Jyotiba Fule Nagar (Amroha), Aligarh Others: Rewari, Jind, Jhunjhunu, Patna
Zone 2	Rest of the Bihar State Districts in Andhra Pradesh / Telangana: Ananthapur, Bapatla, Gadwal, Guntur, Kamareddy, Kurnool, Mahabubnagar, Medak, Nalgonda, Nellore, Nizamabad, Rangareddy, Suryapet, Wanaparthy Districts in Punjab: Amritsar, Gurdaspur Districts in Maharashtra: Ahmednagar, Akola, Beed, Buldhana, Jalna, Latur, Nashik, Palghar, Pune, Raigad Others: Chennai, Bangalore, Kolkata, Dhanbad, Bokaro
Zone 3	Rest of India

Note:

i. Some areas (pin-codes) that are in the immediate vicinity of the districts mentioned in the zone definition above are classified in the respective zones of those districts.

ii. No Zonal Co-payment shall apply if person from a lower zone avails treatment in a higher zone. Example: No Zonal Co-payment shall apply if person from a Zone 3 avails treatment in Zone 2 or Zone 1.

F.II.15 Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

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

- Rectification in Name of the Proposer / Insured Person
- Change of Policyholder
- Rectification in Gender of the Proposer/ Insured Person
- Rectification in Relationship of the Insured Person with the Proposer
- Rectification of Date of Birth of the Insured Person (if this does not impact the premium)
- Change in the correspondence address of the Proposer (if this does not impact the premium)
- Rectification in permanent address
- Change of occupation of the insured (if it does not change the risk class of insured)
- Change in height & weight of the insured (if it does not change the risk class of insured)
- Change/Updation in the contact details viz., Phone No., E-mail Id, etc.
- Updation of alternate contact address of the Proposer

- Change in Nominee Details
- Change in Claim Status (for cases where claims are reported post issuance of renewal notice and renewal policy issued before expiry date).

b) Financial Endorsements - which result in alteration in premium

- Deletion of Insured Member on Death or Separation or Policyholder/Insured Person Leaving the Country only if no claims are paid / outstanding
- Change in Age/Date Of Birth
- Change of occupation of the Insured (if it changes the risk class of insured)
- Addition of Member (New Born Baby or Newly Wedded Spouse)
- Rectification in Gender of the Proposer/ Insured Person
- Disclosure of any illness/ habit
- Change in height & weight of the insured (if it changes the risk class of insured)

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

F.II.16 Underwriting Loading & Special Conditions

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

We may apply a specific sub-limit on a medical condition/ailment depending on the past history and declarations or additional waiting periods (a maximum of 36 months from the date of inception of first policy) on pre-existing diseases as part of the special conditions on the Policy.

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

F.II.17 Electronic Transactions

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

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

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

F.II.18 Terms and conditions of the Policy

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

F.II.19 Revival of policy

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

Specific conditions applicable to revival of policy

a. The policy could be revived maximum within 180 days from lapse of the first payment due date
b. Revival of policy shall be subject to our discretion and may require the below additional conditions (if deemed necessary by us):
    1. Special conditions,
    2. Assessment of current health status or Good health declaration
    3. Undergoing medical examinations
    4. Payment of all the premium (inclusive of applicable taxes) that was due and unpaid
c. Any claim/medical expense incurred during the lapsed period (time from when the grace period ends till the time payment is made) shall not be paid even after revival of policy i.e. no claim would be admissible for the break-in period in your policy.
d. If a 'Good Health Declaration' is sought by us and is later proven to be fraudulent, the entire policy shall be cancelled, and no claims shall be payable.
e. The Company reserves the right to accept or decline the revival of such lapsed policy and the continuation of coverage and benefits such as waiting period credits, accrued Bonuses and moratorium period protection is purely subject to Insurer's approval by way of issuance of the continued policy. In such an event, the coverage under the policy would re-commence from the date of company's decision of acceptance of revival of policy and subject to payment of all due premiums.

F.II.20 Coverage Standards & Protocols

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

Our goal is to deliver care that is appropriate, effective, and safe. Equally important is avoiding treatments that are not medically necessary, as this helps safeguard patient well-being. Insurance, by design, is to support healthcare needs and not to change treatment choices. Furthermore, a key principle

in insurance suggests that having coverage should not influence healthcare decisions. Patients naturally consider the benefits of treatment along with its cost and choose care that offers the best value and medical results. This approach supports responsible, value-based care that focuses on what is truly needed for recovery and long-term health.

