Manipal Cigna
Health Insurance

EVERY DETAIL MATTERS TO YOUR HEALTH.

FIND THEM LISTED IN YOUR POLICY TERMS & CONDITIONS

ManipalCigna ProHealth Group Insurance Policy

Policy Terms and Conditions

I. Preamble & Operating Clause

We will provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to (i) the terms, conditions and exclusions of this Policy, (ii) the receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

II. Benefits under the Policy

If any claim arises as a result of treatment taken for an Illness or Injury during the Policy Period which becomes payable under any applicable Base Cover and/or Optional Covers, then We shall indemnify the Medical Expenses incurred or pay for the listed Benefits, in accordance with the terms, conditions and exclusions of the Policy subject to availability of the Sum Insured for the Benefit applicable and any limit specified in the Policy Schedule / Certificate Of Insurance. All limits mentioned in the Policy Schedule / Certificate Of Insurance are applicable for each Policy Year of coverage.

Base Covers

The Policy provides coverage which includes In-patient Hospitalisation Expenses, Day Care Treatment, Pre-hospitalisation Medical Expenses, Post- hospitalisation Medical Expenses, Domiciliary Hospitalisation, Road Ambulance Cover and Donor Expenses Cover provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Year:

i. Room charges up to the category/limit specified in the Policy Schedule / Certificate Of Insurance,

ii. Charges for accommodation in ICU/CCU/HDU,

iii. Operation theatre cost,

iv. Medical Practitioner fees,

v. Specialist fee,

vi. Surgeon's fee,

vii. Anaesthetist fee,

viii. Radiologist fee,

ix. Pathologist fee,

x. Assistant Surgeon fee,

xi. Qualified Nurses fee,

xii. Medication,

xiii. Cost of diagnostic tests as an In-patient such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy and Drugs, consumables, blood, oxygen.

xiv. Surgical Appliance and/or Medical Appliance.

If the Insured Person is admitted in a room where the room category or the Room Rent incurred is higher than that which is specified in the Policy Schedule / Certificate Of Insurance, then the Policyholder / Insured Person shall bear a rateable 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/eligible Room Rent to the Room Rent actually incurred.

This Benefit will be limited to the amount specified in the Policy Schedule / Certificate Of Insurance.

All claims under this Benefit can be made as per the process defined under Section V. 4. and 5.

2. Day Care Treatment Cover

We will pay for the Medical Expenses incurred during the Policy Year for an Insured Person in case of Day Care Treatment or Surgery undertaken for the Illness / condition covered under Base Cover that requires less than 24 hours Hospitalisation due to advancement in technology and which is undertaken in a Hospital / nursing home / Day Care Centre on the recommendation of a Medical Practitioner provided that the Medical Expenses are incurred for Medically Necessary Treatment. Any Treatment in an Out-Patient department (OPD) is not covered under this Benefit.

The benefit under the policy will be limited to the amount specified in the Policy Schedule / Certificate Of Insurance.

All claims under this Benefit can be made as per the process defined under Section V. 4 and 5.

3. Pre – hospitalisation Medical Expenses Cover

We will, on a reimbursement basis, pay the Pre-hospitalisation Medical Expenses of an Insured Person which are incurred due to an Illness or Injury that occurs during the Policy Year immediately prior to the Insured Person's date of Hospitalisation or Day Care Treatment up to the limits specified in the Policy Schedule / Certificate Of Insurance, provided that a claim has been admitted under Section II. 1. or II. 2. and the Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.

The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to Any one illness.

All claims under this Benefit can be made as per the process defined under Section V. 5.

4. Post – hospitalisation Medical Expenses Cover

We will, on a reimbursement basis, pay the Post-hospitalisation Medical Expenses of an Insured Person which are incurred due to an Illness or Injury that occurs during the Policy Year immediately post discharge of the Insured Person from the Hospital or Day Care Treatment up to the limits specified in the Policy Schedule / Certificate Of Insurance, provided that a claim has been admitted under Section II.1. or II.2. and the Post-hospitalisation Medical Expenses are related to the same Illness or Injury.

The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to Any one illness.

All claims under this Benefit can be made as per the process defined under Section V. 5.

5. Road Ambulance Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges up to the limits specified in the Policy Schedule / Certificate Of Insurance that are incurred during the Policy Year towards transportation of an Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury covered under the Base Cover in case of an Emergency, necessitating the Insured Person's admission to the Hospital.

The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Section II 1 or II 2 and the expenses are related to the same Illness or Injury.

All claims under this Benefit can be made as per the process defined under Section V. 5.

6. Domiciliary Hospitalisation Cover

We will pay the Medical Expenses incurred on the Domiciliary Hospitalisation of an Insured Person during the Policy Year which would otherwise have been covered under Section II. 1. and subject to the following conditions:

a) The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation.

b) The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was not available.

c) If a claim has been accepted under this Benefit, Post-hospitalisation

Medical Expenses shall not be payable.

d) Pre-hospitalisation Medical Expenses will be payable up to the specified number of days in accordance with Section II. 3 above.

This Benefit will be available up to the Sum Insured specified in the Policy Schedule / Certificate Of Insurance.

All claims under this Benefit can be made as per the process defined under Section V. 5.

7. Donor Expenses Cover

We will cover In-patient Hospitalisation Medical Expenses incurred during the Policy Year towards the donor for harvesting the organ up to the limits specified in the Policy Schedule / Certificate Of Insurance, provided that:

a) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules.

b) We have admitted a claim towards In-patient Hospitalisation under the Base Cover and it is related to the same condition.

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

d) We will not cover expenses towards the donor in respect of:

i. Any Pre-hospitalisation Medical Expenses or Post - hospitalisation Medical Expenses;

ii. Cost towards donor screening;

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

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

All claims under this Benefit can be made as per the process defined under Section V. 4. and 5.

