MANIPALCIGNA PRIME SENIOR

Plans: Classic | Elite
Policy Contract

B. Preamble

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

If any Claim arising as a result of a Disease/Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the benefits in accordance with terms, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any). All limits mentioned in the Policy Schedule are applicable for each Policy Year of coverage.

C Definitions

C.I Standard Definitions

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

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

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

4. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising any of the following:
   1. Central or State Government AYUSH Hospital; or
   2. Teaching hospitals attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
   3. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i) Having at least five In-patient beds;
      ii) Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii) Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv) Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.

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

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

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

8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment

does not reduce the Sum Insured.

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

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

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

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

The following are excluded -

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

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

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

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

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

vi. Chronic lymphocytic leukemia less than RAI stage 3

vii. Non-invasive papillarycancer 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;

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

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

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

ii. new characteristic electrocardiogram changes

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

II The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris.

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

c) Open Chest CABG

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

II The following are excluded:

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

d) Open Heart Replacement or Repair of Hear Valves

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

e) Coma of Specified Severity

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

the following:

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

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

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

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

f) Kidney Failure Requiring Regular Dialysis

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

g) Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

h) Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

i) Permanent Paralysis of Limbs

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

j) Motor Neuron Disease with Permanent Symptoms

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

k) Multiple Sclerosis with Persisting Symptoms

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

i. investigations including typicalMRI 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. Neurological damage due to SLE is excluded.

12. **Cumulative Bonus**

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

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

a. has qualified nursing staff under its employment

b. has qualified medical practitioner (s) in charge

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

d. maintains daily records of patients and will make

these accessible to the Insurance Company's authorized personnel.

14. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
    ii) Which would have otherwise required a Hospitalization of more than 24 hours.

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

15. **Deductible** means a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies 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.

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

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

18. **Domiciliary Hospitalization** means medical treatment for an illness/ disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b) the patient takes treatment at home on account of non-availability of room in a hospital.

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

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

21. **Hospital** means any institution established for In-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 In-patient beds,in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;
    iii. has qualified medical practitioner (s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
    v. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

23. **Illness** means a sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a) Acute condition- Acute conditionis a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery
    b) Chronic condition-A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

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

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

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

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

28. **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.

29. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which
   i. Is required for the medical management of the Illness or injury suffered by the Insured;
   ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
   ii. Must have been prescribed by a Medical Practitioner.
   iv. Must conform to the professional standards widely accepted ininternational medical practice or by the medical community in India.

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

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

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

33. **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.

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

35. **OPD Treatment** 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.

36. **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.

37. **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.

38. **Post-hospitalization Medical Expenses**

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

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

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

39. **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.

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

41. **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.

42. **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.

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

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

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

C.II Specific Definitions

1. **Age** or **Aged** is the age at last birthday, and which means completed years as at the date of Inception of the Policy.

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

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

4. **Associated Medical Expenses.** 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.

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

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

7. **Covered Relationships shall include** spouse, children, brother and sister of the Policyholder who are children of same parents, father, mother, grandparents, grandchildren, parent in laws, son in law, daughter in law, sister in-law, brother in-law, uncle, aunt, niece and nephew.

8. **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 stabilization at which time this medical condition or symptom is not considered an emergency anymore.

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

10. **High Dependency Unit/ ward** is a specially staffed and equipped area of a hospital that provides a level of care intermediate between intensive care and the general ward care

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

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

13. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (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.

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

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

16. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, Premium Paid (including taxes), 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.

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

18. **Single Private Room** means a single Hospital room with any rating and of most economical category available at the time of hospitalization with/without air-conditioning facility where a single patient isaccommodated and which has an attached toilet (lavatory and bath). The room should have the provision for accommodating an attendant. This excludes a suite or higher category.

19. **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.

20. **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum liability for any or all claims during the Policy Period specified in the Policy Schedule separately in respect of that Insured Person.
    i. In case where the Policy Period is 2/3 years,the Sum Insured specified on the Policy is the limit for the first Policy Year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted will be available for the second/third year.
    ii. In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

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

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

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

D. Benefits covered under the policy

D.I. Basic covers

D.I.1. In-patient Hospitalization

We will cover Medical Expenses of an Insured Person in case of Medically Necessary Hospitalization arising from a Disease/ Illness or Injury provided such Medically Necessary Hospitalization is for more than 24 consecutive hours provided that the admission date of the Hospitalization due to Disease/Illness or Injury is within the Policy Year. We will pay Medical Expenses for the following:

a. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to Category as specified in the Policy Schedule/ Product Benefit Table of this Policy.
b. Intensive Care Unit charges for accommodation in ICU ,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon ,
e. Anesthetist,
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.

Room category coverage under each plan will be covered up to Single Private AC Room or up to the limits as specified in the Policy Schedule, subject to maximum of Sum Insured Opted. For ICU accommodation, we will Cover up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy.

If the Insured Person is admitted in a room category that is higher than the one that is specified in the Policy Schedule, then the Policyholder/Insured Person shall bear only the difference between the room rent of the entitled room category and the room rent actually incurred.The Policyholder/Insured Person need not bear ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category and the room rent actually incurred

The following are some of the instances where the Insured Person avails room category higher than the entitled room category yet, need not bear ratable proportion of the total Associated Medical Expenses:

i. Unavailability of the entitled room category
ii. Unavailability of necessary medical facility in the entitled room category for the purpose of treatment of illness/injury/condition for which the insured was admitted
iii. In case of an emergency hospitalization wherein the Insured is not in a position to select or wait for the entitled room category.

Under In-patient Hospitalization expenses, when availed under In-patient 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.

The following procedures will be covered (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a hospital up to the limits as specified in the Policy Schedule/Product Benefit Table of this Policy in a Policy Year:

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

Medical Expenses incurred for the Medically Necessary Treatment of the Insured Person for In-patient Hospitalization arising from or associated with Human Immunodeficiency Virus (HIV) or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or

variations thereof, sexually transmitted diseases (STD), will be covered up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year. This coverage is provided in accordance with the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 as amended from time to time. The necessity of the Hospitalization is to be certified by an authorized Medical Practitioner.