A. Medical Protocols

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

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

These guidelines are designed to help explain:

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

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

To ensure patient safety and quality of care, coverage under this policy shall be aligned with treatments and medicines that are approved by recognized regulatory authorities such as the

Central Drugs Standard Control Organisation (CDSCO), Food and Drug administration (FDA), and other relevant bodies in India. Any treatment, medicine not approved by CDSCO, FDA and other appropriate authorities in India shall not be covered under the policy.

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

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

B. Position statements

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

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

Medical protocols published by these establishments will outline how we assess different medicines,

treatments, procedures, investigations, and therapies. Depending on the clinical and scientific evaluation, we may either cover the Reasonable and Customary charge incurred on a treatment wholly or partially or may recommend suitable alternatives or may seek additional review or in some cases may be unable to provide coverage under this product.

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

C. Prolonged Hospitalization extending beyond 10 days

a. It is important that you inform us in a timely manner. If we do not receive intimation within 10 days from the date of admission, we may apply an additional cumulative co-payment of 10% on the final admissible claim amount.

b. We may request for indoor case papers, treatment sheets, and daily monitoring records to help us understand and support the medical need for the extended stay.

c. If the medical records indicates that the insured's health parameters have stabilized and yet the hospitalization continues, expenses related to the extended period of stay may not be payable under this policy.

D. Organ Transplants

a. For live donor organ transplants, we kindly request that you inform us at least 7 days in advance, even if the hospitalization is planned at a non-network hospital. This allows us to assist you more effectively through the process.

b. In the case of a cadaveric organ transplant, where advance planning may not always be possible, please inform us as early as feasible, and no later than 48 hours from the date and time of admission, even if treatment is at a non-network hospital.

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

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

F.II.21 Switching between Plans

There are 2 plans under Lifetime Health product i.e. India Plan and Global Plan. Policyholders are allowed to switch from one plan to another only at renewals. This shall be subject to Underwriting. If the Policyholder switches from India Plan to Global Plan then all waiting periods shall apply afresh to the enhanced part of the risk ie. Waiting periods shall apply afresh to the Global covers that would come into force.

F.II.22 Personal Data and Privacy

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

G OTHER TERMS AND CONDITIONS

G.I CLAIM PROCESS & MANAGEMENT

G.I.1 Condition Preceding

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

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

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

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

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

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

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

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

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

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

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

G.I.3 Claim Intimation

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

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

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

Emergency Hospitalization, You/the Insured Person will intimate such admission within 24 hours from the date and time of such admission but not later than discharge from the hospital.

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

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

G.I.4 Cashless Facility

Cashless facility is available only at our Network Hospital or Common empanelment of hospital/healthcare providers as specified by Insurance Council. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital or Common empanelment of hospital/healthcare providers as

specified by Insurance Council, by presenting the health card as provided by Us with this Policy, along with a valid photo identification proof (Voter ID card/Driving License/Passport/PAN Card/ any other identity proof as approved by Us)

(a) For Planned Hospitalization:

i. The Insured Person should approach the Network provider at least 48 Hours days prior to the admission for Hospitalization

ii. The Network Provider or common empanelment of hospital/healthcare providers will issue the request for authorisation letter prescribed by the IRDAI.

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

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

v. Wherever the information provided in the request is sufficient to ascertain the authorisation we shall issue the authorisation Letter to the Network Provider or common empanelment of hospital/healthcare providers. Wherever additional information or documents are required we will call for the same from the Network provider or common empanelment of hospital/healthcare providers and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 1 hour from receipt of request.

vi. The Authorisation letter will include details of amount sanctioned, any specific limitation on the claim, any co-pays or deductibles and Non-Medical expenses (as defined under Annexure III of the policy), if applicable.

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

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

i. The Network Provider shall request Us for an enhancement of authorisation limit as described under

ii. Section G.I.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit.

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

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

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

At the time of discharge:

i. the Network Provider or common empanelment of hospital/healthcare providers may forward a final request for authorization for any residual amount to us along with the discharge summary and the billing format in accordance with the process described at G.I.4.(a) above.