There are Optional covers available with the Policy. Refer Policy Terms & Conditions annexed herewith for Optional Covers.

III. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. Under Individual basis, each Insured Person has a separate Sum Insured. Under Family Floater basis, the Sum Insured limit is shared by the whole family of the group member as specified in the Policy Schedule / Certificate Of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy Year. The cover type basis shall be as specified in the Policy Schedule / Certificate Of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

Relationships covered under the Policy are as specified in the Policy Schedule / Certificate Of Insurance.

IV. PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

1. Permanent Exclusions

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1. Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells.
2. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalisation. 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.
3. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy, surrogate or vicarious pregnancy.
5. Routine medical, eye examinations, cost of spectacles, laser Surgery for cosmetic purposes or corrective Surgeries or contact lenses.
6. Ear examinations, cost of hearing aids or cochlear implants.
7. Vaccinations except post-bite Treatment.
8. Any physical, psychiatric or psychological examinations or testing, any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products, issue of medical certificates and examinations as to suitability for employment or travel.
9. Laser Surgery for Treatment of focal error correction other than for focal error of +/- 7 or more and is a Medically Necessary Treatment.
10. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all Illness / Injury caused by and/or related to HIV.
11. All sexually transmitted diseases including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis and any condition directly or indirectly caused by or associated with them.
12. Vitamins and tonics unless forming part of Treatment for Illness or Injury and prescribed by a Medical Practitioner.
13. 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.
14. Artificial life maintenance, including life support machine use, where such Treatment will not result in recovery or restoration of the previous state of health.
15. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD).
16. Treatment for general debility, ageing, convalescence, sanatorium Treatment, rehabilitation measures, private duty nursing, respite care, run down condition or rest cure.
17. External Congenital Anomaly or defects, inherited disorders or any complications or conditions arising therefrom including any developmental conditions of the Insured Person.
18. Sterility, fertility, infertility including IVF and other assisted conception procedures and its complications, subfertility, impotency, venereal disease, puberty, menopause.
19. Intentional self-Injury, suicide or attempted suicide (whether sane or insane).
20. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or Treatment that is not scientifically recognised or Unproven/Experimental treatment, or any form of clinical trials or any kind of self-medication and its complications.
21. Ailment requiring Treatment due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and Treatment for de-addiction, or rehabilitation.
22. Any Illness or Hospitalisation arising or resulting from the Insured Person or any of his family members committing any breach of law with criminal intent.
23. Any Treatment received in convalescent homes, convalescent Hospitals, health hydros, nature cure clinics or similar establishments.
24. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness / Injury for which the Insured Person was Hospitalised.
25. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.
26. Any Cosmetic Surgery, aesthetic Treatment unless forming part of Treatment for cancer or burns, any elective Surgery or cosmetic procedure that improve physical appearance, Surgery for sex change or Treatment of obesity/morbid obesity (unless certified to be life threatening) and weight control programs, or Treatment/Surgery /

complications/Illness arising as a consequence thereof.

27. Treatment received outside India.
28. Any robotic, remote Surgery or Treatment using cyber knife.
29. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and Treatment even if the same requires confinement at a Hospital.
30. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.
31. Any form of Alternative Treatment:

    i) AYUSH Treatment;

    ii) Hydrotherapy, Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.
32. Injury caused while engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
33. Injury caused whilst flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air charter company.
34. 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.
35. All expenses directly or indirectly, 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), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
36. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.
37. For complete list of non-medical expenses, please refer to the Annexure II "Non-Medical Expenses" and also on Our website. Any opted Deductible (Per claim / Aggregate / Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule / Certificate Of Insurance to this Policy.
38. Any physical, medical or mental condition or Treatment or service that is specifically excluded in the Policy Schedule / Certificate Of Insurance under Special Conditions.

2. Pre-Existing Disease Waiting Period

A Waiting Period since beginning of cover under the first Policy, specified in the Policy Schedule or Certificate of Insurance shall apply to all Pre-Existing Diseases for each Insured Person.

3. Initial Waiting Period for Hospitalisation

A Waiting Period since beginning of cover under the first Policy, specified in the Policy Schedule / Certificate Of Insurance shall apply to any Illness contracted and/or Medical Expenses incurred in respect of any Illness by the Insured Person other than Hospitalisation due to Accident.

4. Specific Illness Waiting period

A Waiting Period since beginning of cover under the first Policy, specified in the Policy Schedule / Certificate Of Insurance shall apply to the Treatment, of the following, whether medical or surgical for all Medical Expenses along with their complications on Treatment towards:

a) Cataract,

b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,

c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Oestoarthritis and Osteoposrosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertibral discs(other than caused by Accident), all Vertibrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal,

d) Varicose Veins and Varicose Ulcers,

e) Stones in the urinary uro-genital and biliary systems including calculus diseases,

f) Benign Prostate Hypertrophy, all types of Hydrocele,

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

h) Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.

i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,

j) Any Surgery of the genito-urinary system unless necessitated by malignancy.

If these diseases are Pre-Existing Diseases at the time of proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as mentioned in the Policy Schedule / Certificate Of Insurance shall apply.

V. Claims Procedure

Processing of claims for Cashless facility and/or for reimbursement and providing access to the Network Provider will be through Our TPA. Details of the TPA will be available on the health card issued by Us to the Insured Persons.

A TPA will be used for accessing Network Providers and for facilitating claim processing.

The updated applicable list of Network Providers is available on the TPA's website. Details of applicable Network Providers may also be obtained from the TPA's call center. In advance of availing Cashless Facility from a Network Provider, the updated list may be checked to ensure that the Network Provider can provide Cashless facility in respect of the Treatment required by the Insured Person.