Medical Expenses incurred for the Medically Necessary treatment taken of the Insured Person for the In-patient Hospitalization, arising from or associated with a Mental illness or a medical condition impacting mental health will be covered up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy in a Policy Year. This coverage is provided in accordance with The Mental Health Care Act, 2017 as amended from time to time. For the below mentioned ICD Codes, the Insured Person should have been continuously covered under this Policy for at least 24 months before availing this benefit.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

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

D.I.2. Pre-hospitalization

We will, on a reimbursement basis cover Medical Expenses of an Insured Person which are incurred due to a Disease/ Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalization up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, provided that a Claim has been admitted under In-patient benefit under Section D.I.1 and is related to the same illness/condition.

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

D.I.3. Post-hospitalization

We will, on a reimbursement basis cover Medical Expenses of an Insured Person which are incurred due to a Disease/Illness or Injury that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, provided that a Claim has been admitted under In-patient benefit under Section D.I.1 and is related to the same illness/condition.

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

D.I.4. Day Care Treatment

We will cover payment of Medical Expenses of an Insured Person in case of Medically Necessary Day Care Treatment or Surgery that requires less than 24 hours of Hospitalization due to advancement in technology and which is undertaken in a Hospital/Nursing Home/ Day Care Centre on the recommendation of a Medical Practitioner, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, provided that:

a. The Day Care Treatment is Medically Necessary and follows the written advice of Medical Practitioner.
b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is under taken by an Insured Person as Day Care Treatment.
c. We will not cover any OPD Treatment and Diagnostic Service under this benefit.

Coverage will also include pre-post hospitalization expenses up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy.

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

D.I.5. Domiciliary Hospitalization

We will cover Medical Expenses of an Insured Person, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, which are towards 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 Hospitaltransfer; or

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

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

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

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

i. Asthma, COPD, bronchitis, tonsillitis and upper and lower respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza,

ii. Arthritis, gout and rheumatism including the rheumatism of bones, joints and also rheumatic heart disease,

iii. Chronic nephritis and nephritic syndrome,

iv. All types of Diarrhea and dysenteries, including gastroenteritis,

v. Diabetes mellitus and Diabetes Insipidus,

vi. Epilepsy / Seizure disorder,

vii. Hypertension,

viii. Pyrexia of unknown origin.All Claims under this benefit can be made as per the process defined under Section G.I.5.

D.I.6. Road Ambulance

We will provide for reimbursement of Reasonable and Customary expenses up to the limits as specified in the Policy Schedule/Product Benefit Table of this Policy, that are incurred towards road transportation of an Insured Person by a registered Healthcare or Ambulance Service Provider to a nearest Hospital for treatment of an Illness or Injury covered under the Policy in case of an Emergency, necessitating the Insured Person's admission to the nearest Hospital. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner.

a. Reasonable and Customary expenses shall include:

(i) Costs towards transferring the Insured Person from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital; or

(ii) When the Insured Person requires to be moved to a better Hospital facility due to lack of super specialty treatment inthe existing Hospital.

b. Payment under this cover is subject to a claim being admissible under Section D.I.1 'In-patient Hospitalization', for the same Illness/Injury;

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

D.I.7. Donor Expenses

We will cover In-patient Hospitalization Medical Expenses towards the donorfor harvesting the organ up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, subject to the below mentioned 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, provided that –

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

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

c. We will also cover Medical Expenses towards the donor in respect of:

i. Any Pre or Post-hospitalization Medical Expenses up to 30 days each,

ii. Cost towards donor screening for organ transplant surgery, provided that the organ transplant surgery is successful. This benefit shall be payable only once in the Policy Year

iii. Any complication in respect of the donor, consequent to harvesting, which arise during hospitalization or up to 30 days from the date of discharge of the donor, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy. This benefit shall be over and above the Sum Insured.

We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.All Claims under this benefit can be made as per the process defined under Section G.I.4 & G.I.5.

D.I.8. Restoration of Sum Insured

We will provide for a 100% restoration of the Sum Insured for annumber of times in a Policy Year, provided that:

a. The Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year.

b. This restored amount can be used for all future claims related and/or not related to the illness/ disease/injury for which a claim has been made in the particular policy year for the same Insured Person

c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section D of the Policy and shall not apply to the first claim in the Policy Year. Restoration of the Sum Insured will only be provided for coverage under Section D.I.1 'In-patient Hospitalization', Section D.I.2 'Pre-Hospitalization', Section D.I.3 'Post-Hospitalization', Section D.I.4 'Day Care Treatment', Section D.I.6 'Road Ambulance', Section D.I.7 'Donor Expenses', Section D.I.9 'AYUSH Treatment', Non-Medical Items (if Section D.III.8. 'ManipalCigna Health 360 - Shield' is opted and applicable)

d. The Restored Sum Insured will not be considered while calculating the Cumulative Bonus

e. Such Restoration of Sum Insured will be available for any number of times, during a Policy Year to each insured in case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

f. If the Policy is issued on a floater basis, the Restored Sum Insured will also be available on a floater basis.

g. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

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

   i. The Sum Insured

   ii. Cumulative Bonus (if earned)

   iii. Restored Sum Insured

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

D.I.9. AYUSH Treatment

We will pay the Medical Expenses incurred during the Policy Year, up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalization Day Care Centre for AYUSH Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

The Insured Person has undergone treatment in an AYUSH Hospital/AYUSH Day Care Centre.

D.I.10.Daily Cash for Shared Accommodation

We will pay a daily cash amount up to the limits as specified in the Policy Schedule/Product Benefit Table of this Policy for the Insured Person for each continuous and completed period of 24 hours of Hospitalization provided that,

a. We have accepted claim under Section D.I.1 In-patient Hospitalization during the Policy Year

b. The Insured Person has occupied a shared room accommodation during such Hospitalization

c. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously

What is not covered:

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

This benefit shall be over and above the Sum Insured.

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

D.I.11 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, provided that:

i. Air Ambulance is used in case of an Emergency life threatening health condition of the Insured Person which requires immediate and rapid ambulance transportation to the hospital or a medical centre which ground transportation cannot provide;

ii. The Illness/Injury, causing Emergency, is covered under the Section D.I.1 In-patient Hospitalization;

iii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment to monitor 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. Restoration of Sum Insured shall not be available under this benefit.

v. Air Ambulance service is offered by a Registered Ambulance service provider;

vi. 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;

vii. Payment under this cover is subject to a claim being admissible under Section D.I.1 'In-patient Hospitalization' or under Section D.I.4 'Day Care Treatment', for the same Illness/Injury;

Benefit under this cover is payable up to the limits as specified in the Policy Schedule/Product Benefit Table of this Policy subject to maximum up to ₹10 Lacs in a policy year and this is over and above the Sum Insured.