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

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

(b) In case of Emergency Hospitalization

i. The Insured Person may approach the Network Provider or common empanelment of hospital/healthcare providers for Hospitalization for medical treatment.

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

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

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

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

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

The Network Provider or common empanelment of hospital/healthcare providers will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us. The following claim documents should be submitted to Us within 15 days from the date of discharge from Hospital -

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

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

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

We at our sole discretion, reserve the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder/Insured Person

is required to check the applicable/latest list of Network Hospital on the Company's website or by calling our call centre.

G.I.5 Claim Reimbursement Process

(a) Collection of Claim Documents

a. Wherever Insured person has opted for a reimbursement of expenses, he/she may submit the following original documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 30 days from the date of discharge from the Hospital.

All the following documents shall be required in original, except in case of deductible we require attested photocopy of below documents and settlement letter of previous insurer (partial payment cases) for India Plan and Global Plan.

- Duly completed claim form.
- Photo Identity proof of the patient.
- Medical practitioner's prescription advising admission
- Bills with itemized break-up
- Payment receipts
- Discharge summary including complete medical history of the patient along with other details
- Investigation/Diagnostic test reports etc supported by the prescription from attending medical practitioner
- OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
- Sticker/Invoice of the Implants, wherever applicable
- MLR (Medico Legal Report) copy if carried out and FIR (First Information Copy) if registered, where ever applicable
- NEFT details (to enable direct credit of amount in bank account) and original cheque of the proposer with pre-printed name
- KYC (Identity proof with Address) of the proposer, where claim liability is above Rs1 Lakh as per AML guidelines
- Legal heir/succession certificate, wherever applicable
- Any other relevant document required by Company/TPA for assessment of the claim
- Any other document as needed by Us

Claim documents required to be submitted for Personal Accident Plus cover

In case of Accidental Death

- MLC/ FIR report
- Post Mortem Report if applicable and conducted
- Original Death certificate issued by the office of Registrar of Birth & Deaths
- Occupation Certificate
- Disappearance Certificate by relevant body
- Personal Identification documents of the deceased Insured Person (AADHAAR Card, Pan Card etc.)
- Death summary issued by a Hospital along with the Injury event
- Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased

- Any other document as needed by Us

In case of Permanent Total Disablement, Permanent Partial Disablement

- MLC/FIR if applicable
- Original treating Medical Practitioner's certificate describing the disablement along with the Injury event;
- Occupation Certificate
- Original Discharge summary from the Hospital;
- Photograph of the Insured Person reflecting the disablement;
- Prescriptions and consultation papers of the treatment;
- Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.
- Medical Practitioner's certificate confirming the injury, commencement date of the Injury, total duration of the disablement
- Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable;

Health+ claim documents to be submitted in original

- Claim form - filled and signed
- Hospital main bill
- Hospital break-up bill
- Discharge summary
- Original investigation test reports confirming the diagnosis
- Doctor's recommendation for corrective and medical aids
- BMI report
- Policy details for verification of waiting period
- Doctor's recommendation for the necessity of bariatric surgery
- Payment receipt
- Any other document as needed by Us

Women+ claim documents to be submitted in original

In case of reimbursement - For Vaccination benefits, below mentioned documents are required in original.

- Claim form - filled and signed
- Doctor recommendation and consultation paper
- Payment receipt
- Any other document as needed by Us

For cashless process please refer Section G.I. 4. Global+ claim documents to be submitted in original

- Claim form - filled and signed
- Hospital main bill
- Hospital break-up bill
- Discharge summary
- Air ambulance bill with treatment given in Air ambulance
- Passport photocopy with recent visa stamps
- Original investigation test reports confirming the diagnosis
- Doctor's letter confirming fit for medical evacuation and repatriation

- Any other document as per claim and need of case.

The process for Cashless and Reimbursement shall remain the same for international claims. Cashless may be availed for planned international OPD treatments and will have to be pre-authorized, subject to payability under policy.

We may call for any additional documents/information as required based on the circumstances of the claim.
Email notification to be sent to insured.

Our branch offices shall give due acknowledgement of collected documents to the Insured person.