We, in our sole discretion, reserve the right to modify, add or restrict any Network Provider for providing Cashless facilities under the Policy. Before availing a Cashless facility, the Policyholder / Insured Person is required to check the applicable/latest list of Network Providers on the TPA's or Our website or by calling the TPA's or Our call centre.

1. Condition Precedent

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

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

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

2. Policyholder's / Insured Person's Duty at the time of Claim

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

(a) Forthwith intimate, file and submit the claim form and documents as prescribed in accordance with the procedure set out under Section V.3, V.4 and V.5 as mentioned below.

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

(c) If so requested by Us, the Insured Person must submit himself / herself

for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.

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

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

3. Claim Intimation

Upon the discovery or occurrence of an Illness /Injury or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee as the case may be must notify Us / Our TPA either at the call centre or in writing and shall undertake the following.

- In the case of Planned Hospitalisation - The Insured Person will intimate such admission at least 3 days prior to the planned date of admission.
- In the case of Emergency Hospitalisation - The Insured Person will intimate such admission within 48 hours of such admission but not later than discharge from the Hospital.

Following details are to be provided to TPA/Us at the time of intimation of claim:

i) Policy Number

ii) Name of the Policyholder

iii) Name of the Insured Person in whose relation the claim is being lodged

iv) Nature of Illness / Injury / Accident / Critical Illness

v) Name and address of the attending Medical Practitioner and Hospital

vi) Date of admission

vii) Any other information as requested by Us

4. Cashless Process

Cashless facility for Hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury /Accident / Critical Illness / or any other contingency that may give rise to a claim under this Policy.

For all cashless authorisations, Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limit (if applicable), Co-Payment and / or opted Deductible (Per claim / Aggregate / Corporate) (if applicable) directly with the Hospital.

Pre-Authorisation Process

The Insured Person can avail Cashless facility at the time of admission into any Network Provider by presenting the health card as provided by Us with this Policy along with a valid passport size photo, photo identification proof and address proof (voter ID card / driving license / passport / PAN card / any other identity proof as approved by Us).

(a) For Planned Hospitalisation:

i. The Insured Person shall at least 3 days prior to admission to the Hospital approach the Network Provider for Hospitalisation for undergoing medical Treatment.

ii. The Network Provider will issue the request for authorisation letter for Hospitalisation in the pre-authorisation form.

iii. The Network Provider shall send the pre-authorisation form along with all the relevant details to the 24 (twenty four) hour authorisation/ cashless department along with contact details of the treating Medical Practitioner and the Insured Person. Upon receiving the pre-authorisation form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.

iv. Wherever the information provided in the request is sufficient to ascertain the authorisation and the claim is admissible, We shall issue the authorisation letter to the Network Provider. Wherever additional information or documents are required, We will call for the same from the Network Provider and upon satisfactory receipt of the last necessary documents, the authorisation will be issued.

v. The authorisation letter will include details of sanctioned amount, diagnosis, and date of approval.

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

(b) In case of Emergency Hospitalisation

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

ii. The Network Provider shall forward the request for authorisation to Us within 48 hours of admission to the Hospital as per the process under Section V.4 (a) above.

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

iv. In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any situation which requires saving of life, limb, sight or any other medical Emergency.

v. The Network Provider shall refund such deposit amount to the Insured Person less any token amount to take care of non-covered expenses once the pre-authorisation is issued.

Enhancement to Pre-Authorised Amount:

In the event that the cost of Hospitalisation exceeds the authorised limit as mentioned in the authorisation letter:

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

b. We shall accept or decline such request for enhancement of pre-authorised limit for enhancement.

In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the Insured Person, the Network Provider shall obtain a fresh authorisation letter from Us in accordance with the process described under V.4 (a) above.

Discharge Process:

At the time of discharge:

i. The Network Provider may forward a final request for authorisation for any residual amount to Us along with the discharge summary and the detailed bill break up in accordance with the process described at V.4.(a) above.

ii. Upon receipt of the final authorisation letter from Us, the Insured Person may be discharged by the Network Provider.

Note: (Applicable to V a & V b): Cashless facility for Hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury / Accident / Critical Illness as the case may be which are covered under the Policy. For all cashless authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim / Aggregate / Corporate) (if applicable), directly with the Hospital.

Submission of Claim Documents:

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

- Claim Form duly filled and signed
- Original pre-authorisation request
- Copy of pre-authorisation approval letter (s)
- Copy of photo ID of Insured Person verified by the Hospital
- Original discharge/death summary
- Operation theatre notes(if applicable)

- Original Hospital main bill and break up bill
- Original investigation reports, X Ray, MRI, CT Films, HPE
- Medical Practitioner's 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 Hospitalisation due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Insured Person may be required to pay for the Treatment and submit the claim for reimbursement to Us which will be considered subject to the Policy Terms and Conditions.

5. Claim Reimbursement Process

(a) Collection of Claim Documents for indemnity based covers

i. Wherever the Insured Person has opted for a reimbursement of Medical Expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 15 days from the date of discharge from the Hospital. The Insured Person can obtain a claim form from any of Our branch offices or download a copy from Our website www.manipalcigna.com

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

Original copy of consultations
Claim form duly signed
Hospital discharge summary in original
Operation theatre notes (if applicable)
Hospital main bill in original
Hospital break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Medical Practitioner's reference slip for investigation
Pharmacy bills, prescription and invoices
MLC / FIR report, post mortem report if applicable and conducted
KYC documents (photo ID proof, address proof, recent passport size photograph)
Cancelled cheque with name for NEFT payment
Payment receipt
Death summary, death certificate, if applicable
Bills from registered service provider (Road Ambulance cover)

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

In case there is a delay in submission of claim documents as specified in V5. (a) above, then in addition to the documents mentioned in V.5. (a) above, the Insured Person will also be required to provide Us the reason for such delay in writing. We will condone the delay on merit for delayed claims where the delay has been proved to be for reasons beyond the claimant's control.