What is not covered: Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.

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

D.II. Value added covers

D.II.1. Domestic Second Opinion

You may choose to secure a second opinion, as per the Plan opted and as specified in the Policy Schedule, from Our Network of Medical Practitioners in India if an Insured Person is diagnosed with/ advised a treatment listed and defined under Critical Illness during the Policy Year. The expert opinion would be directly sent to the Insured Person.

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

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

(b) That the expert opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner

(c) 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.

(d) 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.

(e) 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.

(f) The expert opinion under this Policy shall be limited to covered Critical 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) This benefit can be availed by each Insured Person only once during a Policy Year for one Critical Illness. However, one can avail this benefit for multiple critical illnesses in a year.

(i) Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus.

(j) For the purpose of this benefit covered Critical Illnesses shall include –

1. **Cancer of Specified Severity**

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

The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukemia less than RAI stage 3

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

viii. All Gastro-Intestinal Stromal Tumors

histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of Specific Severity

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

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

ii. new characteristic electrocardiogram changes

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

II The following are excluded:

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

3. Open Chest CABG

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

II The following are excluded:

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

4. Open Heart Replacement or Repair of Heart Valves

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

5. Coma of Specified Severity

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

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

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

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

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

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke Resulting in Permanent Symptoms

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

The following are excluded:

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

8. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

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

11. Multiple Sclerosis with Persisting Symptoms

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

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

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

II. Neurological damage due to SLE is excluded.

12. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization.

There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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

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

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

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

13. Aorta Graft Surgery

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

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

You understand and agree that We will not cover:

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

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

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

14. Deafness

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

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

15. Blindness

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

II. The Blindness is evidenced by:

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

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

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

16. Aplastic Anemia

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

a. Blood product transfusion;
b. Marrow stimulating agents;
c. Immunosuppressive agents; or
d. Bone marrow transplantation.

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

a. Absolute neutrophil count of less than 500/mm or less;
b. Platelets count less than 20,000/mm³ or less;
c. Reticulocyte count of less than 20,000/mm³ or less.

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

17. Coronary Artery Disease

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

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

18. End Stage Lung Failure

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

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

19. End Stage Liver Failure

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

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

Liver failure secondary to drug or alcohol abuse is excluded.

20. Third Degree Burns

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

21. Fulminant Hepatitis

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

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

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

22. Alzheimer's Disease

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

The following conditions are however not covered:

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

23. Bacterial Meningitis

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

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

We will not cover Bacterial Meningitis in the presence of HIV infection under this Section.

24. Benign Brain Tumor

a. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imagingstudies such as CT scan or MRI.
b. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are however not covered by Us:

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

25. Apallic Syndrome

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

26. Parkinson's Disease

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

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

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

Activities of daily living:

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

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

27. Medullary Cystic Disease

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

28. Muscular Dystrophy

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

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

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

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

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

iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

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

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

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

29. Loss of Speech

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

30. Systemic Lupus Erythematous

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

The WHO lupus classification is as follows:

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

31. Loss of Limbs

a. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self inflicted injury, alcohol or drug abuse is excluded.

32. Major Head Trauma

a. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

c. The Activities of Daily Living are:

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

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

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

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

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

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

d. The following are excluded:

a) Spinal cord injury

33. Brain Surgery

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

34. Cardiomyopathy

The unequivocal diagnosis by a consultant cardiologist of Cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiolog and resulting in permanent physical impairments to the degree of at

least Class IV of the New York Association (NYHA) Classification of cardiac impairment.

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

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

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

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

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

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

35. Creutzfeldt-Jacob Disease (CJD)

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

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

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

36. Terminal Illness

An Insured Person shall be regarded as terminally ill only if he/she is diagnosed as suffering from a condition which, in the opinion of two appropriate independent Medical Practitioners, is highly likely to lead to death within12 months from the date of the diagnosis and the Insured Person is not receiving any active treatment for the terminal illness, other than that of the pain relief. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with the Indian Medical Association and approved by Us. All Claims under this benefit can be made as per the process defined under Section G.I.13.

D.II.2. Tele-Consultation

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

Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus.

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

D.II.3. Cumulative Bonus

We will increase Your Sum Insured at the rate, as specified in the Policy Schedule/Product Benefit Table of this Policy, on the Base Sum Insured, if the Policy is renewed with Us without any break:

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

b) If you have opted for 'Classic' Plan or 'Elite' Plan, the Cumulative Bonus shall be accumulated irrespective of claim in the preceding Policy Year.

c) The Cumulative Bonus will not be accumulated in excess of 100% of the Sum Insured under the current Policy with Us under any circumstances.

d) Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of that Policy Year if the policy is renewed with us within grace period and will be available for any claims made in the subsequent Policy Year.

e) Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple

policies and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last policy year amongst all the expiring polices being merged.

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

g) Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.

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

i) Cumulative bonus shall not be available for claims made under D.II Value Added covers, D.I.11 Air Ambulance Cover and D.I.10 Daily Cash for Shared Accommodation

j) This clause does not alter Our right to decline a Renewal or cancellation of the Policy for reasons as mentioned under Section F.I.6 and F.I.7

D.II.4.Premium Waiver Benefit

In case, the Policyholder who is also an Insured Person under the Policy suffers Death due to an injury caused by an Accident within 365 days from the date of the event or he/she is diagnosed with a Critical Illness, listed under this section, We will pay the next one full Policy Year's Renewal Premium (including Optional covers, Riders and Taxes) of the Policy, as per the Plan opted and as specified in the Policy Schedule, for a policy tenure of 1 year. The premium shall be waived towards existing Insured Persons covered under the same policy, with benefits same as the expiring Policy.