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

G.I.6 Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider or Common empanelment of hospital/healthcare providers) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.
b. We shall settle the payable claim amount after scrutinizing the claim documents.
c. In case a reimbursement claim is received when a Pre-Authorization letter has been issued, before approving such claim, a check will be made with the provider whether the Pre-authorization has been utilized as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed

G.I.7 Claim Assessment

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

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

ii) The Claim amount assessed under Section G.I.7.i will be deducted from the Sum Insured.

1. Claim Assessment for benefit covers

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

2. Claim process for Deductible plan

If the claim amount is more than deductible, then final payable amount will be ascertained after all NME and
room rent deduction, the claim will then be processed in two scenarios below:

- If this final payable amount is less than opted deductible, then claim will not be settled. The amount
  however will be calculated as aggregate for future claims.
- If final payable amount is more than opted deductible, then amount over and above deductible opted value
  will be paid.

3. Claim process for Restoration

For Restoration, Claims will be assessed as per regular cashless & reimbursement claim process. Once the sum insured is exhausted, only for unrelated illness of the same member/ any illness of another member, the Restoration will be triggered. The Restoration is post Our confirmation.

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

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

- In case of a claim (Cashless/Re-imbursement), an amount equivalent to the balance of the instalment premiums payable, in that policy year, would be recoverable from the admissible claim amount payable in respect of the Insured person.
- In case of a claim (Cashless/Re-imbursement), of amount equivalent or less then balance of the instalment premiums payable, in that policy year, would be recoverable first before the assessment of claim is made in respect of the claim intimated by the Insured person.

5. Emergency evacuation & Medical repatriation

a. In the event of an Insured Person requiring Emergency evacuation and repatriation, Insured Person, must notify Us immediately either at Our call centre or in writing.

b. Emergency medical evacuations shall be pre-authorized by us.

c. Our team of Medical specialists in association with the Emergency Assistance Service Provider shall determine the Medical Necessity of such Emergency Evacuation or Repatriation post which the same will be approved. Hospi cash Benefit Claims.

All documents supporting the illness and/or hospitalization would be requested on a case-to-case basis.

G.I.8 Claims Investigation

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

G.I.9 Pre and Post-hospitalization claims

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

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

G.I.10 Representation against Rejection

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

G.I.11 Payment Terms

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

- If You/Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any One Illness" under this Policy shall be applied as if they were under a single claim.
- For Cashless Claims, the payment shall be made to the Network Hospital or common empanelment of hospital/healthcare providers whose discharge would be complete and final.
- For Reimbursement Claims, the payment will be made to you. In the unfortunate event of Your death, We will pay the nominee (as named in the Policy Schedule) and in case of no nominee to the Legal Heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of its liability under the Policy.

G.I.12 Deductible

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

b. Wherever such hospitalization claims as stated under G.I.12.a above is being covered under another Policy held by You, We will assess the claim on available photocopies duly attested by Your Insurer / TPA as the case may be.

G.I.13 Domestic/ Global Second Opinion

a. Receive Request for Expert Opinion on major illness Insured person can submit his/her request for an expert opinion by calling Our call centre or register request through email. Similarly for global opinion, insured will need to contact our overseas service provider.

b. Facilitating the Process

We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner. The expert opinion is available multiple time in the event of the Insured Person being diagnosed with different major illness. In case of Global opinion, the expert opinion is available once during the lifetime of an Insured Person for one covered Major Illness.

G.I.14 Health Check-up, Screening, Consultation and Tele-Consultation

a. Insured Person shall seek appointment by calling Our call center.

b. We will facilitate his/her appointment and We will guide him/her to the nearest Network Provider for conducting the medical examination.

c. Reports of the Medical Tests can be collected directly from the centre

G.I.15 Claim Processing for Portability

For portability cases core claims system will validate credit period, pre-existing diseases & waiting period clauses during claims entry. Claims team will assess the claim as per regular cashless & reimbursement claim process.