6. Scrutiny of Claim Documents

- We shall scrutinise the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person / Network Provider as the case may be.
- If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person/Network Provider of the same every 10 (ten) days thereafter.
- We will send a maximum of 3 (three) reminders.
- We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilised as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.
- The Pre-hospitalisation Medical Expenses Cover claim and Post-hospitalisation Medical Expenses Cover claim shall be processed only after decision of the main Hospitalisation claim.

7. Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Base or Optional cover in accordance with the terms of this Policy.

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

i. If a room / Intensive Care Unit accommodation has been opted for where the rent or category is higher than the eligible limit for that Insured Person under the Policy, then, the Insured Person shall bear the rateable proportion of the Medical Expenses (including surcharge or taxes thereon) as specified in the Policy Schedule / Certificate Of Insurance in the proportion of the difference between Room Rent of the entitled room category/eligible Room Rent to the room rent actually incurred excluding pharmacy and consumables which shall be paid on actuals.

ii. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule / Certificate Of Insurance, Our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.

iii. Opted Deductible (Per claim / Aggregate / Corporate), if any, shall be applicable on the amount payable by Us after applying (i),and (ii) above.

iv. Co-Payments if any, shall be applicable on the amount payable by Us after applying (i), (ii) and (iii).

v. At any given stage, if the Insured Person's total cost sharing amount under V.7 (iv) above is equal to the opted Out of Pocket Maximum (OOP) limit, no further deductions will apply subject to the Sum Insured available for specific Benefits (if applicable) and in any case not greater than the Sum Insured available under the Policy.

The claim amount assessed under Section V.7 (i), (ii), (iii), (iv), and (v) will be deducted from the following amounts in the following progressive order after applying Sub Limit–

i) Opted Deductible (Corporate / Per claim / Aggregate), & Co-Payments (if opted)

ii) Sum Insured

iii) Cumulative Bonus (if applicable)

iv) Restored Sum Insured (if applicable)

v) Corporate Buffer / Corporate Buffer for CI only (if applicable)

Claim Assessment for Benefit Plans:

We will pay fixed benefit amounts as specified in the Policy Schedule / Certificate Of Insurance 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.

8. Claims Investigation

We may investigate claims at Our own discretion to determine the validity of the claim. Such investigation shall be concluded within 15 days from the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. Verification carried out, if any, will be done by individuals or entities authorised by Us to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by Us.

9. Pre-hospitalisation Medical Expenses Cover and Post-hospitalisation Medical Expenses Cover claims

The Insured Person should submit the Post-hospitalisation Medical Expenses

Cover claim documents at his/her own expense within 15 days of completion of Post-hospitalisation Treatment or period, or eligible Post-Hospitalisation period of cover, whichever is earlier.

We shall receive Pre-hospitalisation Medical Expenses Cover and Post-hospitalisation Medical Expenses Cover claim documents either along with papers for In-patient Hospitalisation Expenses Cover or separately and process the same based on merit of the claim derived on the basis of the documents received.

10. Settlement and Repudiation of a claim

We shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.

In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document.

In case of delay beyond stipulated 45 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

11. Representation against Rejection

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

12. Claim Payment Terms

- We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
- All claims will be payable in India and in Indian rupees.
- We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimised the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.
- The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
- If the Insured Person suffers a relapse within 45 days from 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 Provider whose discharge would be complete and final.

For Reimbursement claims, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person’s death, We will pay the Nominee (as named in the Policy Schedule / Certificate Of Insurance) 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 Our liability under the Policy.

VI. Terms and conditions

1. Duty of Disclosure

The Policy shall be null and void and no Benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the group proposal form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by the Policyholder / Insured Person / Dependent or any one acting on their behalf, under this Policy. Under such circumstance, We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

2. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by the Policyholder or any of the Insured Persons, shall be the Condition Precedent to Our liability under this Policy.

3. Reasonable Care

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Illnesses, Accident or Injury that may give rise to any claim under this Policy.

4. 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. All endorsement requests will be made by the Policyholder only.

5. Material Information for administration

The Insured Person and / or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any claim / Benefit provided under the Policy. Billing for the Policy will be processed on the exact number of Insured Persons covered under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons.

We reserve the right to apply additional options, exclusions or to reflect any circumstances the Policyholder or Insured Person advises in their application form or declares to Us as a material fact.

Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person / Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy.

6. Material Change

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

7. Eligibility

To be eligible for coverage under the Policy, the Insured Person must be-

- A group member / Employee of the Policyholder or non-employer group enrolled member.
- There is no minimum or maximum Age for entry in to the Policy.
- The relationships which may be covered under the Policy are -
  - The Employee’s/member’s legal Spouse, Dependent parents ,
  - The Employee’s/member’s unmarried children who are under the Age of 25, either in full-time education or residing at the same residence as the Employee / Member.
  - Covered relationships also include brother and sister of the Employee/member who are children of the same parents, grandparents, grandchildren, parent in laws, son in law, daughter in law, uncle, aunt, niece and nephew, etc.
- New Born Babies will be accepted for cover (subject to the limitations of the New Born Benefit) from birth if maternity and any one of the parents are covered. Acceptance of New Born Babies as Insured Persons is subject to written notification within 30 days of birth and receipt of the agreed premium within a further 30 days following notification.