In case of any change in Policy benefits, complete premium will be paid by the Policyholder.The cover is available subject to below conditions:

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

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

a) Cancer of Specified Severity
b) Myocardial Infarction (First Heart Attack of Specific Severity)
c) Open Chest CABG
d) Open Heart Replacement or Repair of Heart Valves
e) Coma of Specified Severity
f) Kidney Failure Requiring Regular Dialysis
g) Stroke Resulting in Permanent Symptoms
h) Major Organ/Bone Marrow Transplant
i) Permanent Paralysis of Limbs
j) Motor Neuron Disease with Permanent Symptoms
k) Multiple Sclerosis with Persisting Symptoms

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

Any claim under this benefit will not impact the Sum Insured and/or Cumulative Bonus.

D.II.5. Discount from Network Providers

The Insured Person can avail discounts on Diagnostics, Pharmacy, Medical Devices, Health Supplements and other health-related services offered through our Network Providers.

D.II.6. Health Check Up:

(a)The Insured Person may avail a comprehensive Health Check Up with Our Network Provider as per the details mentioned in the table below.

Sum Insured (in ₹)	Classic Plan	Elite Plan
<=10 Lacs	Up to ₹ 2000 per insured person	Up to ₹ 3500 per insured person
>10 Lacs	Up to ₹ 2500 per insured person	Up to ₹ 5000 per insured person

Availability/ Applicability	Once after every claim free Policy Year (Available from 2nd Policy Year onwards)	Once in a policy year from 1st Policy Year onwards

(b) The Insured member shall choose to undergo Health Check Ups of Insured member's choice on Cashless basis with Our Network Provider, subject to the maximum limits as specified against the applicable Sum Insured.

(c) All the tests must have been done on the same date.

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

(e) We shall cover Health Check Up only on cashless basis.

(f) This benefit shall be over and above the Sum Insured.

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

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

D.III.Optional covers

The following optional covers shall apply under the Policy for an Insured Person if specifically mentioned on the Policy Schedule and shall apply to all Insured Persons under a single policy without any individual selection.

D.III.1.Any Room Upgrade

We will upgrade the Room category coverage under Section D.I.1 In-patient hospitalization up to 'Any Room Category' subject to maximum of Sum Insured Opted and as specified in the Policy Schedule.

D.III.2.Premium Management

We will limit the Room category coverage under Section D.I.1In-patient hospitalization up to the limits and plan opted and as specified in the Policy Schedule. For ICU accommodation, we will cover up to the opted Sum Insured and as specified in the Policy Schedule.If the Insured Person is admitted in a room category that is higher than the one that is specified in the Policy Schedule, then the Policyholder/Insured Person shall bear only the difference between the room rent of the entitled room category and the room rent actually incurred

The Policyholder/Insured Person need not bear ratable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent of the entitled room category and the room rent actually incurred.

The following are some of the instances where the Insured Person avails room category higher than the entitled room category yet, need not bear ratable proportion of the total Associated Medical Expenses:

i. Unavailability of the entitled room category

ii. Unavailability of necessary medical facility in the entitled room category for the purpose of treatment of illness/injury/condition for which the insured was admitted

iii. In case of an emergency hospitalization wherein the Insured is not in a position to select or wait for the entitled room category This Optional Cover is available only under Classic Plan.

D.III.3.Restoration of Sum Insured:

We will provide for a 100% restoration of the Sum Insured for any number of times in a Policy Year, provided that:

a. The Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year.

b. This restored amount can be used for all future claims related and/or not related to the illness/ disease/injury for which a claim has been made in the particular policy year for the same Insured Person

c. The Restored Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section D of the Policy and shall not apply to the first claim in the Policy Year. Restoration of the Sum Insured will only be provided for coverage under Section D.I.1 'In-patient Hospitalization', Section D.I.2 'Pre-Hospitalization', Section D.I.3 'Post-Hospitalization', Section D.I.4 'Day Care Treatment', Section D.I.6 'Road Ambulance', Section D.I.7 'Donor Expenses', Section D.I.9 'AYUSH Treatment', Non-Medical Items (if Section D.III.8. ManipalCigna Health 360 Shield is opted and applicable)

d. The Restored Sum Insured will not be considered while calculating the Cumulative Bonus

e. Such Restoration of Sum Insured will be available for any number of times, during a Policy Year to each insured in case of an Individual Policy and can be utilized by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.

f. If the Policy is issued on a floater basis, the Restored Sum Insured will also be available on a floater basis.

g. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.

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

   i. The Sum Insured

   ii. Cumulative Bonus (if earned)

   iii. Restored Sum Insured

This benefit shall be available only under Classic Plan on opting Sum Insured 5 Lacs and above.

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

D.III.4.Reduction in PED Waiting Period:

We will provide an option to reduce the pre-existing disease waiting period under this Policy to 90 days, on payment of applicable additional premium for this cover.

This Optional cover is available at the purchase of this Policy and shall apply to all insured persons covered under the policy

D.III.5.Deductible

You can opt for a Deductible, as specified in the Policy Schedule/ Product Benefit Table of this Policy. Wherever a Deductible is selected such amount will be applied for each Policy Year on the aggregate of all Claims in that Policy Year. Deductible shall apply to all sections other than D.I.10 Daily Cash for Shared Accommodation, D.II. Value added covers and D.III.7 ManipalCigna Health 360-OPD if opted.

For the purpose of calculating the Deductible and assessment of admissibility all claims must be submitted in accordance with Section G.I.14 of Claims Process.

All other terms, conditions, waiting periods and exclusions shall apply.For Deductible of ₹ 10,000, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal.

For Deductible of ₹ 25,000 and above, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. On opting out of deductible of ₹ 25,000 and above, the enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as applicable under the base policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of the insured member at renewal.

D.III.6.Add on - ManipalCigna Health 360-Shield

Along with this Product You can also avail the ManipalCigna Health 360-Shield Add On Cover (UIN: MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All waiting periods, exclusions and terms and conditions of applicable rider will apply.

For the purpose of this Benefit, coverages are mentioned under the ManipalCigna Health 360 - Shield Add on Cover Policy documents.

D.III.7.Add on - ManipalCigna Health 360-OPD

Along with this Product You can also avail the ManipalCigna Health 360-OPD Add On Cover (UIN: MCIHLIA23023V012223) or its subsequent revisions. Please ask for the Prospectus and Proposal Form of the same at the time of purchase. All exclusions and terms and conditions of applicable rider will apply.

For the purpose of this Benefit, coverages are listed under the ManipalCigna Health 360 - OPD Add on Cover Policy documents.