G.I.16 Application of Multiple policies clause

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

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

i) **Cashless hospitalization:** In case the Insured avails Cashless Facility for Hospitalization then Insured/ or common empanelment of hospital/healthcare providers will intimate us of the admission through a preauthorisation request with all details & estimated amount for the Hospitalization. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the

amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy/policies so chosen. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

ii) **Reimbursement claim:** In case the Insured gets admitted & pays the entire bill & then files for reimbursement claim then he will have to intimate us of the admission 48 hours before admission for planned admissions & within 24 hours post admission for emergency hospitalization but in no case later than discharge from the Hospital. Insured will need to submit details of the other insurance policies to the Company. Post discharge insured will send all the original documents along with bills & claim form to one of the insurer & certified copies of all documents. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy/policies so chosen. Post discharge, the Insured will send all original documents, bills, and claims forms to one Insurer and certificate copies of all documents to the others.

b) Retail policy & group policy from the Company:

i). **Cashless process:** In case the insured needs to utilize cashless facility for hospitalization then the insured/hospital will intimate the Company about the hospitalization through preauthorisation process. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/ policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy/policies so chosen. Post discharge hospital will send as many separate claims as no. of policies with the Company with attached AL letters & original documents with the 1st claim & copy of documents with the other claims for settlement to the Company. The Company will settle all the claims as per policy terms & conditions & AL issued.

ii).**Reimbursement Claim process:** In case the Insured gets admitted & pays the entire bill & then files for reimbursement claim then he will have to intimate the Company of the admission 48 hours before admission for planned admissions & within 24 hours post hospitalization for emergency hospitalization along with all the policy numbers. Post discharge insured will send all original documents & bills along with duly filled claim form. The policyholder having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy/policies so chosen.

G.II . Annexure – I:
Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email:- oio.ahmedabad@cioins.co.in	Gujarat, Dadra and Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462001. Tel.: 0755 - 2769201 / 2769202/2769203 Email:- oio.bhopal@cioins.co.in	Madhya Pradesh and Chhattisgarh
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455/2596429/ 2596003 Email:- oio.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017 Tel.:- 0172 - 2706468 Email:- oio.chandigarh@cioins.co.in	Punjab, Haryana, (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044 - 24333668 / 24333678 Email:- oio.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Delhi and following Districts of Haryana - Gurugram, Faridabad, Sonepat and Bahadurgarh

Tel.:- 011 - 46013992/ 23213504/ 23232481 Email:- oio.delhi@cioins.co.in	
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2632204/2602205/2631307 Email:- oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Hyundai Showroom A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 23376991 / 23376599 / 23328709 / 23325325/23312122 Email:- oio.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email:- oio.jaipur@cioins.co.in	Rajasthan
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email:- oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email:- oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman and Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522 - 4002082 / 3500613 Email:- oio.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.

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

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

G.III Annexure-II:

Sr.no.	What am I covered for	India Plan	Global Plan
i	Sum Insured[1] (INR)	✓	✓
ii	Sum Insured[2] (INR)	×	✓
iii	Deductible (Optional) (INR)	₹25K / 50K / 1L / 2L / 3L / 4L/5L/10L.	₹25K / 50K / 1L / 2L / 3L / 4L/ 5L/ 10L.
vi	Major Illness	×	✓
iv	Waiver of Deductible	×	✓
v	Area of Cover	×	✓
Sr.no.	**Cover/s**	**India Plan**	**Global Plan**
1	Hospitalization Expenses	✓	✓
2	Day Care Treatment	✓	✓
3	Pre - hospitalization	✓	✓
4	Post - hospitalization	✓	✓
5	AYUSH Treatment	✓	✓
6	Road Ambulance Cover	✓	✓
7	Donor Expenses	✓	✓
8	Domiciliary Expenses	✓	✓
9	Adult Health Check-up	✓	✓
10	Robotic and Cyber Knife Surgery	✓	✓
11	Modern and Advanced Treatments	✓	✓
12	HIV/AIDS and STD Cover	✓	✓
13	Mental Care Cover	✓	✓
14	Restoration	✓	✓
15	Premium Waiver Benefit	✓	✓
16	Personal Accident Plus *(Optional; coverage is available only if opted)* – If opted coverage will be restricted to India only	✓	✓
17	Global Hospitalization for Major Illness	×	✓
18	Global Pre- hospitalization	×	✓
19	Global Post- hospitalization	×	✓
20	Global Ambulance Cover	×	✓
21	Medical Evacuation	×	✓
22	Medical Repatriation	×	✓
23	Repatriation of Mortal Remains	×	✓
24	Global Travel Vaccination	×	✓
25	Global Robotic and Cyber Knife Surgery	×	✓
26	Global Modern and Advanced Treatments	×	✓
Optional Packages			
I	**Health+** **(Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under Health+ is over and above that of Base Plan (India Plan/ Global Plan, as opted	✓	✓