Renewals will be available for lifetime, provided the Insured Person is still employed with / continues to be a member of the group / Employee of the Policyholder. Relationships covered under the Policy are as specified in the Policy Schedule / Certificate Of Insurance. It is clarified that for the purpose of availing this Policy, the Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7.

8. Geography

The geographical scope of this Policy applies to events limited to India unless specified under this Policy in a particular Benefit or definition. However all admitted or payable claims shall be settled in India in Indian rupees.

9. Dispute Resolution & Applicable Law

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

10. Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorised official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy. Premium payments under this Policy will be allowed monthly/quarterly/half yearly or in the form of annual payments.

Premium will be subject to revision at the time of renewal of the Policy and as approved by the IRDAI. Further, premium shall be paid in Indian Rupees and in favour of ManipalCigna Health Insurance Company Limited.

11. Free Look period

A period of 15 days from the date of receipt of the Policy document is available to You to review the terms and conditions of this Policy and to return if the same is not acceptable. The Policyholder has the option of cancelling the Policy stating the reasons for cancellation. If there are no claims reported (paid/outstanding) under the Policy then We shall refund the premium after deducting the risk premium on pro rata basis and after retaining 50% of costs for any medical tests if conducted. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look period shall not be available on Renewal of this Policy.

12. Parties to the Policy

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

13. Currency

The monetary limits applicable to this Policy will be in INR.

14. Addition and Deletion of a Member

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

(a) Additions

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

(b) Deletions

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

In case of refund of premium being generated on the Policy due to deletion of an Insured Person, the same will be refunded or adjusted against future premium instalments due on the Policy.

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

15. Changes to the terms and conditions of the Policy

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

- for changes to the list of Benefits, at least 90 days' notice in writing if allowed as per IRDAI;
- for changes to the Policy terms and conditions, or ending the Policy, at least 90 days' notice in writing. The change will take place, failing which, the Policy will end on the next Annual Renewal Date.

16. Nominee

The Insured Person can, on the Effective Date or at any time before the expiry of the Policy make a nomination for the purpose of payment of claims.

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

In case of death of any Dependent of an Insured Person where such Dependent is covered under this Policy, for the purpose of payment of claims, the Nominee would be the Insured Person.

17. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve You/Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

18. Endorsements

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

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

- Rectification in name of the proposer / Insured Person.
- Rectification in gender of the proposer / Insured Person.
- Rectification in relationship of the Insured Person with the proposer.
- Rectification of date of birth of the Insured Person (if this does not impact the premium).
- Change in the correspondence address of the proposer.
- Change/updation in the contact details viz., phone number, E-mail ID, etc.
- Updation of alternate contact address of the proposer.
- Change in Nominee details.

b) Financial Endorsements – which result in alteration in premium

- Deletion of Insured Person on death or upon separation or Policyholder/Insured Person leaving the country only if no claims are paid / outstanding.
- Change in Age/date of birth.
- Addition of member (New Born Baby or newly wedded Spouse).
- Change in address (resulting in change in zone).
- Rectification in gender of the proposer / Insured Person.

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

19. Multiple Policies

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

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

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

2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies
3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

20. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly. It is further clarified that if any special condition is stipulated in the Policy Schedule and/or Certificate of Insurance, then such special condition shall have effect accordingly.

21. Records to be maintained

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

22. Grace Period & Renewal

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 or from the date of next instalment due date. We will not be liable to pay for any claim arising out of an Injury / Accident / condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act, 1938 shall be applicable. If the Policy is Renewed within the Grace Period, the Insured Persons shall be eligible for continuity of cover.

For Contributory Policy

We shall not be bound to give notice that such Renewal premium is due. A Policy shall be ordinarily Renewable except on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the Insured Person or on his behalf.

Where such behaviour has been noticed on the part of an Employee / Member, we will terminate the cover for the specific Employee / Member and his/her Dependants including further Renewals and continue the cover for the remaining group members while bringing such instances to the knowledge of the Policyholder. Where it is found that the Policyholder is involved in such above situations, the complete Policy will be terminated.

Revival Period:

Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the Policy. However, We will be liable to pay in respect of all claims where the Treatment/admission/Accident has commenced/occurred before the date of termination of such Policy.

Renewal Terms

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

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

23. Cancellation by You

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

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

The grid is applicable for single premium Policy.

(Term more than 1 Year is available only for Credit Linked Policy)

In force up to	Policy Period				
	1	2	3	4	5
15-90 Days	50	75	83	88	90
91- 180 Days	25	63	75	81	85
181- 273 Days	15	58	72	75	83
274- 365 Days	0	50	67	75	80
366-455 Days		25	50	63	70
456- 545 Days		13	42	56	65
546 – 638 Days		8	38	54	63
639 – 730 Days		0	33	50	60
731 – 820 Days			17	38	50
821 - 910 Days			8	31	45
911 – 1003 Days			5	29	43
1004 - 1095 Days			0	25	40
1096 - 1185 Days				13	30
1186 - 1275 Days				6	25
1276 - 1368 Days				4	23
1369 - 1460 Days				0	20
1461 - 1550 Days					10
1551 - 1640 Days					5
1641 - 1733 Days					3
Above 1733 Days					0

For installment premium, We will refund premium on pro rata basis after deducting Our expenses.

24. Our Right of Termination

Termination of Policy:

Prior to the termination of the Policy, at the expiry of the period shown in the Policy Schedule / Certificate Of Insurance, cover will end immediately for all Insured Persons, if:

- there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- there is non-cooperation by You / Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorised or an approval for Cashless facility has been issued, We will not be held responsible for any Treatment costs if the Policy ends or an Employee or member or Dependant leaves the Policy before Treatment has taken place. However, We will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

Termination for Insured Person's cover

Cover will end for a Member or dependent:

- If the Policyholder stops paying premiums for the Insured Person(s) and their Dependants (if any);
- When this Policy terminates at the expiry of the period shown in the Policy Schedule / Certificate Of Insurance.
- If he or she dies;
- When he or she ceases to be a Dependant;
- If the Insured Person ceases to be a member of the group.

25. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy then this Policy shall be void in respect of such Insured Person and all claims being processed shall be forfeited for all Insured Persons within the family. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

26. 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.

27. Portability

a. Where We have discontinued or withdrawn this product or where the Insured Person will not be eligible to Renew as he/she ceases to be a member of the group, such Insured Person will have the option to migrate to the nearest substitute policy being issued by Us with continuity of benefits and in accordance with the Portability guidelines issued by the IRDAI (to the extent applicable).

b. Continuity of benefits will be provided for the period based on the number of years of continuous coverage under this Policy with Us.

c. The application for Portability should have been received by Us at least 45 days before ceasing to be a member of the group/Employee of the Policyholder.

d. Subject to the decision of our underwriting team, We will decide the terms and conditions upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.

e. Subject to board approved Underwriting Policy.

28. Underwriting Loadings & Discounts

a. We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy based upon the health status of the persons proposed to be insured and declarations made at the time of enrolment. These loadings will be applied from the Inception Date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.

b. We may apply a specific Sub Limit on a medical condition/ailment depending on the past history and declarations or additional Waiting Periods on Pre-Existing Diseases as part of the Special Conditions on the Policy.

c. We shall inform You about the applicable risk loading or Special Condition through a counter offer letter and You would be required to respond with Your consent and additional premium (if any) within 7 working days of the issuance of such counter offer letter.

d. In case, You neither accept the counter offer nor respond to Us within 7 working days, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

29. Operation of Policy & Certificate of Insurance

The Policy shall be issued for the duration as specified in the Policy Schedule / Certificate Of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

30. Electronic Transactions

The Policyholder / Insured Person agrees to comply with all the terms and 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 the Policyholder / Insured Person. 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 the Policyholder / Insured Person.

31. Communications & Notices

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

a. The Policyholder/Insured Person, at the address as specified in the Policy Schedule/Certificate Of Insurance

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

c. No insurance agents, brokers, other person or entity is authorised to receive any notice on 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.

32. Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to Insured Person(s) or to their Nominee/Legal Representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete, valid and construed as an effectual discharge in favour of Us.

33. Grievances Redressal Procedure

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

Our website: www.manipalcigna.com

Email: servicesupport@manipalcigna.com

Toll Free : 1800-102-4462

Contact No. : + 91 22 61703600

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

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

If You/Insured Person are not satisfied with Our redressal of Your grievance through one of the above methods, You/Insured Person may contact Our Head of Customer Service at The Grievance Cell, ManipalCigna Health Insurance Company Limited, 401/402, Raheja Titanium, Western Express Highway, Goregaon East, Mumbai 400063 or email headcustomercare@manipalcigna.com

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

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

V. Definitions

1. **Age or Aged** means the age as on last birthday.
2. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. **Annual Renewal Date** means the anniversary of the Inception Date each year or any other date which We and the Policyholder may agree in writing.
4. **Alternative Treatments** are forms of Treatments other than “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

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

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

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

8. **Associated Medical Expenses** shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/ surgeon / anesthetist / Specialist and diagnostic tests conducted within the same Hospital where the Insured Person has been admitted.

9. **AYUSH Treatment** refers to the medical and /or Hospitalisation Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.

10. **Benefit** means any benefit shown in the Policy Schedule and/or Certificate of Insurance.

11. **Base Sum Insured** means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.

12. **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-authorisation is approved.

13. **Certificate of Insurance** means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy.

14. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

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

    b. **External Congenital Anomaly** – Congenital anomaly which is in the visible and accessible parts of the body.

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

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

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

19. **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 hrs because of technological advancement, and

    ii. which would have otherwise required a hospitalisation of more than 24 hours.

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

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

    i. has qualified nursing staff under its employment;

    ii. has qualified medical practitioner/s in charge;

    iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

    iv. maintains daily records of patients and will make these accessible to the insurance company's authorised personnel.

21. **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..

22. **Dental Emergency** means severe pain which cannot be relieved by painkillers, or facial swelling or uncontrollable bleeding after an extraction, where such Emergency occurs either outside the business hours of the Employee's / Members or Dependant's usual Dentist or if the Employee / Member or Dependant is staying at a place which is away from the Dentist they usually visit. The Treatment covered in such an instance is to purely stabilise the problem and relieve severe pain.

23. **Dental Injury** means an Injury to the Employee / Member or Dependant's dentition and supporting structures (including damage to dentures while being worn) caused by extra-oral impact.

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

25. **Dependent** means the Employee's / Member's parents, Spouse or child who have been enrolled in the Policy.

26. **Dependent Child** refers to a child (natural or legally adopted), who is under Age 25, either in full-time education or residing at the same residence as the Employee / Member at the commencement of any Treatment and is financially dependent on the Employee / Member. For the purpose of coverage under this Policy the Age limit for a dependent child shall be 25 years. However, with respect to coverage under specific sections separate Age limits shall be defined under each Benefit.

27. **Disclosure to information norm**

    The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

29. **Domiciliary Hospitalisation** 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:

    - the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    - the patient takes treatment at home on account of non-availability of room in a hospital.

30. **Effective Date** means the date shown on the Certificate of Insurance on which the Insured Person was first included under the Policy.

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

32. **Employee** means any member of Your staff who is proposed and sponsored by You and who becomes an Insured Person under this Policy.