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 period shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

E.I. Standard Exclusions

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

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

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

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance)

Regulations then waiting period for the same would be reduced to the extent of prior coverage.

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

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 and other disorders of lens and Retina,

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

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, 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,

iv. Varicose Veins and Varicose Ulcers,

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

vi. Benign Prostate Hypertrophy, all types of Hydrocele,

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

viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/ throat disorder or surgery,

ix. gastric and duodenal ulcer, any type of Cysts/ Nodules/ Polyps/ Benign tumors including internal tumors and skin tumors, and type of breast lumps,

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

xi. Congenital Internal diseases

xii. Rheumatism including the rheumatism of bones, joints and also rheumatic heart disease

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

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

a) Expenses related to the treatment of any illness within 30 days of continuous coverage from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

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

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

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

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

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

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

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

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

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

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

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

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

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

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

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

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

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

E.I.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. Mental Illness Cover Waiting Period

Any treatment arising out of a condition caused by or associated to a Mental illness or a medical condition under below mentioned ICD Codes impacting mental health, shall not be covered until 24 months of continuous coverage has elapsed for the particularInsured Person since the inception of the first Policy with Us.

ICD 10 CODES	DISEASES
F05	Delirium due to known physiological condition
F06	Other mental disorders due to known physiological condition
F07	Personality and behavioural disorders due to known physiological condition
F20	Schizophrenia
F23	Brief psychotic disorders
F25	Schizoaffective disorders
F29	Unspecified psychosis not due to a substance or known physiological condition
F31	Bipolar disorder
F32	Depressive episode
F39	Unspecified mood [affective] disorder
F40	Phobic Anxiety disorders
F41	Other Anxiety disorders
F42	Obsessive-compulsive disorder
F44	Dissociative and conversion disorders
F45	Somatoform disorders
F48	Other nonpsychotic mental disorders
F60	Specific personality disorders
F84	Pervasive developmental disorders
F90	Attention-deficit hyperactivity disorders
F99	Mental disorder, not otherwise specified

E.II.3. 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.4. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.

E.II.5. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

E.II.6. External Congenital Anomaly or defects or any complications or conditions arising therefrom.

E.II.7. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was Hospitalized.

E.II.8. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a typethat

normally requires a stay in the hospital

E.II.9. Treatment taken outside the geographical limits of India

E.II.10. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

E.II.11. Any form of Non-Allopathic treatment (except AYUSH Treatment), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

E.II.12. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack or in any other sequence to the loss.

E.II.13. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, active participation in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.

E.II.14. All non-medical expenses including convenience items for personalcomfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized- belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment. For complete list of Non-medical expenses, please refer to the Annexure III List- I "Items for which Coverage is not availablein the Policy"

E.II.15. Any deductible amount or percentage of admissible claim under co-pay if applicablezand as specified in the Policy Schedule.

E.II.16. Pre-existing condition disclosed by the Insured Person will be reviewed according to the company's underwriting policy.

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

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

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

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

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

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

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.4 of the Policy and limits as specified in the Policy Schedule)

E.III.2. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.6 of the Policy and limits as specified in the Policy Schedule)

E.III.3. All non-medical expenses including convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for

which the Insured Person was hospitalized - belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses, procedure charges and cost of treatment. For complete list of Non-medical expenses, please refer to the Annexure III List - I "Items for which Coverage is not availablein the Policy"

(Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.6 of the Policy and limits as specified in the Policy Schedule)

F. General Terms and Clauses

F.I. Standard General Terms and Clauses

F.I.1. Disclosure of Information

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

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

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

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

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

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

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

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

F.I.4. Complete Discharge

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

F.I.5. Multiple Policies

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

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

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

F.I.6.Fraud

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

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

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

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 grounds of Fraud, if the insured person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

F.I.7. Cancellation

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

A. Policy Tenure of 1 Year:

1. If no claim has been made during the policyperiod, 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.8. Migration

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

F.I.9. Portability

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

F.I.10.Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation, non-disclosure 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, 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.11. Withdrawal of Policy

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

F.I.12. Moratorium Period

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

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

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

i. Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.
ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.
iii. 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.14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

F.I.15.Free Look period

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

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

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

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

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

F.I.16. Redressal of Grievance

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

Email: customercare@manipalcigna.com,

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

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

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,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India

or

Email: headcustomercare@manipalcigna.com.

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

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

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

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

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

F.I.17. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)} and in case

there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy

F.II. Specific Terms and Clauses

F.II.1. Material Change

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

F.II.2. Alterations in the Policy

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

F.II.3. Change of Policyholder

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

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

F.II.4. No Constructive Notice

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

F.II.5. Mandatory Co-payment

A mandatory co-payment of 20%, as mentioned in the Policy Schedule/ Product Benefit Table, is applicable on all claims irrespective of Age of entry in to the Policy. This mandatory co-payment shall be applied on the admissible claim amount.

You shall have an option to reduce or increase the mandatory co-payment, up to the rate as mentioned in the Product Benefit Table and as specified in the Policy Schedule, which shall supersede the mandatory co-payment rate mentioned above.

Any modification of co-payment option is available during inception of the first Policy and/or subsequent renewals and may be subject to Underwriting.

F.II.6. Records to be maintained

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

F.II.7. Grace Period

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

F.II.8. Renewal Terms

a. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.
b. We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy.
c. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure of material facts by You.
d. Where We have discontinued or withdrawn this product/plan You will have the option to renew 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 90 days prior to date of such revision or modification.

g. Alterations like increase/decrease in Sum Insured or Change in Plan/Product, addition/ deletion of members, addition/deletion of optional covers/ridersaddition 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 or addition on renewal. The terms and conditions of the existing policy will not be altered.

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

i. Wherever the 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 of the Plan opted.

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

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

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.

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.9. Premium calculation

Premium will be calculated based on the Sum Insured opted, Age, gender, risk classification and Zone of Cover. Default Zone of Cover will be based on Your City-Location based on Your correspondence address. All Premiums are age based and will vary each year as per the change in age group.

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

Premium can be paid on Single, 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, a loading will be applied on the premium.

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

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

Zone Classification

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

Zone II: Bangalore, Hyderabad, Chennai, Chandigarh, Ludhiana, Pune

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the location-City of the proposed Insured Persons.