II	**Women+** **(Available to female of age 12 years and above)** **(Each benefit is available on Individual Basis)** (Sum Insured/ limits specified under the Women+ is over and above that of Base Plan(India Plan/ Global Plan, as opted)	✓	✓
III	**Global+** This optional package is available to all Insured Persons covered under the Policy. Selection of this package is allowed at Policy level only. **Please note:** This package is available only if Global Plan is opted.	×	✓
Add on cover (Rider) **This section lists the Add on cover available under your plan**			
ManipalCigna Critical Illness	Lump sum payout upon diagnosis of a Critical Illness.		
ManipalCigna Lifetime Plus	This add-on provides following benefits: 1. Maternity Expenses a. Maternity Cover b. New Born Baby Cover: c. First Year Vaccination: d. Infertility Cover: 2.Surrogacy Cover 3.Oocyte Donor Cover 4.Cumulative Bonus (Applicable only on India SI – SI1 of Lifetime Health) Worldwide Medical Emergency Hospitalization		
ManipalCigna Health 360	This add-on provides following benefits: 1. Health 360 – OPD 2. Health 360 – Advance 3. Health 360- Shield		

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

Annexure – III:

LIST I - ITEMS FOR WHICH COVERAGE IS NOT AVAILABLE IN THE POLICY

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

LIST II – ITEMS THAT ARE TO BE SUBSUMED INTO ROOM CHARGES

1. BABY CHARGES (UNLESS SPECIFIED/ INDICATED
2. HAND WASH
3. SHOE COVER
4. CAPS
5. CRADLE CHARGES
6. COMB
7. EAU.DE-COLOGNE / ROOM FRESHNERS
8. FOOT COVER
9. GOWN
10. SLIPPERS
11. TISSUE PAPER
12. TOOTH PASTE
13. TOOTH BRUSH
14. BED PAN
15. FACE MASK
16. FLEXI MASK

17. HAND HOLDER
18. SPUTUM CUP
19. DISINFECTANT LOTIONS
20. LUXURY TAX
21. HVAC
22. HOUSE KEEPING CHARGES
23. AIR CONDITIONER CHARGES
24. IM IV INJECTION CHARGES
25. CLEAN SHEET
26. BLANKETA/VARMER BLANKET
27. ADMISSION KIT
28. DIABETIC CHART CHARGES
29. DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES
30. DISCHARGE PROCEDURE CHARGES
31. DAILY CHART CHARGES
32. ENTRANCE PASS / VISITORS PASS CHARGES
33. EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34. FILE OPENING CHARGES
35. INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36. PATIENT IDENTIFICATION BAND / NAME TAG
37. PULSEOXYMETER CHARGES

LIST III- ITEMS THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES

1. HAIR REMOVAL CREAM
2. DISPOSABLES RAZORS CHARGES (for site preparations)
3. EYE PAD
4. EYE SHEILD
5. CAMERA COVER
6. DVD, CD CHARGES
7. GAUSE SOFT
8. GAUZE
9. WARD AND THEATRE BOOKING CHARGES
10. ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11. MICROSCOPE COVER
12. SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13. SURGICAL DRILL
14. EYE KIT
15. EYE DRAPE
16. X-RAY FILM
17. BOYLES APPARATUS CHARGES
18. COTTON
19. COTTON BANDAGE
20. SURGICAL TAPE
21. APRON
22. TORNIQUET
23. ORTHOBUNDLE, GYNAEC BUNDLE

LIST IV - ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT

1. ADMISSION/REGISTRATION CHARGES
2. Hospitalization FOR EVALUATION/ DIAGNOSTIC PURPOSE
3. URINE CONTAINER
4. BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5. BIPAP MACHINE
6. CPAP/ CAPD EOUIPMENTS
7. INFUSION PUMP_ COST
8. HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9. NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIETCHARGES
10. HIV KIT
11. ANTISEPTIC MOUTHWASH
12. LOZENGES
13. MOUTH PAINT
14. VACCINATION CHARGES
15. ALCOHOL SWABES
16. SCRUB SOLUTION/STERILLIUM
17. GLUCOMETER & STRIPS
18. URINE BAG