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

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

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

36. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made

to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

37. **Home nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after Hospital Treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for Treatment which would normally be provided in a Hospital.

    In either case, the Specialist who treated the patient must have recommended these services.

38. **HDU** - High Dependency Unit is an area in a Hospital, usually located closely to the Intensive Care Unit where patients can be cared for more extensively than in a normal ward but not to the point of care provided in the Intensive Care Unit.

39. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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 authorised personnel.

40. **Hospitalisation** 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.

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

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

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

        i. It needs on going or long-term monitoring through consultations, examinations, check-ups, and / or tests

        ii. It needs on going or long-term control or relief of symptoms

        iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it

        iv. It continues indefinitely

        v. It recurs or is likely to recur

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

43. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance when the coverage under the Policy commences.

44. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

45. **In-patient** means an Employee / Member or Dependent who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.

46. **Insured Person** means the Employee / Member or Dependents named in the Policy Schedule / Certificate Of Insurance, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium is paid.

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

48. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges.

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

50. **Maternity expenses** means:

    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation);

    b. expenses towards lawful medical termination of pregnancy during the Policy Year.

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

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

53. **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.

54. **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 the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

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

    i. is required for the medical management of the illness or injury suffered by the insured;

    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

    iii. must have been prescribed by a medical practitioner;

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

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

57. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.

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

59. **New Born Baby** means baby born during the Policy Year and is aged upto 90 days.

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

61. **Operation** means any procedure described as an operation in the schedule of Surgical Procedures.

62. **Out-Patient** means a patient who undergoes OPD treatment.

63. **OPD treatment** means the one in which the Insured visits a clinic /

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

64. **Private Room** means a single occupancy accommodation in a private Hospital.

65. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group proposal form and Policy Schedule / Certificate Of Insurance 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.

66. **Policy Anniversary Date** means the day of the calendar year on which the current Policy coverage commenced.

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

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

69. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

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

71. **Portability** means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained for Pre-Existing Diseases and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer.

72. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:

    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

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

73. **Post-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

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

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

74. **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.

75. **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.

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

77. **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.

78. **Spouse** means the Employee's legal husband or wife proposed to be covered under the Policy.

79. **Specialist** is a Medical Practitioner who:

    - Has received advanced specialist training;
    - Practices a particular branch of medicine or Surgery;
    - Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital which We accept as being of equivalent status.

    It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist for the purpose of physiotherapy as described in the list of Benefits.

80. **Short-Term** means a period of time consistent with the recuperation time required for the Treatment and as prescribed by the treating Medical Practitioner with the approval of Our medical director.

81. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

82. **Surgical Appliance and/or Medical Appliance** means:

    - An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
    - An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
    - A prosthesis or appliance which is medically necessary and is part of the recuperation process on a Short-Term basis.

83. **Service Partner** is an assistance company utilised by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.

84. **Sub Limit** defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.

85. **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.

86. **TPA** means any person who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016 by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services. The list and details of TPA are set out in Annexure III of this Policy and are also available on Our website.

87. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve Illness within the scope of the Policy.

88. **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.

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

90. **We/Our/Us** means the ManipalCigna Health Insurance Company Limited.

91. **You/Your/Policyholder** means the person named in the Policy Schedule / Certificate Of Insurance who has concluded this Policy with Us.

ANNEXURE II: LIST OF OMBUDSMEN OFFICES

Contact Details	
Ombudsmen Centres Office of The Governing Body of Insurance Council (Monitoring Body for Offices of Insurance Ombudsman) 3rd Floor, Jeevan Seva Annexe, Santacruz (West), Mumbai - 400054. Tel.: 26106671/6889. Email ID: inscoun@ecoi.co.in Web: www.ecoi.co.in If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/ not responded for 30 days then you can approach The Office of the Insurance Ombudsman (Bimalokpal). Please visit our website for details to lodge complaint with Ombudsman.	
Contact Details	**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@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

ManipalCigna ProHealth Group Insurance Policy • UIN : CTTHLGP18023V021718

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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Email:- bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & 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.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, 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.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure- II (Non-Medical Expenses)

SNO	ITEM
I	**TOILETRIES / COSMETICS / PERSONAL COMFORT OR CONVENIENCE ITEMS / SIMILAR EXPENSES**
1	HAIR REMOVAL CREAM
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
3	BABY FOOD
4	BABY UTILITIES CHARGES
5	BABY SET
6	BABY BOTTLES
7	BRUSH
8	COSY TOWEL
9	HAND WASH
10	MOISTURISER PASTE BRUSH
11	POWDER
12	RAZOR
13	SHOE COVER
14	BEAUTY SERVICES
15	BELTS / BRACES
16	BUDS
17	BARBER CHARGES
18	CAPS
19	COLD PACK / HOT PACK
20	CARRY BAGS
21	CRADLE CHARGES
22	COMB
23	DISPOSABLES RAZORS CHARGES (for site preparations)
24	EAU-DE-COLOGNE / ROOM FRESHNERS
25	EYE PAD
26	EYE SHEILD
27	EMAIL / INTERNET CHARGES
28	FOOD CHARGES (other than patient's diet providedby hospital)
29	FOOT COVER
30	GOWN
31	LEGGINGS
32	LAUNDRY CHARGES
33	MINERAL WATER
34	OIL CHARGES
35	SANITARY PAD
36	SLIPPERS
37	TELEPHONE CHARGES
38	TISSUE PAPER
39	TOOTH PASTE
40	TOOTH BRUSH