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

(b) Persons paying Zone II premium

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

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

(c) Person paying Zone III premium

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

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

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

i. **Lifetime Discounts**

a. **Employee Discount:** 15% discount on the premium

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

c. **Long Term policy discount** Long term discount of 7.5% for selecting a 2 year policy and 10% for selecting a 3 year policy. This discount is available only with 'Single' Premium Payment mode

d. **Family discount:** (Applicable only with cover on individual basis) 10% discount on the premium is applicable for covering 2 or more members under the same individual Policy.

ii. **Short Term Discounts**

a. **ManipalCigna Existing Customer Discount:** 5% discount will be applicable to customers (Proposer/Insured) of ManipalCigna who are already covered under Group/Retail Products. Discount would be applicable once, only at inception and shall not be offered to Portability/ Migration related proposals wherein the customer does not have any other Policy from ManipalCigna apart from the Ported or Migrated Policy. Existing Customer can be a proposer and/or an Insured under this Policy

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

Discount under F.II.10.i (d) is applicable only to individual policies. All other discounts mentioned above are available to both individual as well as floater policies. Maximum discount in a single policy shall not exceed 40%.

Family Discount, Long Term Discount and Worksite Marketing Discount is applied on the total Policy premium which is sum total of individual premium for Family policies.Employee Discount and Worksite Marketing Discount/ManipalCigna Existing Customer Discount are mutually exclusive

F.II.11Loadings & Special Conditions

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

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

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

F.II.12. Communications & Notices

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

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

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

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

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

F.II.13. Electronic Transactions

You agree to comply with all the terms, conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic,

computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.

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

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

F.II.14. Limitation of Liability

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

F.II.15. 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.16. Dispute Resolution

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

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:

G.I.3. Claim Intimation

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

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

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

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

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged

- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by Us

G.I.4. Cashless Facility

Cashless facility is available only at our Network Hospital 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 at least 48 hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

ii. The Network Provider or common empanelment of hospital/healthcare providers will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDA.

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

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider 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 authorization We shall issue the authorization 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 authorization will be issued. All authorizations will be issued within a period of 1 hours from the receipt of last complete documents.

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

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

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

i. The Network Provider shall request Us for an enhancement of authorization limit as described under Section G.I.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

ii. 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 of receiving the complete documents for final discharge from Network provider or Common empanelment of hospital/healthcare providers.

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

(b) In case of Emergency Hospitalization

i. The Insured Person may approach the Network Provider 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 finalized.

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

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

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

The Network Provider 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 -

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

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

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

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

G.I.5. Claim Reimbursement Process

(a) Collection of Claim Documents

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

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

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted
KYC documents (Photo ID proof, address proof, recent passport size photograph)
Cancelled cheque for NEFT payment

Payment receipt.

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

ii. Our branch offices shall give due acknowledgement of collected documents toYou.

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

G.I.6. Scrutiny of Claim Documents

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 claim payable 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 admissiblclaims under the Policy in the following progressive order -

(a) For Plans without Deductible Option

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 not apply to all “Associated Medical Expenses”. [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of Associated Medical Expenses)]

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

(b) For Plans with Deductible Option

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 not apply to all “Associated Medical Expenses”. [(a). Cost of Pharmacy & consumables, (b). Cost of implant and medical device, (c). Cost of diagnostic test, will not be part of associated medical expenses)]

ii) Arrived payable claim amount will be assessed against the deductible.

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

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

i) Deductible (if opted)
ii) Co-payment
iii) Zonal Co-payment (if applicable)
iv) Sum Insured
v) Cumulative Bonus
vi) Restored Sum Insured

Claim Assessment for Benefit Plans:

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

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

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

G.I.8. Claims Investigation

We may, at Our discretion, depending upon the facts of the case, investigate and determine the validity of claims. Such investigation shall be conducted on case to case basis and will be concluded

accordingly. Any verification or investigation will be carried out by individuals or entities authorized by Us, and the cost of such verification/ investigation will be borne by Us

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

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

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

G.I.10. Representation against Rejection:

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

G.I.11 Payment Terms

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

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

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.

Claim process Applicable to the following Sections:

G.I.12 Domestic Second Opinion

(a) Receive Request for Expert Opinion on Critical IllnessYou can submit Your request for an expert opinion by calling Our call centre or register request through email.

(b) Facilitating the Process We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner in India. The expert opinion is available only in the event of the Insured Person being diagnosed with covered Critical Illness.

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

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

(b) We will facilitate Your appointment and We will guide You to the nearest Network Provider for conducting the medical examination.

(c) Reports of the Medical Tests can be collected directly from the centre.

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

G.I.15 Application of Multiple policies clause

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

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

i) **Cashless hospitalization:** If the Insured Person avails cashless facility for hospitalization, the Insured, Network Provider, or common empanelment of hospital/healthcare provider will intimate us of the admission through a pre-authorization request with all details and

estimated amount for the hospitalization. The Policyholder with multiple policies has the right to claim amounts disallowed under the initial chosen policy from other policies.

b) **Reimbursement claim:** If the Insured Person is admitted and pays the entire bill, then files for a reimbursement claim, they must inform us 48 hours before admission for planned admission or within 24 hours post hospitalization for emergencies, but no later than discharge. Post discharge, the Insured will send all original documents, bills, and claims forms to one Insure rand 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 pre-authorization process. The policyholder having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. 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 authorization 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 & authorization letter 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

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

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 **Email:** bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 **Email:** bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 **Email:** bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.:- 0674-2596461/2596455 **Email:** bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh - 160 017 Tel.:- 0172 - 4646394 / 2706468 **Email:** bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana, (excluding 4 districts viz 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:** bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).

DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.:- 011 - 23237539 **Email:** bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.:- 0361-2132204/2132205 **Email:** bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 23312122 **Email:** bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a 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- 2740363/2740798 **Email:** bimalokpal.jaipur@cioins.co.in	State of 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:** bimalokpal.ernakulam@cioins.co.in	States of Kerala and Union Territory of (a) Lakshadweep (b) 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:** bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim, and Union Territories of 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:** bimalokpal.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:** bimalokpal.mumbai@cioins.co.in	State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and Thane
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:** bimalokpal.noida@cioins.co.in	State of Uttaranchal and the 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:** bimalokpal.patna@cioins.co.in	States of 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:** bimalokpal.pune@cioins.co.in	States of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbai Metropolitan.