41	GUEST SERVICES
42	BED PAN
43	BED UNDER PAD CHARGES
44	CAMERA COVER
45	CLINIPLAST
46	CREPE BANDAGE
47	CURAPORE
48	DIAPER OF ANY TYPE
49	DVD, CD CHARGES
50	EYELET COLLAR
51	FACE MASK
52	FLEXI MASK
53	GAUSE SOFT
54	GAUZE
55	HAND HOLDER
56	HANSAPLAST / ADHESIVE BANDAGES
57	INFANT FOOD
58	SLINGS
59	WEIGHT CONTROL PROGRAMS / SUPPLIES / SERVICES
60	COST OF SPECTACLES / CONTACT LENSES / HEARING AIDS ETC.
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
62	HORMONE REPLACEMENT THERAPY
63	HOME VISIT CHARGES
64	INFERTILITY / SUBFERTILITY / ASSISTED CONCEPTION PROCEDURE
65	OBESITY (including morbid obesity) TREATMENT IF EXCLUDED IN POLICY
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES
69	DONOR SCREENING CHARGES
70	ADMISSION / REGISTRATION CHARGES
71	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
72	EXPENSES FOR INVESTIGATION / TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM / HIV / AIDS ETC IS DETECTED / DIRECTLY OR INDIRECTLY
74	STEM CELL IMPLANTATION / SURGERY AND STORAGE
75	WARD AND THEATRE BOOKING CHARGES
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
77	MICROSCOPE COVER
78	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
79	SURGICAL DRILL
80	EYE KIT
81	EYE DRAPE
82	X-RAY FILM

83	SPUTUM CUP
84	BOYLES APPARATUS CHARGES
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
86	ANTISEPTIC OR DISINFECTANT LOTIONS
87	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES
88	COTTON
89	COTTON BANDAGE
90	MICROPORE / SURGICAL TAPE
91	BLADE
92	APRON
93	TORNIQUET
94	ORTHOBUNDLE, GYNAEC BUNDLE
95	URINE CONTAINER
II	**ELEMENTS OF ROOM CHARGE**
96	LUXURY TAX
97	HVAC
98	HOUSE KEEPING CHARGES
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
100	TELEVISION & AIR CONDITIONER CHARGES
101	SURCHARGES
102	ATTENDANT CHARGES
103	IM IV INJECTION CHARGES
104	CLEAN SHEET
105	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
106	BLANKET/WARMER BLANKET
III	**ADMINISTRATIVE OR NON-MEDICAL CHARGES**
107	ADMISSION KIT
108	BIRTH CERTIFICATE
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
110	CERTIFICATE CHARGES
111	COURIER CHARGES
112	CONVEYANCE CHARGES
113	DIABETIC CHART CHARGES
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
115	DISCHARGE PROCEDURE CHARGES
116	DAILY CHART CHARGES
117	ENTRANCE PASS / VISITORS PASS CHARGES
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
119	FILE OPENING CHARGES
120	INCIDENTAL EXPENSES / MISC. CHARGES (not explained)
121	MEDICAL CERTIFICATE
122	MAINTENANCE CHARGES
123	MEDICAL RECORDS

124	PREPARATION CHARGES
125	PHOTOCOPIES CHARGES
126	PATIENT IDENTIFICATION BAND / NAME TAG
127	WASHING CHARGES
128	MEDICINE BOX
129	MORTUARY CHARGES
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)
IV	**EXTERNAL DURABLE DEVICES**
131	WALKING AIDS CHARGES
132	BIPAP MACHINE
133	COMMODE
134	CPAP / CAPD EQUIPMENTS
135	INFUSION PUMP - COST
136	OXYGEN CYLINDER (for usage outside the hospital)
137	PULSEOXYMETER CHARGES
138	SPACER
139	SPIROMETER
140	SP 02 PROBE
141	NEBULIZER KIT
142	STEAM INHALER
143	ARMSLING
144	THERMOMETER
145	CERVICAL COLLAR
146	SPLINT
147	DIABETIC FOOT WEAR
148	KNEE BRACES (long / short / hinged)
149	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
150	LUMBOSACRAL BELT
151	NIMBUS BED OR WATER OR AIR BED CHARGES
152	AMBULANCE COLLAR
153	AMBULANCE EQUIPMENT
154	MICROSHIELD
155	ABDOMINAL BINDER
V	**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**
156	BETADINE / HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS, ETC.
157	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
159	SUGAR FREE TABLETS
160	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
161	DIGESTION GELS
162	ECG ELECTRODES
163	GLOVES

164	HIV KIT
165	LISTERINE / ANTISEPTIC MOUTHWASH
166	LOZENGES
167	MOUTH PAINT
168	NEBULISATION KIT
169	NOVARAPID
170	VOLINI GEL / ANALGESIC GEL
171	ZYTEE GEL
172	VACCINATION CHARGES
VI	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**
173	AHD
174	ALCOHOL SWABES
175	SCRUB SOLUTION / STERILLIUM
VII	**OTHERS**
176	VACCINE CHARGES FOR BABY
177	AESTHETIC TREATMENT / SURGERY
178	TPA CHARGES
179	VISCO BELT CHARGES
180	ANY KIT WITH NO DETAILS MENTIONED (delivery kit, orthokit, recovery kit, etc)
181	EXAMINATION GLOVES
182	KIDNEY TRAY
183	MASK
184	OUNCE GLASS
185	OUTSTATION CONSULTANT'S / SURGEON'S FEES
186	OXYGEN MASK
187	PAPER GLOVES
188	PELVIC TRACTION BELT
189	REFERAL DOCTOR'S FEES
190	ACCU CHECK (glucometry / strips)
191	PAN CAN
192	SOFNET
193	TROLLY COVER
194	UROMETER, URINE JUG
195	AMBULANCE
196	TEGADERM / VASOFIX SAFETY
197	URINE BAG
198	SOFTOVAC
199	STOCKINGS

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