G.III. Annexure - II:

<table>
<tr><td>Title</td><td colspan="3">Description
Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief</td></tr>
<tr><td>Your Coverage Details:</td><td>Identify your Plan</td><td>Classic</td><td>Elite</td></tr>
<tr><td rowspan="3">Basic Cover

This section lists the Basic benefits available on your plan</td><td>Identify your Opted Sum Insured (in ₹)</td><td>₹3 Lacs, ₹5 Lacs, ₹7.5 Lacs ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs</td><td>₹5 Lacs, ₹7.5 Lacs, ₹10 Lacs, ₹15 Lacs, ₹20 Lacs, ₹25 Lacs, ₹50 Lacs</td></tr>
<tr><td>Inpatient Hospitalization (When you are hospitalized)</td><td colspan="2">Room Rent: Covered up to Single Private A/C Room
For ICU - Covered up to Sum Insured
This benefit shall also offer the below covers up to the limits mentioned:
a. Listed Modern and Advanced Treatments: Up to Sum Insured
b. HIV/AIDS & STD: Up to Sum Insured
c. Mental Illness Up to Sum Insured
For ICD Codes mentioned below: Waiting Period of 24 months shall apply
<table>
<tr><th>ICD 10 CODES</th><th>DISEASES</th></tr>
<tr><td>F05</td><td>Delirium due to known physiological condition</td></tr>
<tr><td>F06</td><td>Other mental disorders due to known physiological condition</td></tr>
<tr><td>F07</td><td>Personality and behavioural disorders due to known physiological condition</td></tr>
<tr><td>F20</td><td>Schizophrenia</td></tr>
<tr><td>F23</td><td>Brief psychotic disorders</td></tr>
<tr><td>F25</td><td>Schizoaffective disorders</td></tr>
<tr><td>F29</td><td>Unspecified psychosis not due to a substance or known physiological condition</td></tr>
<tr><td>F31</td><td>Bipolar disorder</td></tr>
<tr><td>F32</td><td>Depressive episode</td></tr>
<tr><td>F39</td><td>Unspecified mood [affective] disorder</td></tr>
<tr><td>F40</td><td>Phobic Anxiety disorders</td></tr>
<tr><td>F41</td><td>Other Anxiety disorders</td></tr>
<tr><td>F42</td><td>Obsessive-compulsive disorder</td></tr>
<tr><td>F44</td><td>Dissociative and conversion disorders</td></tr>
<tr><td>F45</td><td>Somatoform disorders</td></tr>
<tr><td>F48</td><td>Other nonpsychotic mental disorders</td></tr>
<tr><td>F60</td><td>Specific personality disorders</td></tr>
<tr><td>F84</td><td>Pervasive developmental disorders</td></tr>
<tr><td>F90</td><td>Attention-deficit hyperactivity disorders</td></tr>
<tr><td>F99</td><td>Mental disorder, not otherwise specified</td></tr>
</table></td></tr>
<tr><td>Pre-hospitalization</td><td>Medical Expenses Covered up to 30 days before the date of hospitalization; Covered up to the Sum Insured</td><td>Medical Expenses Covered up to 60 days before the date of hospitalization; Covered up to the Sum Insured</td></tr>
</table>

	Post-hospitalization	Medical Expenses Covered up to 60 days post discharge from the hospital; Covered up to the Sum Insured	Medical Expenses Covered up to 90 days post discharge from the hospital; Covered up to the Sum Insured
	Day Care Treatment	Covered up to the Sum Insured	
	Domiciliary Hospitalization (Treatment at Home)	Covered up to the Sum Insured Pre and Post Hospitalization Expenses: 30 days each	
	Road Ambulance (Reimbursement of Ambulance Expenses)	Covered up to the Sum Insured	
	Donor Expenses (Hospitalization Expenses of the donor providing the organ)	Covered up to the Sum Insured including: • Pre & Post Hospitalization expenses (Up to 30 days each) of the donor • Cost towards donor screening once in a Policy year for successful transplant • Complications arising during hospitalization or up to 30 days from date of discharge - Up to 25% of SI subject to maximum of ₹2 Lacs, Over and above SI We will not cover expenses towards the Donor in respect of cost associated to the acquisition of the organ.	

	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims)	Not Available	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same, in addition to the Sum Insured Applicable for below covers only 1. D.I.1 - In-patient Hospitalization 2. D.I.2 - Pre - hospitalization 3. D.I.3 - Post - hospitalization 4. D.I.4 - Day Care Treatment 5. D.I.6 - Road Ambulance 6. D.I.7 - Donor Expenses 7. D.I.9 - AYUSH Treatment 8. Non-Medical Items (if ManipalCigna Health 360 Shield is opted and applicable) Restoration shall not get triggered for the 1st claim The maximum liability under a single claim shall not be more than Base Sum Insured + Cumulative Bonus + Restored Sum Insured
	AYUSH Treatment	Covered up to the Sum Insured	
	Daily Cash for Shared Accommodation	Not Available	Daily Cash benefit for occupying shared accommodation while hospitalized of ₹800 per day up to maximum of ₹5,600 per hospitalization Payable for each continuous and completed 24 Hours of Hospitalization during the Policy Year This benefit gets triggered post 48 hours of In-patient hospitalization and shall be payable from 1st day onwards.
	Air Ambulance cover	Not Available	Covered up to sum insured subject to maximum of ₹10 Lacs in addition to the Sum Insured for expenses incurred on Air Ambulance

Value Added Covers This section lists the additional value added benefits that are available along with your plan	Domestic Second Opinion	Not Applicable	Available for 36 listed Critical Illnesses
	Tele-Consultation	Unlimited Tele-consultation including specialist during the Policy Year	
	Cumulative Bonus	A guaranteed bonus of 10% of Sum Insured for every completed Policy Year, subject to a maximum accumulation up to 100% of the Sum Insured.	
	Premium Waiver Benefit	Not Applicable	Waives off one year Policy Premium (including premium for optional covers, rider and taxes) upon occurrence of any of the listed contingencies (Accidental death/ listed Critical Illnesses) to the Policyholder who is also an Insured Person in the Policy
	Discount from Network Provider	Discount on Pharmacy, Diagnostics, Medical Devices, Health Supplements and other health-related services offered by the Network Providers of ManipalCigna Health Insurance Company Limited	
	Health Check Up	Once after every claim free year For Sum Insured up to ₹10 Lacs: Up to ₹2,000 per insured member For Sum Insured above ₹10 Lacs: Up to ₹2,500 per insured member Available from 2nd policy year onwards. The Health Check-up shall be offered on cashless basis only. However, the eligible insured may avail health check from the MCHI Network of Health Check Up Center up to the limit specified	Available each policy year For Sum Insured up to ₹10 Lacs: Up to ₹3,500 per insured member For Sum Insured above ₹10 Lacs: Up to ₹5,000 per insured member Annually from 1st policy year onwards The Health Check-up shall be offered on cashless basis only. However, the eligible insured may avail health check from the MCHI Network of Health Check Up Center up to the limit specified

Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Any Room Upgrade	The Insured Person shall be eligible to upgrade the room type category eligibility under the Policy to "Any Room Category" in a Hospital.	
	Premium Management (Not available on Opting 'Any Room Upgrade' Optional Cover)	Room Rent: Covered up to ₹3000 per day For ICU - Covered up to Sum Insured	Not Available
	Restoration of Sum Insured (When opted Sum Insured is insufficient due to claims) (Applicable for Sum Insured 5 Lacs and above)	Multiple Restoration is available in a Policy Year for all illnesses, whether unrelated or same in addition to the Sum Insured Applicable for below covers only 1. D.I.1 - In-patient Hospitalization 2. D.I.2 - Pre - hospitalization 3. D.I.3 - Post - hospitalization 4. D.I.4 - Day Care Treatment 5. D.I.6 - Road Ambulance 6. D.I.7 - Donor Expenses 7. D.I.9 - AYUSH Treatment 8. Non-Medical Items (if ManipalCigna Health 360 Shield is opted and applicable) Restoration shall not get triggered for the 1st claim The maximum liability under a single claim shall not be more than Base Sum Insured + Cumulative Bonus + Restored Sum Insured	Not Available
	Reduction in PED waiting period	Option to reduce the Pre-Existing Disease waiting period to 90 Days	

Loss Sharing This sections lists the various circumstances under which you will bear some portion of the claim out of your pocket	Co-payment	Mandatory Co-payment of 20% shall be applicable on all claims Co-payment is applicable on all claims irrespective of Age of entry in to the Policy The insured shall have the option to reduce the co-payment to 0% or 10% or increase the co-payment to 30% Any modification of Co-Payment option is available during renewal and may be subject to Underwriting
	Deductible	Deductible of ₹10,000, ₹25,000, ₹50,000, ₹1,00,000, ₹2,00,000, ₹3,00,000, ₹4,00,000 or ₹5,00,000 can be opted at the inception or during any Renewal of the Policy. For Deductible of ₹10,000, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. For Deductible of ₹25,000 and above, the cover can be opted either at inception or can be opted or removed at the time of Policy Renewal. On opting out of deductible of ₹25,000 and above, the enhanced coverage during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods or earlier. All waiting periods as applicable under the base policy shall apply afresh for this enhanced limit from the effective date of such enhancement.
Add on cover (Rider) This section lists the Add on cover available under your plan	ManipalCigna Health 360-Shield	Coverage available for NME and DME NME: Covered up SI as part of base SI DME: Listed DME covered up to ₹1 Lac
	ManipalCigna Health 360-OPD	Coverage available for OPD as per package opted

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

G.IV. Annexure - III

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

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

59.	KIDNEY TRAY
60.	MASK
61.	OUNCE GLASS
62.	OXYGEN MASK
63.	PELVIC TRACTION BELT
64.	PAN CAN
65.	TROLLY COVER
66.	UROMETER, URINE JUG
67.	AMBULANCE
68.	VASOFIX SAFETY

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

Sl. No.	Item
1.	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2.	HAND WASH
3.	SHOE COVER
4.	CAPS
5.	CRADLE CHARGES
6.	COMB
7.	EAU-DE-COLOGNE I ROOM FRESHNERS
8.	FOOT COVER
9.	GOWN
10.	SLIPPERS
11.	TISSUE PAPER
12.	TOOTH PASTE
13.	TOOTH BRUSH
14.	BED PAN
15.	FACE MASK
16.	FLEXI MASK
17.	HAND HOLDER
18.	SPUTUM CUP
19.	DISINFECTANT LOTIONS
20.	LUXURY TAX
21.	HVAC
22.	HOUSE KEEPING CHARGES
23.	AIR CONDITIONER CHARGES
24.	IM IV INJECTION CHARGES
25.	CLEAN SHEET
26.	BLANKET / WARMER BLANKET
27.	ADMISSION KIT
28.	DIABETIC CHART CHARGES
29.	DOCUMENTATION CHARGES I ADMINISTRATIVE EXPENSES
30.	DISCHARGE PROCEDURE CHARGES
31.	DAILY CHART CHARGES
32.	ENTRANCE PASS I VISITORS PASS CHARGES
33.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34.	FILE OPENING CHARGES
35.	INCIDENTAL EXPENSES I MISC. CHARGES (NOT EXPLAINED)
36.	PATIENT IDENTIFICATION BAND I NAME TAG
37.	PULSEOXYMETER CHARGES

List III - Items that are to be subsumed into Procedure Charges

1.	HAIR REMOVAL CREAM
2.	DISPOSABLES RAZORS CHARGES (for site preparations)
3.	EYE PAD
4.	EYE SHEILD
5.	CAMERA COVER
6.	DVD, CD CHARGES
7.	GAUSE SOFT
8.	GAUZE
9.	WARD AND THEATRE BOOKING CHARGES
10.	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11.	MICROSCOPE COVER
12.	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13.	SURGICAL DRILL
14.	EYE KIT
15.	EYE DRAPE
16.	X-RAY FILM
17.	BOYLES APPARATUS CHARGES
18.	COTTON
19.	COTTON BANDAGE
20.	SURGICAL TAPE
21.	APRON
22.	TORNIQUET
23.	ORTHOBUNDLE, GYNAEC BUNDLE

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